April 22, 2019

George Sigounas, MS, PhD
Administrator
Health Resources and Services Administration
US Department of Health and Human Services

Re: Comments on 2018 Behavioral Health Workforce Projections

Dear Dr. Sigounas:

We, the undersigned organizations, are writing to express concern about HRSA's latest behavioral health workforce projections and to offer suggestions for future improvements in workforce estimates for behavioral health professionals caring for children, adolescents, and young adults.

Multiple sources illustrate the growing and unmistakable unmet need for behavioral health services among children, adolescents, and young adults. As many as 1 in 5 children in the US suffers from a diagnosable mental health disorder, with 50% of all lifetime cases of mental illness beginning by age 14 and 75% by age 24.[1,2] According to the 2016 National Survey of Children's Health, 49% of children under age 18 with a mental health disorder did not receive needed treatment or counseling from a mental health professional.[3] SAMHSA's 2017 National Survey on Drug Use and Health revealed that 56% of young adults, ages 18-25, with a serious mental illness reported an unmet need for mental health services in the past year.[4] Further, from 2011 to 2015, there was a 28% growth in emergency department visits for psychiatric purposes among individuals ages 6 to 24, and only 16% of these patients were seen by a mental health professional during their emergency visit.[5]

HRSA's new workforce projections predict that by 2030, there will be an oversupply of behavioral health professionals of about 100,000.[6] Just two years before releasing these projections, HRSA estimated a shortage of about 250,000 behavioral health professionals by 2025.[7] The disconcerting differences between these two reports lead many to question the reliability and usefulness of HRSA's methodology. HRSA's latest findings also raise serious concerns about the implications for current and future investments in the behavioral health workforce, which are compounded by alternative estimates that demonstrate an undersupply of behavioral health professionals. Estimates from the University of Michigan's HRSA-funded Behavioral Health Workforce Research Center indicate that 74% of the 3,135 counties in the US do not have a single child and adolescent psychiatrist, and for every 100,000 children in the US, there are only 15 child and adolescent psychiatrists.[8]

Our comments below address HRSA's methodology for modeling supply and demand and the need for developing new estimates, taking into account the complexity of projecting national behavioral health workforce supply and demand estimates as they pertain to children, adolescents, and young adults.

- There are no credible data sources nor national consensus for estimating the supply and demand of behavioral health professionals available to care for children, adolescents, and young adults. We recommend HRSA, with the national associations representing behavioral health care professionals and workforce experts, consider new methods to obtain supply and demand estimates for all behavioral health professions that offer a specialization in child and adolescent care, including psychiatry, psychology, social work, psychiatric nursing, and school counselors. The professional associations can identify the best available data sources on supply, trends affecting workforce supply and demand, and provide feedback on HRSA's findings.
- HRSA underestimates the prevalence of behavioral health conditions for children and adolescents in its projections of behavioral health workforce demand. The National Survey on Drug Use and Health, which was used in HRSA's simulation model, only includes data on youth ages 12 and older and restricts the definition of mental illness among adolescents to include only those with a major depressive episode in the past year and/or alcohol or substance abuse disorder.[4] We recommend HRSA and SAMHSA update the prevalence estimates for behavioral health conditions among children, adolescents, and young adults used in HRSA's workforce projections.

- HRSA estimated a 20% unmet need for behavioral health services.[9] Although they recognize the difficulties in calculating unmet need, noting this number to represent a "lower bound" of unmet need, we believe that this percentage grossly underestimates the unmet need for children, adolescents, and young adults. We recommend HRSA develop an updated estimate of unmet need for this population drawing on clinical and research experts.
- HRSA's recent projections of future demand are flawed because they do not account for the pervasive behavioral health shortages that already exist and the persistent inequities in utilization due to access problems. We recommend HRSA consider models that adjust for population need and socioeconomic status as well as a new utilization model. One example is the health care utilization equity analysis model used by the Association of American Medical Colleges to adjust for utilization inequities.[10] In addition, since there is no consensus on methods for determining appropriate behavioral health workforce supply estimates, we recommend HRSA consider, as a short-term strategy, using a benchmarking approach by identifying areas of the country that have the highest ratios of child and adolescent psychiatrists to child populations and working backward to determine how many child and adolescent psychiatrists would be needed for the entire country to reach that same level.

We urge HRSA to consider our concerns and suggestions for improving behavioral health workforce projections for professionals serving children, adolescents, and young adults. We caution the use of the latest HRSA findings to inform funding decisions about behavioral health workforce development programs. The limitations described above call for critical review of HRSA's methods for calculating behavioral health workforce supply and demand and for much-needed investment in the development of new and updated data sources and methods to estimate the available behavioral health workforce supply, distribution, and demand for professionals caring for children, adolescents, and young adults.

Thank you for considering our comments. We would appreciate the opportunity to meet with you to discuss these ideas further. Please contact Peggy McManus at mmcmanus@thenationalalliance.org.

National Organizations
The National Alliance to Advance Adolescent Health
Active Minds
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Art Therapy Association
American Association for Psychoanalysis in Clinical Social Work
American Association of Suicidology
American College Health Association
American Dance Therapy Association
American Group Psychotherapy Association
American Psychiatric Association
American Psychological Association
Anxiety and Depression Association of America
Association for Ambulatory Behavioral Healthcare
Children's Defense Fund
Council on Social Work Education
Depression and Bipolar Support Alliance
Eating Disorders Coalition
Family Voices
First Focus Campaign for Children
Juvenile Law Center
National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association for Children's Behavioral Health
National Association for Rural Mental Health

National Association of Anorexia Nervosa and Associated Disorders
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National Black Child Development Institute
National Federation of Families for Children's Mental Health
National Council for Behavioral Health
Psychotherapy Action Network
School-Based Health Alliance
Society for Adolescent Health and Medicine
The Trevor Project
ZERO TO THREE

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Department of Psychiatry, University of New Mexico
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Division of Child and Adolescent Psychiatry, Cincinnati Children's Hospital, University of Cincinnati (OH)
Division of Child and Adolescent Psychiatry, Cooper Medical School of Rowan University (NJ)
Division of Child and Adolescent Psychiatry, Johns Hopkins Medicine (MD)
Division of Child and Adolescent Psychiatry, Maria Fareri Children's Hospital, New York Medical College
Division of Child and Adolescent Psychiatry, MedStar Georgetown University Hospital/Georgetown University School of Medicine (DC)
Division of Child and Adolescent Psychiatry, Robert Wood Johnson Medical School, Rutgers University (NJ)
Division of Child and Adolescent Psychiatry, Stony Brook University (NY)
Division of Child and Adolescent Psychiatry, Tufts Medical Center (MA)
Division of Child and Adolescent Psychiatry, University of Massachusetts Medical School
Division of Child and Adolescent Psychiatry, University of Michigan
Division of Child and Adolescent Psychiatry, University of Texas Medical Branch at Galveston
Division of Child and Adolescent Psychiatry, Virginia Commonwealth University
Division of Child Psychiatry, Weill Cornell Medicine (NY)
Institute for Juvenile Research, Division of Child and Adolescent Psychiatry, University of Illinois at Chicago
Leadership Education in Adolescent Health (LEAH) Programs at:
- Boston Children's Hospital
- Children's Hospital Los Angeles
- Children's Hospital of Philadelphia
- University of Alabama at Birmingham
- University of California, San Francisco
- University of Minnesota
- University of Washington

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