



Children's Mental Health Plan Workforce Workgroup

Draft Report of Workgroup Proceedings

December 17, 2007 – April 15, 2008

Division of Children and Families
Office of Planning
New York State Office of Mental Health

The ideas and recommendations expressed in this draft report reflect those of the individuals participating in the workgroup and not necessarily those of New York State agencies serving children and families. The mention of specific interventions or service models does not imply endorsement by these agencies.

The Office of Mental Health would like to extend its gratitude to each workgroup member and all who contributed to the development of this report.

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I. Vision, Values and Framework

Vision

We envision a mental health workforce in New York State that is able to ensure access to effective services that meet the needs of children and youth and leads to their mental wellness, recovery, stability and academic success. New York will maintain a well-qualified, culturally competent mental health workforce that is distributed geographically throughout the State proportional to the needs of the population, and support that workforce with career ladder opportunities. Such a workforce is essential to accomplishing the goal of creating a seamless system of care for children and families regardless of where they live in New York State. Leaders in New York State will establish and define core competencies necessary to successfully care for, support and treat children and adolescents and their families, whether care is provided through the mental health care or other child-caring systems.

The State Office of Mental Health (OMH), in collaboration with the counties and local providers, will develop an accountability mechanism to monitor the progress made toward achieving the mental health workforce recommendations outlined in this plan. This accountability process will result in an annual report to the OMH Commissioner.

Values

The workforce in New York State should be capable of promoting each child's mental health and well-being within the context of the following organizing values:¹

- **Person-centered and youth-guided**
The workforce takes into consideration each child's family and community contexts and is able to provide developmentally appropriate services and supports specific to each child's needs. These services and supports should reflect the influences of culture and language, and rely upon youth-guided, family-driven, and strengths-based approaches.
- **Family-driven**
Services and supports should take into account that the family is the primary

¹ Adapted from the Child and Adolescent Service System Program values. Pires S. *Building systems of care: A primer*. Washington, DC: National Technical Assistance Center, George Washington University Center for Children's Mental Health. Available online at http://gucchd.georgetown.edu/files/products_publications/TACenter/PRIMER_Part1.pdf; and the values of the Substance Abuse and Mental Health Administration *Family guide to systems of care for children with mental health needs*, which is available online at <http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0029/default.asp>

support system. Families may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child.

- ***Strengths-based***

Services and supports should advance a philosophy that promotes individual and family strengths as the basis of all service support and treatment planning.

- ***Community-based***

Services and supports should extend to each child's community and draw upon informal and formal resources, including an adequately prepared workforce, to promote each child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

- ***Multi-systemic***

Services and supports should be collaborative among systems that serve children and take place within a cultural, linguistic, social and emotional context. Representatives from these systems and families should be well trained to work together to promote each child's health and well-being.

- ***Indicative of culture and linguistic competence***

Culture determines our world view and provides a general design for living and patterns reflected in our behavior. Therefore, services and supports should take into consideration respect for, an understanding of, and responsiveness to the behaviors, ideas, attitudes, values, beliefs, customs, heritage, languages, rituals, ceremonies and practices characteristic of particular groups of people. Workforce training and education should convey the understanding that culture and language shape how children and youth learn about themselves, how they interact and relate to others, and how they view authority figures.

- ***Promoted widely***

Deliberate, thoughtful, integrated and shared approaches should be taken to promote and enhance children's well-being within the context of workforce development.

Framework

Developing, recruiting and retaining a qualified, competent workforce depend upon a set of essential characteristics including:

- Strong and consistent leadership
- Quality assurance and accountability
- Supportive organizational environment
- Safe and suitable working conditions

- Manageable workloads
- Equitable employment incentives
- Meaningful supervision and mentoring
- Authentic cultural and linguistic competence
- Quality comprehensive education and professional preparation
- Employment career ladders
- Competency-based training and professional development
- Significant cross-system community connectedness
- Timely and accurate data
- Strong family and community partnerships
- Practice-enhancing research and evaluation

Despite recent advances in mental health services in New York State, the existing workforce dedicated specifically to children’s mental health is limited in that it leaves the needs of too many children and adolescents unfulfilled. This disparity is created by the following:

- A lack of access to mental health care caused by factors including a shortage of child and adolescent psychiatrists; a geographic mal-distribution of mental health professionals; a lack of integration between mental health and primary care; and limited access to and use of psychiatric nurse practitioners
- An overwhelmingly White mental health workforce, with minorities generally under-represented across disciplines; and a lack of diversity that fails to reflect the communities being served and contributes to disparities in mental health services experienced by racial and ethnic minorities
- Inconsistent use of the expertise of paraprofessionals and specialists throughout the system
- Limited access to peer specialists, including parent advocates and youth advocates
- Sparse lateral and/or ascending professional options
- Systemic compromises regarding services in the home, school, and residential settings that have yet to be addressed
- Lack of adequate attention to cultural and linguistic competence
- A need for clearly defined core competencies necessary to successfully screen, assess, intervene, support and treat children and adolescents and their families

- An aging and mal-distributed licensed workforce that has inadequate numbers of young entrants skilled in working in particular with rural and minority populations
- Direct client care workers in all sectors who lack access to career paths

The recommendations that follow are presented to increase access for children and families throughout New York State, as well as the professionals dedicated to serving them. The recommendations cover five overarching goals: (1) continually meet current and future needs, with built-in feedback, (2) improve recruitment and retention, (3) broaden the workforce, (4) ensure the existence and attainment of core competencies, and (5) improve cultural considerations. The strategies to achieve these goals address geographic disparities, career ladders, and adequate psychiatrists throughout the State; increases in our State's capacity for public mental health services; and an examination of the types of services children and youth require for comprehensive health and success. A glossary of terms used in this report is included in Appendix 1.

II. RECOMMENDATIONS

Goal 1: Continually Meet Ongoing Workforce Needs, with Built-in Feedback

Recommendation 1.1

Support and establish an OMH Office of Workforce Development, Recruitment and Retention to improve workforce development practices; strengthen and maintain a specific focus on workforce issues, particularly those that impact children, adolescents, and young adults; utilize data to inform decision making; oversee a workforce advisory function; and provide policy leadership with the executive, legislative, and judicial branches on mental health workforce issues.

Rationale

In 2006, the Institute of Medicine (IOM) concluded that an ongoing, priority commitment of attention and resources is needed to address complex problems in the mental health workforce in the areas of knowledge and skills, cultural diversity and understanding, geographic distribution, and adequate numbers to ensure access to and quality of needed mental health services.² Recruiting and retaining individuals in the behavioral health workforce is of grave concern and a major problem for local provider organizations and State behavioral health systems. Qualified providers are not available in sufficient numbers for selected populations, including children and adolescents. In 2007, OMH concluded that the crisis in professional recruitment and retention now threatens access to and quality of care

² Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: The National Academies Press. p. 286.

throughout OMH and community mental health agencies, and recommended that the agency establish an Office of Professional Recruitment and Retention.³

New York State's mental health workforce is the principal "infrastructure" through which access to care is provided and effectiveness of care is assured. Multiple and compelling problems regarding this workforce have been identified, which span issues of workforce composition, recruitment, retention, training, education, and the sustained adoption of newly learned skills and best practices. Given the serious impact these problems present regarding access to and quality of needed mental health services, a concerted agenda is required to systematically address them. There is presently no structure in New York State for sustained and coordinated planning around mental health workforce issues.

Strategies

- Ensure that a structure and process exist to provide a broad, ongoing response to the many mental health workforce issues in the State that call for attention by:
 - Leveraging improvement in workforce development practices through existing funding and employment mechanisms
 - Implementing interventions to strengthen the workforce
 - Maintaining a specific focus on workforce issues impacting children, adolescents, and young adults
 - Utilizing results from the proposed OMH mental health workforce survey (described in Recommendation 2.1) to inform and support the Office's functions and responsibilities and, specifically, workforce issues impacting children, adolescents, and young adults
 - Informing the work of the Commissioners on Cross-Systems Youth
 - Disseminating best practices in workforce recruitment, retention and development to employers of the mental health workforce
 - Overseeing a Children and Youth Workforce Advisory Committee (described below)
 - Advising the New York State executive, legislative, and judicial branches on mental health workforce issues, licensure and policy
- Support and establish a Child and Youth Workforce Advisory Committee within OMH as a permanent body charged with planning, coordinating, and promoting interventions to strengthen the workforce.
 - Have diverse membership from across the child-serving systems of care (e.g., child welfare, education, juvenile justice, developmental disabilities, substance use), Civil Service and Office of the Professions participation, and provider, advocate, and active family and youth membership.

³ Sederer L, Kealey E, & Runnels P. (October 2007). *An OMH assessment of clinical care, professional workforce, research, and local government opportunities*. Albany, New York: New York State Office of Mental Health. pp. 29-31.

- Address workforce issues related to the needs of specific populations, including infants, toddlers, preschoolers, school-age children, youth, and young adults.

Recruitment and Retention

- Track the magnitude and characteristics of recruitment and retention problems.
- Identify best practices in workforce recruitment, retention and development.
- Explore using professional staff on the retiring end of the workforce spectrum as mentors to new employees.
- Increase recruitment through an informational campaign that highlights career and job opportunities in behavioral health.
- Promote cultural diversity and the employment of persons receiving services and family members in the mental health workforce.

Collaboration with the State Educational System

- Research the capacity of the State's educational system to train professionals and paraprofessionals for work within the mental health system.
- Promote and encourage training in evidence-based practices.
- Link New York's mental health and higher education systems in a coordinated effort to ensure development of a pipeline of culturally diverse and appropriately trained mental health providers sufficient in numbers to meet existing and future workforce needs.

Strategic Planning

- With stakeholders, conduct strategic workforce assessment, planning, implementation, monitoring and reporting.
- Work with the behavioral health, higher education, and licensing systems to improve career ladders.

Recommendation 1.2

Adopt the recommendations of the National Technical Assistance Center for Children's Mental Health to improve the mental health care of children and families.⁴

Rationale

Mental health transformation requires workforce transformation. Transforming systems to meet the needs of children, youth and families requires a workforce that understands the values and principles of a system of care and has leaders who can lead this change process. As states and communities are working to implement

⁴ National Technical Assistance Center for Children's Mental Health. (February 2005). *Transforming the workforce in children's mental health*. (Issue Brief). Washington, DC: National Technical Assistance Center for Children's Mental Health. This brief is based on: Huang L, Macbeth G, Dodge J, & Jacobstein D. Transforming the workforce in children's mental health. *Administration and Policy in Mental Health*, 32(2), 167-187, November 2004. It presents earlier work of the Annapolis Coalition.

comprehensive, coordinated services and supports for children with or at risk for mental health problems and their families, the issue of leadership and a well-trained human service delivery workforce becomes increasingly more critical to ensure high quality outcomes for children, youth and their families. The recommendations of the Technical Assistance Center for Children's Mental Health are offered as essential next steps toward achieving these transformation goals.

Strategies

- State human service agencies can:
 - Adopt cross-agency workforce development plans with consistent competencies.
 - Create strong bridges between mental health and other child-serving systems (e.g., child welfare, education, juvenile justice, developmental disabilities, substance use) and practitioners.
 - Develop stakeholder consensus around core competencies for direct care.
 - Standardize curricula across agency systems and in multiple practice areas.
 - Engage diverse parents, caregivers and youth as competency instructors.
 - Utilize tele-health and web-based learning strategies, especially in rural areas.
 - Promote scholarship and internship opportunities to address professional shortages in the public sector.
 - Offer university and community college loan and loan repayment programs for the public sector service.
 - Work with historically Black colleges and universities and minority representatives of professional organizations to recruit, prepare and support students for public sector service.
 - Promote paraprofessional training in needed service technologies and effective interventions.
 - Implement marketing strategies to interest high school students in public service.
 - Build strong links to federally funded Comprehensive Community System of Care grant sites to expand knowledge about effective approaches.
- Community provider agencies can:
 - Develop curricula to train personnel in key Systems of Care services and supports.
 - Develop ongoing paraprofessional training programs.
 - Offer staff a range of incentives for personnel growth and training in competencies needed for cross-agency collaboration and new ways of working with families.
 - Offer incentives for practice in areas with underserved populations.
- Universities and community colleges can:

- Design and promote pre-service education that is aligned with competencies needed in the public sector to provide new service delivery models and approaches.
 - Promote and expand cross-disciplinary training in the treatment of co-occurring mental health problems.
 - Recruit and support students from diverse racial, ethnic and cultural backgrounds.
- Professional associations and organizations can:
 - Promote cutting-edge service delivery models.
 - Refine accreditation and credentialing standards to support cross-disciplinary competencies.
 - Advocate for public-sector workforce improvements in recruiting, retaining, training and remunerating at the federal and State levels.
- Family and youth advocates and advocacy organizations can:
 - Promote the involvement of diverse caregivers in all agency systems planning and implementation activities.
 - Develop partnerships with universities and colleges to develop and co-teach courses.
 - Educate legislators in human service workforce issues and advocate for solutions.
- Individual citizens can:
 - Explore training and educational opportunities to work in child-serving agencies.
 - Request ongoing training from child-serving agencies and organizations.

Goal 2: Improve Recruitment and Retention

Recommendation 2.1

Address issues related to mental health workforce recruitment and retention through careful analysis of the current workforce and emerging workforce needs, career opportunities, fair and adequate compensation and benefits, adequate training, and attention to opportunities for cross-systems workforce collaborations.

Rationale

While available data describe an aging and mal-distributed licensed mental health workforce in New York State, data are lacking to describe mental health workers specializing in children and adolescent mental health/psychiatric care; nurses specializing in mental health/psychiatric care; and unlicensed professionals who

provide critical services in the New York State mental health system. Moreover, data are not available to assess the State's mental health workforce by race/ethnicity and language skills compared to target populations receiving mental health services; implications of recent social work license changes on the future mental health workforce;⁵ and mental health workforce recruitment, retention and development needs on the local and State levels. Such data are critical as the State moves forward in developing adequate recommendations for the legislatively mandated Children's Mental Health Plan. Their availability would permit a more accurate assessment of what is needed to build a culturally competent, qualified and adequately trained mental health workforce in New York State.

Furthermore, it is well acknowledged that recruiting and retaining individuals in the behavioral health workforce is of grave concern and a major problem for local provider organizations and State behavioral health systems. Qualified providers are not available in sufficient numbers for selected populations, including children and adolescents. In 2007, OMH concluded that the crisis in professional recruitment and retention now threatens access to and quality of care throughout OMH and in community-based mental health agencies.⁶

Of particular concern in the recruitment and retention crisis are compensation differences among identically credentialed professionals working in the not-for-profit, local and State sectors, and their impact on not-for-profit community-based mental health agencies. MSWs working for State agencies, public school districts and hospitals, for example, typically earn substantially more than MSWs working for community-based not-for-profit agencies. These earning differentials are considered among the more important factors affecting the ability of community-based not-for-profit providers to both recruit and retain qualified employees. The overall shortage of qualified providers for children and adolescents makes the recruitment and retention crisis even more severe for the community-based providers serving these populations. In addition, the differential in earnings across sectors is exacerbated with respect to retention of direct care staff by the absence in the not-for-profit sector of elongated career ladders that are at the heart of State, county, and school district compensation systems.

⁵ In 2004, legislation was enacted to establish the professions of licensed master social worker (LMSW) and licensed clinical social worker (LCSW) and distinctly different education, examination and experience requirements for licensure. The on-going implementation of these changes make it necessary to clarify the role of the LMSW and the LCSW in providing services to children with serious mental illness. The creation of four new mental health professions (mental health counselors, marriage and family therapists, creative arts therapists and psychoanalysts) must be incorporated into the planning for workforce recruitment, training and retention. Until January 1, 2010, individuals in programs operated, approved or funded by OMH, OCFS, OMRDD, and OASAS—hundreds of non-profit community-based programs that deliver clinic and treatment services to children and their families every day—are exempt. The State Education Department, OMH and Civil Service should collaborate with interested parties to clarify the duties of direct care staff, consistent with the practice of the professions defined in statute.

⁶ Sederer, L., Kealey, E., & Runnels, P. (October 2007). *An OMH assessment of clinical care, professional workforce, research, and local government opportunities*. Albany, New York: New York State Office of Mental Health. pp. 29-31.

These issues are critically important in our efforts to strengthen the community-based system of mental health care for children, adolescents and young adults and thereby improve outcomes. The 2005 OMH Patient Characteristics Survey data show that overall, 66% of the services provided to this population are outpatient and 21% are community support non-residential. More information about the variables impacting recruitment and retention in community-based not-for-profit agencies is critical to identifying strategies to support and sustain the community-based system of care.

The proposed survey of the existing mental health workforce described below must be supplemented by a review of the professionals' tasks that are performed and/or required and the licensed professionals who can perform these tasks independently or under supervision. Changes in the Education Law have opened the door for new professions that are authorized and/or licensed to provide mental health services and that affect the current and future mental health workforce. It is imperative that Civil Service and State agencies, including OMH, collaborate to amend and/or create titles that reflect the qualifications and practice of the professions. A system-wide approach can address concerns about differentials in job duties and reimbursement rates for similarly qualified licensed professionals across the child-caring systems (e.g., OMH, OCFS, OASAS, SED). In creating the job duties and descriptions, there must be consideration of reimbursement policies to ensure funding for services provided by comparable professionals.

Finally, training opportunities for staff are often focused on skill levels needed by staff employed in a single system, and do not address cross-system needs of individuals receiving treatment. While many of the children and adolescents being served have co-morbid conditions, the systems of care across various agencies are not well integrated and training across workforces does not currently exist.

Strategies

- Conduct a statewide survey of mental health providers to include assessments of:
 - Workforce size, occupational composition, race/ethnicity, and language proficiency
 - Workload standards that will define additional workforce needed to meet current estimated public mental health needs for each category of employees (i.e. the number of professionals or paraprofessionals per 100,000 population)
 - Additional workforce needed to be proficient in various non-English languages to meet current needs
 - Vacancy rates and recruitment (including emerging professions) and retention needs and barriers

- Effects of the social work licensure law on the availability and vacancy rates of LCSWs, which form the backbone of the mental health workforce
 - Specifically designated positions for individuals with recipient and/or family member experience in the mental health system
 - Job functions and staff numbers that are continuous across sectors (State, county, not for profit)
 - Paraprofessional and nontraditional functions (including graduate level prepared) and how they fit into a system of care
 - Primary care physician competencies in the identification, assessment and treatment of the most commonly occurring mental health problems (e.g. depression, anxiety, disruptive disorders)
 - Current needs and projected need 10 years from now
- Establish career ladders for mental health system professional, clinical, supervisory, and direct care employees, and/or supports for their professional growth.
 - Establish protocols for training and promotional opportunities within the mental health care system. Consider opportunities for professional development of paraprofessional direct care workers, including credentialing and licensing, to improve retention and quality of service.
 - Provide new or enhanced skill development opportunities for staff to allow the acquisition of the skills and/or credentials to advance.
 - Implement specific protocols for recruiting and hiring individuals with recipient/family member experience into the workforce.
 - Use data from the proposed statewide survey to make recommendations to providers regarding the role of paraprofessional and nontraditional positions in the system of care.
- Offer more competitive compensation packages for mental health staff in the public and not-for-profit sectors that perform similar scopes of work.
 - Seek a permanent cost-of-living increase in the mental health budget that must be passed on to provider staff in community-based programs.
 - Convene a workgroup to review benefit packages available to employees in the not-for-profit sector, and make recommendations for funding more adequate packages through the State mental health budget.
- Provide staff with access to adequate staff training and rejuvenation activities designed to reduce “burnout” and increase skill levels, job satisfaction, and team work.
 - Continuously offer free training curricula to providers for all staff levels. Providers and employees will have access to technology to improve availability of training opportunities.

- Encourage providers to use recognition activities such as bonuses, awards, choice of work assignments, paid time off, and promotional opportunities to reinforce positive performance from employees.
 - Consider developing regional “academies” to produce paraprofessional direct care staff in ways similar to police academies generating new law enforcement professionals and/or community colleges producing new professionals in a variety of hands-on fields.
 - Ensure supervision to direct care and supervisory staffs addresses the need for self-care and support around secondary trauma due to ongoing exposure to hearing about traumatic circumstances in the children and youth served.
 - Study aspects of direct care work that might be reasonably considered as unpleasant or stressful, and address them directly with altered work conditions, training, and personal support to staff.
- With leadership from OMH, create and provide training for workforces providing mental health and related services across multiple systems serving children, youth, and their families, including the State Office of Children and Family Services (OCFS), Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Alcohol and Substance Abuse Services (OASAS), State Education Department (SED) and the Department of Health (DOH).
 - Ensure that cross-systems training reflects shared knowledge, skills, abilities and values through the implementation of joint agency training academies.
 - Provide training in recognizing signs, symptoms, and characteristics of co-morbid conditions that are present in the populations being served.
 - Provide training in referral processes so children, youth and families are able to readily access services across systems.
 - Provide certification for levels of staff, ranging from direct care and support to clinical and managerial staff, who are to provide integrated network services.
 - Expand promotional opportunities for staff working across systems of care.
- With leadership from OMH, collaborate with the provider community to develop a plan for shared recruitment and retention activities.
 - Develop a statewide recruitment web portal on the OMH website to advertise all vacant positions within the public and not-for-profit mental health field.
 - Develop a marketing strategy to encourage individuals to become members of the mental health workforce.
 - Serve as the patron of mental health throughout the State, less the proprietor of its own business, and lead the structuring of positions

according to a consistent compensation schedule, regardless of the auspice of the position.

- Partner with the SUNY/CUNY system to provide educational opportunities for the mental health workforce to earn higher education credits while employed and improve opportunities for advancement within the mental health system in return for a commitment to serve a specified period in underserved areas or positions.

Goal 3: Broaden the Workforce

Recommendation 3.1

Secure access to psychiatric services for all children throughout the State, regardless of geographic location and with attention to underserved areas, by (1) increasing the number of child and adolescent psychiatrists; (2) creating opportunities for child and adolescent psychiatrists to serve as consultants to teams of mental health, primary care, and other practitioners and workers; and (3) expanding child psychiatric services through the use of child and adolescent psychiatric nurse practitioners and advanced practice nurses.

Rationale

The recent National Institute of Mental Health Study (National Co-Morbidity Survey-R) examined the prevalence of emotional and behavioral disturbances across age groups and concluded that half have onset before age 14, and 75% begin by age 24. These findings identify emotional and behavioral disturbances as chronic conditions of youth. Treatment for these emotional and behavioral issues is often delayed, with as long as a decade between first symptoms and initiation of treatment.

According to the New York State Conference of Local Mental Hygiene Directors, “There are currently less than 900 child and adolescent psychiatrists in New York State and almost half of the counties in the state have none. The problem is particularly acute in rural areas In addition, an estimated 1,000 children leave the state each year to seek treatment outside of the state.”⁷

Untreated emotional and behavioral disturbances in childhood contribute to a greater psychiatric co-morbidity and compromised quality of life. The demand for child/adolescent psychiatric providers is increasing across the nation, yet the

⁷ New York State Conference of Local Mental Hygiene Directors STEPS Committee Solutions to End Psychiatric Shortages Campaign Announcement, 2007.

numbers of individuals entering careers in psychiatry are insufficient to meet this growing need.⁸

The need to increase child and adolescent psychiatrists

Child and adolescent psychiatry is the only board-certified medical specialty that trains physicians to treat serious emotional and behavioral disturbances of children and adolescents. The shortage of child and adolescent psychiatrists is a cause for concern nationally and in New York State. According to the American Academy of Child and Adolescent Psychiatry, there were approximately 7,000 child and adolescent psychiatrists in the United States in 2006, and only 300 child and adolescent psychiatrists complete training each year. In 2000, the Bureau of Health Professions at HRSA projected that between 1995 and 2020, the use of child and adolescent psychiatrists will increase by 100%, with general psychiatry's increase at 19%.

In 2006, there were 898 child and adolescent psychiatrists in the State of New York, 47% of whom were located in New York City, 23% in the Hudson River region, 18% in Long Island, 8% in the Western region and 5% in the Central region.⁹ These and other data (see Appendix 2) indicate a serious mal-distribution of child psychiatric services in New York State, with children in the more rural Central and Western areas having significantly reduced access. While 10% of the State's population ages 19 years and younger lives in the Central region, only 5% (n=42) of all child and adolescent psychiatrists practice there. The Western region has 15% of the population ages 19 years and younger, but only 8% of child and adolescent psychiatrists statewide (n=68). In contrast, 47% of child and adolescent psychiatrists in the State practice in New York City, where 42% of the population ages 19 years and under lives; 23% practice in the Hudson River region where 17% of the population lives; and 18% practice in Long Island where 14% of the population lives.

The supply ratio (number per 100,000 population) of child and adolescent psychiatrists in both the Central and Western regions is 2, the lowest in the State (see Appendix 2). In comparison, the Hudson River and Long Island regions have the highest supply ratios in the State with 6 child and adolescent psychiatrists per 100,000 population. New York City is second highest with a supply ratio of 5. Irrespective of access based on population ratios, an unanswered question is access to child and adolescent psychiatrists based on ability to pay.

⁸ The Annapolis Coalition on the Behavioral Health Workforce. (2007). An action plan for behavioral workforce development: A framework for discussion [Executive Summary]. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at <http://www.samhsa.gov/Workforce/Annapolis/ExecSummaryWorkforceActionPlan.pdf>

⁹ See Table 5 in Appendix 1 for a description of the New York State counties included in each of these OMH regions.

The need to create opportunities for child and adolescent psychiatrists to serve as consultants to teams of mental health, primary care, and other practitioners and workers

Primary care providers and educational staff are the first line of defense in determining the need for more specialized mental health services among children and youth. Comprehensive models of care in primary care settings that link identification of mental health problems to evidence-based treatments have been shown to improve outcomes in children. Expanding the system's capacity for early identification needs to include primary care settings. In addition, care coordination with the inclusion of a child's primary care physician is essential to improving long-term outcomes for children and adolescents.

The medical home model which is defined as care that is accessible, family-centered, continuous, coordinated, compassionate, culturally effective and comprehensive provides the most logical prospect for obtaining quality mental health services for all children (ages 0–21 and beyond) throughout their childhood, across the full spectrum of disease presentation and across the various systems that serve children, youth and families. This model includes and often relies upon primary care settings such as private practice, hospital-based practices, school-based health centers and community health centers. Integration of mental health services in the medical home is consistent with the President's New Freedom Commission overall goals, and specifically, goal 4 of "early mental health screening, assessment, and referral to services are common practice." Achieving this goal will need to involve the primary health care systems.

The evolution of co-located models where mental health specialists (e.g., licensed social workers, psychologists, and child and adolescent psychiatrists) reside within primary care practices also offer venues for effective engagement of families in services and improved identification and linkage to needed services. OMH has begun to offer child psychiatric services via telemedicine. The uptake of use of child psychiatric services via telemedicine, however, has been slow. One of the barriers cited is the lack of time as the time spent in coordinating this service and consulting with the psychiatrist is not reimbursable.

Many children in need of psychiatric treatment are still without services in many areas of New York State. In addition, care coordination and comprehensive services and supports require clinical components to ensure effectiveness. While there are not enough child and adolescent psychiatrists to function as case coordinators, prevention specialists, and expert psycho-pharmacologists for every child, utilizing the psychiatric workforce as consultants in these areas can maximize scarce resources. As recommended by the New Freedom Commission, the State should be working with primary care providers to prevent serious and emotional problems through a comprehensive team approach.

The need to expand child psychiatric services through the use of child and adolescent psychiatric nurse practitioners and advanced practice nurses

In New York State, psychiatric mental health nurse practitioners are licensed by the State Education Department Office of the Professions and practice in an expanded specialty nursing role in the field of psychiatry. They are educationally prepared at a master's, post-master or doctoral levels. Many psychiatric mental health nurse practitioners seek national certification through the American Nurses Credentialing Center.¹⁰ National certification examinations are available for adult psychiatric nurse practitioners, family psychiatric mental health nurse practitioners, and clinical specialists in adult and child/adolescent psychiatric mental health nursing.

Psychiatric nurse practitioners can provide a broad range of mental health services, including psychiatric assessment and diagnosis, treatment planning and referral, implementation of psychotherapeutic modalities (individual, group and family therapy), medication management (initiating psychotropic medications and monitoring efficacy of this intervention) patient and family health education, promotion and illness prevention, and consultation. Their scopes of prescriptive authority and requirements for collaborative agreements with psychiatrists are governed under the Nurse Practice Act,¹¹ which specifies that nurse practitioners establish collaborative practice agreements with physicians. Nurse practitioners practice independently within these agreements and do not require physician co-signatures for orders, prescriptions or progress notes.

Psychiatric mental health nurse practitioners are trained to and function well in interdisciplinary teams and often work in partnerships with psychiatrists, expanding the number of children, youth and families that can be served. Additionally, psychiatric nurse practitioners work effectively in consultation roles with primary care providers to promote mental health services within pediatric settings. These activities include support of mental health promotion, provision of education to pediatricians and nurses to promote early assessment of emotional and behavioral problems in primary care, as well as collaborative practice models that offer children, youth and families direct access to mental health care.

Given there are growing numbers of children and adolescents who need specialized mental health services and the shortage of child/adolescent psychiatric providers has also been experienced in New York State, utilizing psychiatric nurse practitioners is critical to enhancing and solidifying psychiatric services for New York State youngsters. However, this understanding must be viewed within the context of the growing nursing shortage in the health care workplace. In addition, given there are 35 applicants for each seat in bachelor-level nursing programs, there is also a

¹⁰ See <http://www.nursecredentialing.org/>

¹¹ Article 139, Sections 6900-6910 of the New York State Education Law.

need to ensure an adequate supply of well-prepared faculty to meet the growing demand for specialized nursing training.

Strategies

Strategies to increase child and adolescent psychiatrists

- Offer to pay for medical school for those students who commit to becoming child and adolescent psychiatrists and serving in New York State's underserved areas and/or public service.
- Work with hospital training programs in New York State to increase the number of child and adolescent psychiatric resident training slots in exchange for a commitment from those residents to practice in New York State (thereby increasing the number of child and adolescent psychiatrists).
- Offer educational loan repayment to child and adolescent psychiatrists who commit to serving in New York State's underserved areas and/or public service, thereby redistributing the scarce supply of these psychiatrists to areas of greatest need.
- Work with primary care training programs (pediatrics, family medicine, and nursing) in New York State to increase training in child and adolescent psychiatry.
- Offer financial incentives to child and adolescent psychiatrists in the private sector to work in New York State's underserved areas and/or public service, thereby redistributing the scarce supply of these psychiatrists to areas of greatest need.
- Work to improve the team coverage of children and youth in the mental health system with case managers, nurse practitioners, parent advocates, psychologists and others, freeing up the child and adolescent psychiatrists to perform the unique roles for which they have been trained.
- Structure payment rates to provide effective access to evaluation, diagnosis and treatment.
- Address reimbursement barriers that impact the ability to grow system capacity.
- Pay for time spent consulting for/with child and adolescent psychiatrists and other mental health workforce members, whether via the web, telemedicine, phone, or in person.

Strategies to create opportunities for child and adolescent psychiatrists to serve as consultants to teams of mental health, primary care, and other practitioners and workers

- Increase the development of services for youth with co-occurring substance abuse and mental health problems and have child and adolescent psychiatrists serve as consultants.
- Improve training of child and adolescent psychiatrists to serve as consultants to other fields by working with training programs within New York State and embedding such training in the mental health community.
- Pay for time spent consulting to screening programs established in schools, primary care, juvenile justice, and other agencies.
- Establish a mechanism for child and adolescent psychiatrists to be available by phone and web for such consultations.
- Assess current salaries within OMH and make them competitive with other public and private entities.
- Consult with primary care physicians, pediatric organizations and State primary care leaders to determine what supports would be necessary to expand primary care involvement in mental health screening processes.
- Provide training to providers to promote screening of all children ages 0 to 5 for social and emotional development as part of routine primary health care visits.
- Provide training to providers to screen high-risk adolescents for depression and substance abuse in primary care settings, schools, and mental health settings.
- Provide training to providers to screen children and adolescents for adverse childhood events in primary care settings.
- Provide training in mental health screening to providers in community mental health centers and other primary care settings with high risk populations or where the prevalence of the mental health problems merits or in the absence of clear data on prevalence.
- Ensure training for providers of services to high-risk children and youth known by primary care, day care, head start and teachers to be involved in settings with high prevalence (juvenile justice and child welfare systems) and link them to services.
- Analyze existing tools for screening and identifying mental health problems and support research to develop new tools where needed, including those needed for the increasing populations of children with dual diagnosis and/or other multi-systemic needs, as well as dissemination of this knowledge.
- Incorporate developmentally and culturally appropriate behavioral health screening into Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screens and provide training to providers.

- Address barriers to coverage of preventive and intervention services in health insurance (same as New Freedom Commission).
- Provide reimbursement for primary care physicians' participation in telemedicine and other health processes associated with mental health screening and service delivery.
- Evaluate current psychiatric vacancies and assess whether these could be converted for psychiatric nurse practitioner practice.
- Evaluate and revise current OMH regulations to allow for full scope of advanced practice psychiatric nurses/child and adolescent psychiatric nurse practitioner practice.
- Consider use of waivers for current OMH regulations to facilitate inclusion of advanced practice psychiatric nurses/child and adolescent psychiatric nurse practitioners.
- Consider developing group practice models with OMH psychiatrists and child and adolescent psychiatric nurse practitioners.
- Expand telemedicine consultation opportunities to include the use of psychiatric nurse practitioners.
- Create loan forgiveness programs to encourage psychiatric nurse practitioners to serve in underserved areas.
- Work with the State Education Department to increase the capacity of current professional educational programs.
- Create funded opportunities for continued training in child and adolescent mental health care as well as participation in translational research activities/clinical performance improvement projects.
- Evaluate and consider enhancement of current incentives provided for education.

Strategies to expand child psychiatric services through the use of child and adolescent psychiatric nurse practitioners and advanced practice nurses

- Promote the hiring of bachelor-level nurses into OMH facilities who could transition into graduate education programs and obtain advanced psychiatric nursing practice credential.
- Promote partnerships between OMH and higher education institutions that provide specific course work in child and adolescent psychiatry. Consider programs that offer online options facilitating access to those in rural areas where the need for service is great. Education and clinical training in this manner offers nurses the opportunity to remain in their home communities for

- Identify OMH child and adolescent facilities (inpatient and outpatient) that may serve as clinical training opportunities for child and adolescent nurse practitioner students. These internships may serve as a training experience for later employment in that facility.
- Examine reimbursement barriers for nurse practitioners and other mental health professionals.

Recommendation 3.2

Increase the number of primary care professionals (e.g., pediatricians, family medicine physicians, developmental specialists, nurse practitioners) with the capacity to identify and treat children and youth with the most common mental health problems. Help to strengthen their mental health screening and treatment competencies and enhance their ability to coordinate community mental health services and supports with local systems serving children, youth and their families (e.g., OMH, SED, OCFS, OMRDD).

Rationale

A growing body of evidence alludes to an alarming prevalence of diagnosable mental health problems in children 9–17 years of age. These include anxiety disorders (13.0%), mood disorders (6.2%), disruptive disorders (10.3%), substance use disorders (2%) and any disorder (20.9%)—the latter being slightly lower for younger children. In New York State, there are an estimated 1 million children with diagnosable mental health conditions, half of whom (500,000) have serious emotional problems.

The current estimates of child and adolescent psychiatrists per youth population indicate that there is lack of capacity in the current mental health system to provide mental health services to children in need of such services. As noted previously, there is a serious shortage of child psychiatric services in New York State. Overall, 24 of the State's 57 counties (not including New York City) have no child and adolescent psychiatrists. Statewide, 368,198 individuals ages 19 or younger live in a county with no child and adolescent psychiatrist. Forty-nine percent (n=178,864) are in the Western region, 32% are in the Central region (n=118,696), and 19% are in the Hudson River region (70,638).

Improving this picture will necessitate implementing innovative models of care that include expanding the role of primary care specialists to include identifying, assessing and treating children and youth with diagnosable mental health conditions. However, while numerous studies have also indicated that families would welcome this, primary care clinicians report a lack of knowledge and skills in

providing quality services. Training of these professionals is essential to improving access to timely and quality mental health services for children and youth. Including this body of knowledge in medical school study and experience is also crucial to ensuring future system capacity.

Community-based care is further challenged by a “silo” system approach, whereby child-serving entities tend to operate in ways that limit the effectiveness of treatment because of structural, regulatory and financial barriers. Our experience with our Substance Abuse and Mental Health Services Administration (SAMSHA) System of Care sites, Coordinated Children’s Services Initiative, and efforts related to out-of-state placements tells us that many of today’s children and youth with emotional problems are involved with more than one specialized service system, including mental health, special education, child welfare, juvenile justice, substance abuse, and health. Because no one agency or system is clearly responsible or accountable for these children and youth, the role of care coordination and primary care is critical.

Strategies

- Make training the primary care workforce to improve knowledge, skills and attitudes regarding the integration of mental health services in primary care a State priority and support it through adequate funding for services such as consultative models, telemedicine, and face-to-face training.
- Review curriculum guidelines and regulations to ensure that basic psychiatry training and clinical experiences are integrated in general education experience for physicians.
- Create loan forgiveness programs to encourage clinicians to serve in underserved areas and to continue fellowship programs that focus on child and adolescent mental health services research.
- Create loan forgiveness and other incentives to encourage minority and bilingual physicians to practice in underserved areas with a focus on children’s mental health.
- Use this comprehensive document to develop and implement a strategic plan designed to develop and sustain the children’s mental health workforce.
- Develop and implement a strategic plan to address the workforce crisis in mental health services and research for racial and ethnic minority youth and their families.

- Improve training for professionals across systems including schools, child care and primary health systems to recognize signs of mental health problems and take appropriate action.
- Pay for time spent consulting with child and adolescent psychiatrists and other mental health workforce members, whether via the web, telemedicine, phone, or in person.
- Establish an OMH office of mental health professionals who can consult to primary care, schools, child care settings, etc.
- Simplify the process (licensing, regulations) to allow mental health services in primary care facilities for children and adolescents ages 0–21.
- Reimburse mental health services in the primary care facility.
- Include the primary care “medical home” in the patient’s community network.
- Improve communication with the primary care facility/provider.
- Develop funding mechanisms to improve payment at parity for mental health services rendered in primary care settings by primary care clinicians.
- Provide payment for licensed social workers who provide mental health services in School-Based Health Centers (SBHC) operating under Article 28 facilities (part of Governor’s 2008 proposal).
- Provide payment for licensed social workers and psychologists who provide mental health services in primary care settings (e.g. day treatment centers) operating under Article 28 facilities.
- Expand knowledge and use of Incident-to-Rules, allowing private offices to receive payment for co-located mental health professionals.

Recommendation 3.3

Increase the capacity of mental health services by supporting family and youth engagement in mental health treatment through peer relationships, family and youth development curriculum/activities, and family support activities.

Rationale

One of the most successful practices in mental health and other health service domains is the inclusion of family advocates/advisors and youth advocates/coordinators into the workforce. Although many service models include parent liaisons, specialists and coordinators, family advocates/advisors in the mental health system are required to be primary caregivers of children with special needs and often, more specifically, primary caregivers of children with mental, behavioral, attention and/or emotional disturbances.

Although nothing can help a family to understand and actively participate in their child's mental health services like the support provided by a family advocate, family advocacy has received little public recognition and families most often come to it through word of mouth. Even less emphasis has been placed on the training and recruitment of family advocates or the route they take to enter the workforce. Until recently, very little attention has been focused on the skills, knowledge and competencies required to be a successful advocate, and advocates have most often relied on "on-the-job" learning. While individual agencies may have developed their own job descriptions, there is no general consensus regarding what the roles of family and youth advocate should be. Even though retention does not seem to be an issue in the advocacy field, there are few opportunities for advancement. Those who have been advocates for a number of years generally have to move on to other positions to get a raise or advance in their career.

OMH recently began a process to review the job descriptions and functioning of family advisors statewide. In New York City (NYC), the Department of Health and Mental Hygiene has been working with family advocates, the family support provider community, parent resource center directors, and OMH's NYC Field Office to restructure family support. This work includes defining the roles of family and youth advocates and identifying needed education, training and career ladders.

In addition, because children and youth are always involved with more than one service system (e.g., mental health, education, juvenile justice, OMRDD, OASAS), there needs to be more collaboration among family and youth advocates across child-serving systems. When advocates in different service systems work in a consultative capacity, family and youth will have more opportunities to clearly understand what services are available in each system and decide what is best for their family. These cross-system collaborations can happen when advocates in the current mental health workforce consult with advocates in other systems and through the provision of cross-system training and sharing of system-specific curriculums.

Another important consideration is the organizational structure in which family advocates work. Currently, family advocates in hospital and mental health service delivery settings may not have the support needed to freely help the families they serve, whereas family advocates within family support, parent resource centers and family-run organizations may have more opportunities to create the comfort zones that accelerate parental awareness, knowledge, navigational skills, treatment participation and involvement in treatment decision-making processes. Regardless of their location, the entry points, qualifications, training needs and opportunities for advancement for family advocates all require consideration. It is crucial that the following recommendations be pursued and developed in collaboration with

representatives from New York State family-run organizations, parent centers, and family representatives across the all child-serving systems.

Strategies

- Support the effectiveness of the workforce by ensuring that family and youth advocates, along with other paraprofessionals, are considered in the work of all workforce advisory bodies, including public task forces/workgroups (i.e., Children’s Mental Health Plan). Commissioner’s advisory groups, and regulatory change groups. This should occur at all levels (i.e., service provider, city/county, and State).
- Family and youth advocates should participate in the development, where appropriate, of OMH-mandated or sanctioned education and training opportunities for the entire workforce. They should also participate as trainers or co-facilitators, when appropriate, to assist the workforce in better understanding the youth and family they are serving.
- Review regulations and requirements that govern graduate, medical and professional level study to ensure that curriculums address the development of the skills, competencies and knowledge required to move the entire children’s mental health system toward the desired outcome of “*Individualized Care that is Family-driven and Youth-guided.*”
- Review mental health, medical and developmental models to ensure the inclusion of family and youth advocates in all practices and structures.
- Provide incentives to mental health providers, clinics and organizations that hire family advocates as a means of expanding youth and family engagement in treatment and program activities.
- Establish qualifications for family advocates that include the critically important experiences associated with being a primary caregiver of a child with special needs.
- Create universal standards for describing the responsibilities of family advocates to ensure that their potential success is not compromised by serving as translators, data collectors, etc.
- Examine the many existing family advocate training formats, including Cornell’s *Family Development Credentialing*,¹² Columbia University’s *Parent Empowerment Project*¹³ and/or Dr. Marilyn L. Steele’s *Strengthening Multi-Ethnic Families*¹⁴ as well as other models to promote dual training completion and broad knowledge in advocacy preparedness and system navigation across the State.

¹² See <http://www.human.cornell.edu/HD/FDC/>

¹³ See *Discovering parent empowerment: findings from two evaluations of parent advocate trainings* at <http://rtckids.fmhi.usf.edu/rteconference/handouts/pdf/20/Session%202000/ramos.pdf>

¹⁴ More information is available at http://www.parentingacrosscultures.com/about_us.html

- Create pathways and funding for family advocates in public service to complete Bachelor- level study at State & City/County colleges/universities free of charge, or develop programs that enable family advocates the opportunity to attend college (i.e., tuition reimbursement, work-study programs and tuition for number of years of public service) similar to graduate level education options available in the public sector.
- Create opportunities for parent advocates to move up via career ladders in the mental health service delivery system.

Goal 4: Ensure the Existence and Attainment of Core Competencies

Recommendation 4.1

Establish and define core competencies necessary for the mental health workforce serving children, youth, and their families across systems of care, in collaboration with other child-serving systems, ensure adequate training and ongoing education, and evaluate the outcomes of the development and mastery of these core competencies.

Rationale

Across New York State, agencies that provide health, social and emotional support services to children, youth and their families utilize a wide range of workforce resources. The competencies of the workforce and the level of skill, knowledge, credentials and experience is varied. It has been established (2007 Annapolis Group Workforce Recommendations) that the foundational knowledge base of the behavioral workforce and its ability to work effectively is insufficient, regarding even the most basic child development theories.¹⁵ In addition, it is commonly held that the role of supervisory personnel must be strengthened to allow for consistent reinforcement of best and evidence-based practices on the job, and that by strengthening supervisors' competencies, we can build a pool of experienced, well-informed staff from which the next generation of service managers can arise. Thus, competencies must be differentiated by tenure for direct service staff and by continuing education and training for supervisory and professional staff. This is developmentally important for children of all ages, from infancy through young adulthood.

In particular, children and youth involved across systems of care need services and linkages in home, community-based, and residential programs. In our State, many linkages have been created to serve cross-systems children, but they are not funded

¹⁵ Annapolis Coalition on the Behavioral Health Workforce. (2007). An action plan for behavioral workforce development: A framework for discussion [Executive Summary]. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at <http://www.samhsa.gov/Workforce/Annapolis/ExecSummaryWorkforceActionPlan.pdf>

or fiscally supported beyond the initial grants that have created them. Resolution of the needs of this distinct population requires not only competent professionals, but also structures in which they can collaborate to assess, research and/or develop the specific strategies children and youth need to be properly served within their homes and communities.

Strategies

- Foster direct service workforce competencies that should be present and measurable:
 - Normative childhood development, including the effects of negative experiences
 - Functional knowledge of family communication, dynamics, engagement and empowerment
 - Functional knowledge of self, individual and group behavior
 - Basic knowledge of group work planning and development
 - Effective listening, speaking, writing, reading and relationship skills
 - Functional knowledge of cultural and human diversity dynamics
 - Awareness of emotional and behavioral issues of childhood and adolescence
 - Awareness of environmental and group risk factors

- Foster supervisory workforce competencies that should be present and measurable:
 - Normative childhood development, including the effects of negative experiences
 - Proficiency in family communication, dynamics, engagement and empowerment
 - Proficiency in cultural, linguistic and human diversity dynamics
 - Basic knowledge of group work planning, development and staff team building
 - Proficient listening, speaking, writing, reading and relationship skills
 - Ability to develop, build and participate in collaborative relationships (understand systems theory, group dynamics, group work, team building, build healthy partnerships)
 - Knowledge of emotional and behavioral disturbances of childhood and adolescence
 - Knowledge of environmental and group risk factors
 - Contextual understanding of specific issues and specialized competencies (substance abuse)
 - Ability to effectively assert authority and differentiate leadership role from peer status

- Foster licensed clinical and managerial professional competencies that should be present and measurable:

- Normative childhood development, including the effects of negative experiences
 - Knowledge of family involvement and person-centered values
 - Proficiency in family communication, dynamics, engagement and empowerment
 - Proficiency in cultural, linguistic and human diversity dynamics
 - Knowledge of resources available on specialized expertise, literature, emerging and best practices, continuing education and training, grants to support workforce competencies, institutes that offer staff training and curricula
 - Proficiency in collaborative relationship development, especially to effect care coordination across systems of care
 - Basic knowledge of group work planning and development
 - Leadership and executive decision-making skills
 - Knowledge of organizational theory and behavior
- Attend to the specific competencies needed to deal with complex and diverse child and family needs, and determine requirement and measurement criteria:
 - Early childhood and youth in transition
 - Family communication and crisis assessment
 - Ethnic, cultural and linguistic capabilities necessary to permit treatment and care coordination
 - Identification and assessment of substance abuse
 - Identification and assessment of sexual aggression
 - Identification and assessment of developmental disabilities.
 - Identification and assessment of trauma (e.g., child abuse)
 - Identification and assessment of risk of harm to self or others
 - Identification and assessment of risk and protective factors and developmental assets
- Survey existing competencies among direct care staff, supervisory, licensed professionals and managerial workers. Catalog the competencies against the list of identified core competencies, identify gaps, and establish training priorities.
- Establish and fund culturally and linguistically competent continuing education and training activities that support increasing the competence of the direct service, supervisory and licensed professionals across the child and adolescent mental health care system; are based on best practices; aimed at individual learning styles and abilities; adaptable across child and adolescent mental health care settings; and geared toward the entire developmental spectrum.
- Efficiently monitor and evaluate competency development, practice and outcomes (e.g., survey, track continuing education credits).

- Create, maintain and fund existing regional and State structures (e.g., systems of care communities) that foster integrated care effectively for children and youth with cross-systems needs and ensure adequate cross-systems training and enhancement of competencies of staff working with these children and families.
- Ensure that minimum training and education competency standards are identified and implemented in settings where care is provided 24 hours each day.
 - Change Medicaid M11Q guidelines to allow children with serious emotional and behavioral disturbances to access home health care services under the supervision of a nurse with psychiatric credentials.

Goal 5: Improve Cultural and Linguistic Considerations

Recommendation 5.1

Improve and enhance cultural and linguistic competency system-wide by integrating culturally sensitive values into all aspects of care for children, youth and their families throughout the system, within programs and agencies, and across policies and regulations, locally and throughout the State.

Rationale

The 1999 Surgeon General’s Report on Mental Health states that, “Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. Those disparities are viewed readily through the lenses of racial and cultural diversity, age and gender.” Additionally, the President’s New Freedom Commission Report on Mental Health says, “The system has neglected to incorporate respect or understanding of histories, traditions, beliefs, languages and value systems of culturally diverse groups.” While this relates to people receiving the services, it also relates to the education system that must prepare staff to integrate this into their day-to-day practice.

“More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness...”¹⁶ To effectively develop a diverse and culturally and linguistically competent workforce that will be accepted into distinct communities, one must fully understand and embrace the cultural considerations that families use when making decisions about treatment or services. Of importance is the need to counteract stigma in recruitment and retention efforts. Many people do not have a positive regard for mental health services, either due to their own negative experience or what they have heard from others. It is, therefore, necessary to encourage opportunities that will allay concerns young people may have about mental health as they consider careers.

¹⁶ Department of Health and Human Services. (1999). Report of the Surgeon General. Available online at <http://www.surgeongeneral.gov/library/mentalhealth/toc.html>

In relation to mental health intervention and treatment, particularly with evidence-based practices, there must be attention to cultural and linguistic competence and/or current practices already in existence within diverse communities. Without such attention, cultural and ethnic inequities could widen.¹⁷

Strategies

- Increase the cultural and linguistic competence of the child- and youth-serving workforce.
 - Increase funding and support for professional development of faculty from diverse cultural backgrounds to create a critical mass of faculty capable of serving as mentors and role models for students interested in providing culturally and linguistically sensitive behavioral health services.
 - Allocate funds to support multicultural undergraduate, graduate and postgraduate training and educational opportunities (e.g., diversity courses, practicum placements, externships and internships, etc.) that will create a critical mass of students who will enter the behavioral health field and provide culturally and linguistically sensitive services.
 - Ensure adequate funding and support for hiring and retaining staff from the culturally diverse community being served.
 - Encourage promotion and development of culturally diverse staff into leadership positions within organizations (community-based organizations, City/local agencies, State agencies).
 - Create workplace environments that are conducive to a diverse workforce.
 - Disseminate standards and tools for culturally and linguistically competent practices by incorporating cultural and linguistic competency models for all professions, paraprofessionals and other sectors of the workforce.
 - Increase the cultural and linguistic competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies.
 - Rigorously evaluate the degree to which these initiatives are successful in recruiting and retaining professionals into the behavioral health field.
- Develop and recruit a culturally diverse workforce.
 - Develop curricula, training programs, mentorship opportunities (internships/volunteer/ work–study) to expose young culturally diverse high school and older students to the field of child mental health.
 - Allocate financial support to encourage culturally and linguistically diverse persons to enter the children’s mental health workforce, with tuition assistance/stipends (e.g., undergraduate, and graduate programs for social

¹⁷ Isaacs, M.R., Huang, L.N., Hernandez, M., and Echo-Hawk, H. (2005). *The road to evidence: The intersection of evidence-based practices and cultural competence in children’s mental health*. Washington, DC: The National Alliance of Multi-Ethnic Behavioral Health Associations.

- work, psychology, nursing, psychiatry, other allied mental health professions such as rehabilitation counselors and special education).
- Develop collaborations with minority committees of local and State professional groups to further explore ways to positively impact the children's behavioral health workforce (e.g., American Academy of Adolescent and Child Psychiatry, National Association of Social Workers)
 - Incorporate cultural considerations into the development and implementation of treatment and research.
 - Encourage youth, families and communities to be an integral part of the choice of treatment offered and available, whether evidence-based or not.
 - Collaborate with culturally diverse youth and families and respect their need to guide treatment and implementation research within their own communities.
 - Work collaboratively with the newly formed OMH Centers of Excellence in Culturally and Linguistically Competent Mental Health Care on an agenda that promotes greater diversity in the children's mental health workforce through studies of coordinated care across systems and the implementation of evidence-based practices.

Appendices

Appendix 1 Glossary of Key Mental Health Terms

Appendix 2 Description of the Licensed Mental Health Workforce in New York State

Appendix 1

Glossary of Key Mental Health Terms

(Adapted from http://systemsofcare.samhsa.gov/ResourceGuide/glossary.html#_edn2#_edn2)

- **Administrators:** Individuals that manage agency functions related to service delivery, training, human resources, financing, management information systems, and quality improvement.
- **Aggression:** Words and action that are deemed to be threatening to others.
- **Anxiety:** Exaggerated or inappropriate responses to the perception of internal or external dangers. Includes panic disorders, phobias, obsessive-compulsive disorders, post-traumatic stress, and generalized anxiety disorders.
- **Assessment:** A professional review of child and family needs that is done when services are first sought or periodically to assess progress. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the provider and family decide what kind of treatment and supports, if any, are needed.
- **Assessment protocol:** A set of guidelines that an agency or individual follows when conducting assessments.
- **Assessment tools:** A variety of standardized instruments that are used to gather information about a person's functioning and/or level of need.
- **Attribute:** An inherent quality or characteristic.
- **Behavioral healthcare:** Continuum of services for individuals at risk of, or living with mental, addictive, or other behavioral health problems.
- **Behavioral therapy:** As the name implies, behavioral therapy focuses on changing unwanted behaviors through rewards, reinforcements, and desensitization. Behavioral therapy often involves the cooperation of others, especially family and close friends, to reinforce a desired behavior.
- **Best practices:** Most often is used to describe guidelines or practices driven more by clinical wisdom, guild organizations, or other consensus approaches that do not necessarily include systematic use of available research evidence.
- **Case manager:** An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)
- **Capacity building:** Involves enhancing the ability of individuals, groups, organizations, and systems to mobilize and develop resources, skills and commitments needed to accomplish shared goals.⁶

- **Child welfare:** Child service sector that focuses on child protection, foster care, and the overall care of children's health and living conditions.
- **Cognitive therapy:** Aims to identify and correct distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or even self-destructive. The goal is to replace such thinking with a more balanced view that, in turn, leads to more fulfilling and productive behavior.
- **Cognitive behavioral therapy:** A combination of cognitive and behavioral therapies which helps people change negative thought patterns, beliefs, and behaviors so they can manage symptoms and enjoy more productive, less stressful lives.
- **Community capacity:** Refers to the ability of community members to use the assets of its residents, associations and institutions to improve quality of life. Each community's collection of assets will be unique, for it will reflect the specific characteristics of its population, its political structures and geography.
- **Conduct Problems:** Behaviors that are characterized by acting out, ranging from annoying, minor oppositional behavior (yelling, temper tantrums) to more serious types of antisocial behavior (aggression, physical destruction, stealing).
- **Continuous quality improvement:** A strategy of continuously assessing the process and outcomes of service delivery to learn how to improve those processes to reach better outcomes and higher quality of mental health care.
- **Cultural competence:** Understanding and appreciating the differences in individuals, families, and communities, which can include: thoughts, speech, actions, customary beliefs, social forms and material traits of a racial, religious or social group. It also affects age, national origin, gender, sexual orientation or physical disability.
- **Depression:** Characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time.
- **Diagnosis:** The process of determining by examination the nature and circumstances of a mental health condition and the decision reached by such examination.
- **Early intervention:** A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.
- **Emerging practices:** Are new innovations in clinical or administrative practice that address critical needs of a particular program, population or system, but do not yet have scientific or broad expert consensus support.
- **Emotional health:** The well-being and appropriate expressions of one's emotions.

- **Evidence:** Refers to data resulting from scientific controlled trials and research, expert or user consensus, evaluation, or anecdotal information.
- **Evidence-based assessment:** Methods and processes that are based on empirical evidence, in terms of both reliability and validity as well as their clinical usefulness for prescribed populations and purposes.
- **Evidence-based practices:** Practices that integrate the best research evidence with clinical expertise and patient values.
- **Externalizing disorder:** Is expressed overtly and can be characterized by aggression, behavioral acting-out, hyperactivity, and conduct disorder.
- **Family-centered services:** Help designed to meet the specific needs of each individual child and family.
- **Family-driven:** Families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.
- **Family-run organizations:** Advocacy and support organizations that are led by family members with expertise/experience in the field of mental health.
- **Fidelity:** Adherence to the key elements of an evidence-based practice shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes.
- **Hyperactivity:** A condition in which children are overactive and impulsive (acts without thinking).
- **Internalizing disorder:** Expressed within the individual and focused on clinically problematic affective and emotional state, such as anxiety or depression.
- **Juvenile justice:** An area of law that applies to children who have not reached the legal age of adulthood/maturity, normally eighteen years of age. The goal of juvenile justice is rehabilitation, not punishment. Also refers to the service sector that is responsible for serving children judged to have committed unlawful acts.
- **Juvenile justice counselor:** Provide custody, supervision, direct care, and counseling to juveniles. Responsibilities include teaching socially desired habits and behaviors, provide recreational activities, and assist with crisis intervention programs.
- **Licensed clinical social worker:** A social worker who helps individuals deal with a variety of mental health and daily living problems to improve overall functioning. A social worker usually has a master's degree in social work and has studied sociology, growth and development, mental health theory and practice, human behavior/social environment, psychology, research methods.
- **Linguistic competence:** capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily

understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. This may include the use of bilingual staff, interpretation services, assistive technology, etc.

- **Medicaid:** A federal program administered by states that is intended to provide funding for health care and health-related services to low-income individuals or other special groups.
- **Mental health:** How people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.
- **Motivational readiness:** The perceived need for improvement or pressure for change.
- **Needs assessment:** Systematic approach for gathering data on the needs of a population to be served.
- **Outcomes:** The results of a specific mental health care service, usually phrased in terms of child and family gains (e.g., improved school performance, improved family communication).
- **Person-centered care:** The recipient of care is the driving force behind making decisions about their treatment.
- **Posttraumatic stress disorder:** Occurs following a traumatic event in which there was threat of injury or death to you or someone else.
- **Practitioner:** Anyone who provides direct services for children or their families. A practitioner may be a licensed independently practicing clinician, a supervised clinical staff member, a certified direct service provider, a person who is trained and meets the criteria to provide direct services or a peer helper.
- **Professional counselor:** A person with an advanced degree in mental health or other social services charged with assessment and treatment.
- **Promising practices:** Clinical practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.
- **Psychiatrist:** A professional who completed both medical school and training in psychiatry and is a specialist in diagnosing and treating mental illness.
- **Psychologist:** A professional with a doctoral degree in psychology who specializes in assessment and therapy.
- **Psychopharmacology:** The practice of using medicine to treat individuals with psychological and psychiatric conditions through the use of medications.

- **Psychotherapist:** An individual with an advanced degree in social services charged with assessment and treatment (see *professional counselor*)
- **Reimbursement:** Refunds for out-of-pocket expenses by an individual or company.
- **Resiliency:** The quality that allows an individual or group to function well despite the odds against them. Two fundamental concepts are associated with resiliency: risk and protective factors. Mental health promotion concepts focus on minimizing the impact of risk factors (such as stressful life events) and enhancing the protective factors such as social support that increase people's ability to deal with life's challenges.
- **School psychologist:** An individual with an advanced degree in psychology who assesses children for the presence of learning problems, as well as emotional problems, diagnoses, and treats children in the school system. Roles of school psychologists will vary by location.
- **Scientific evidence:** Results from a study or research project that has a rigorous controlled design (including a clearly articulated hypothesis and rigorous methodology along with controlled conditions and random assignments to various comparison conditions) that includes sufficient subjects to overcome the possibility that the result could have occurred by chance, and is repeated with the same result in multiple sites with different researchers and different experimental and control groups.
- **Screening instruments:** Typically a brief measure to determine a client's level of need for treatment.
- **Service provider organizations:** Mental health or other social service agencies that offer treatment or other services to children and families.
- **Service system:** Refers to multiple agencies in different sectors (mental health, child welfare, juvenile justice, substance abuse, education, and healthcare) that provide services and treatments for the varying needs of children and families.
- **Stakeholders:** Those people who are interested, involved, and invested in the project or initiative in some way. In mental health, groups of people who might be identified as stakeholders may be: children and families, family organizations, advocates, community groups, funders, mental health and social service providers, or university or college-based research teams.
- **System of care:** A system of care is a method of addressing children's mental health needs. It is developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around the principles of being child-centered, family-driven, strength-based, and culturally competent; and involving interagency collaboration.

- **Wraparound services:** a collaborative team-based approach to offering services for children with emotional and behavioral problems and their families. Team members, who are identified by the child and family and other service providers meet regularly to design, implement, and monitor their individualized treatment plans.
- **Youth-guided:** Youth are experts and considered equal partners in creating system change at the individual, state, and national level.

Appendix 2

Description of the Licensed Mental Health Workforce in New York State

In New York State, the licensed mental health workforce includes psychiatrists, psychologists, psychiatric-mental health nurses, licensed clinical social workers (LCSWs), marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists. There are two primary constraints to describing the characteristics of the mental health workforce in New York. First, demographic information on the mental health workforce is often not collected or, if collected, not recorded and made available for analysis.¹⁸ Second, it is not possible to identify the statewide population of nurses specializing in psychiatric-mental health care because all nursing specialties (other than nurse practitioners) are combined in both the State licensing data¹⁹ and in data collected by professional nursing organizations. The population of psychiatric-mental health nurses in the State is therefore described separately from the other mental health professions.

I. Size of the Mental Health Workforce

In New York State, the licensed mental health workforce includes a total of 50,090 psychiatrists, psychologists, clinical social workers, nurse practitioners—psychiatry, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists (Table 1).

Discipline	Number	Percent of Total
LCSWs ²⁰	24,432	49%
Psychologists ³	11,383	23%
Others ³	6,798	14%
Psychiatrists ²¹	6,439	13%

¹⁸ The New York State Department of Education (DOE) Office of the Professions has informed the Office of Mental Health (OMH) that it does not maintain data on race (ethnicity), gender, and primary or secondary languages for any of its licensed professions. DOE Public Information Unit (personal communication, January 10, 2007).

¹⁹ See <http://www.op.nysed.gov/nursecounts.htm>

²⁰ Data for psychologists, LCSWs, and “Other” categories is as of January 2008 and was provided by the DOE Office of the Professions. County of location reflects the licensee’s primary mailing address on record with the State Education Department. This address may either be the licensee’s home or practice address. Licensees must be registered in order to practice and use a professional title within the State; being registered, however, does not necessarily mean the licensee is actively engaged in practice.

²¹ Data for psychiatrists is from 2005. Inclusion means the psychiatrist is actively engaged in practice. Source: Armstrong DP and Forte GJ. *Annual New York Physician Workforce Profile, 2007 Edition*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany: December 2007. Psychiatrist means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who (1) is certified as a psychiatrist or child and adolescent psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, or if not certified, is “board-eligible” (i.e., has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry); and (2) practices patient care psychiatry or child psychiatry, and is licensed to do so, if required by the State of practice.

Nurse Practitioners–Psychiatry ³	1,038	2%
Total	50,090	100%
* Others include Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.		

LCSWs make up the largest proportion statewide (49%), followed by psychologists (23%), others²² (14%), psychiatrists (13%), and nurse practitioners–psychiatry (2%). In broad terms, New York State has more than twice as many LCSWs as psychologists and 1.75 times as many psychologists as psychiatrists. In the year 2000, a National Center for Health Workforce Analysis ranked New York State second among states in psychiatrists per capita and tenth among states in both psychologists and social workers per capita.²³

By OMH region (Table 2), three quarters of the State’s licensed mental health workers practice in the New York City (39%), Hudson River (20%) and Long Island (17%) regions. Fourteen percent practice in the more rural Western (9%) and Central (5%) regions.

OMH Region	2006 U.S. Census Est. Population	Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}	Nurse Practitioners – Psychiatry ³	Total	Percent of NYS Total
Central	1,968,404	285	400	1,329	530	69	2,586	5%
Hudson River	3,368,980	1196	2,150	5,164	1,232	195	9,899	20%
Long Island	2,795,377	709	1,920	4,615	928	309	8,468	17%
New York City	8,214,426	3,763	4,318	9,125	2,461	173	19,546	39%
Western	2,958,996	446	761	2,038	946	145	4,316	9%
Unknown			1,834	2,161	701	147	4,843	10%
NYS TOTAL	19,306,183	6,439	11,383	24,432	6,798	1,038	50,090	100%
* Others include Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.								

²² Because of their small numbers, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists are combined in an "Other" category in this analysis.

²³ National Center for Health Workforce Analysis. *State Health Workforce Profiles*. Retrieved February 27, 2007 from <http://bhpr.hrsa.gov/healthworkforce/reports/profiles/>

Mental Health–Psychiatric Nurses

Few data are available regarding mental health-psychiatric nurses, although they make up the largest segment of the mental health workforce staffing psychiatric hospitals.²⁴ This discussion is therefore limited to OMH nursing data. In 2007, OMH employed a total of 2,196 full-time equivalent (FTE) mental health–psychiatric nurses (not including nurse practitioners) throughout the State.²⁵ Although it does not represent the total number of mental health-psychiatric nurses licensed to practice in New York State, adding the 2,196 OMH nursing FTEs to the 50,090 licensed mental health workers described earlier identifies 52,286 licensed mental health professionals statewide. It is of note that only nine of the 39 institutions (23%) in New York State with master’s degree and advanced certificate nursing programs offer training in psychiatric and mental health nursing.²⁶

II. Distribution of the Mental Health Workforce

To understand mental health workforce capacity, it is essential to examine the geographic distribution of the workforce in addition to its size (i.e., number of practitioners). Historically, mental health practitioners have aggregated in areas with better mental health insurance benefits and a more educated population.²⁷ Research has shown that practitioners tend to cluster in urban and suburban areas, leaving rural and inner-city areas understaffed.²⁸ As presented in Table 3, this is the case in New York. For example, 58% of psychiatrists and 38% of psychologists practice in New York City, where 43% of the State’s population resides. In contrast, 11% of both psychiatrists and psychologists practice in the more rural Central and Western regions, where 26% of the State’s population resides. Likewise, 30% of nurse practitioners–psychiatry practice in the Long Island region, where 14% of the State’s population resides. In comparison, 7% of nurse practitioners–psychiatry practice in the Central region, where 10% of the State’s population resides.

²⁴ Hanrahan N, Stuart GW, Brown P, Johnson M, Draucker CB, & Delaney K. (2003). The psychiatric-mental health nursing workforce: Large numbers, little data. *Journal of the American Psychiatric Nurses Association, 9*(4), 111-114.

²⁵ These OMH FTEs represent filled civil service job titles including: Community Nursing Services Consultant Mental Health, Community Mental Health Nurse, Director of Nursing, Mental Hygiene Nursing Program Coordinator, Nurse 2 Psychiatric, Nurse 3 Psychiatric, Nurse Administrator 1 Psychiatric, and Nurse Administrator 2 Psychiatric.

²⁶ Retrieved February 14, 2008 from the DOE Office of the Professions web site at <http://www.op.nysed.gov/nurseprogs-masters.htm>.

²⁷ Knesper DJ, Wheeler JR, & Pagnucco DJ. (1984). Mental health services providers' distribution across counties in the United States. *American Psychologist, 39*, 1424–1434.

²⁸ Merwin E, Hinton I Dembling B, & Stern S. (2003). Shortages of rural mental health professionals. *Archives of Psychiatric Nursing, XVII*, 42–51.

OMH Region	2006 U.S. Census Est. Population	Percent State Population	Percent of Profession, Statewide					Nurse Practitioners – Psychiatry ³	Percent of NYS Total
			Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}			
Central	1,968,404	10%	4%	4%	5%	8%	7%	5%	
Hudson River	3,368,980	17%	19%	19%	21%	18%	19%	20%	
Long Island	2,795,377	14%	12%	17%	19%	14%	30%	17%	
New York City	8,214,426	43%	58%	38%	37%	36%	17%	39%	
Western	2,958,996	16%	7%	7%	8%	14%	14%	9%	
Unknown			N/A	16%	9%	10%	14%	10%	
NYS TOTAL	19,306,183	100%	100%	100%	100%	100%	100%	100%	

* Others include Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.

Another way to evaluate licensed mental health workforce capacity and distribution is to examine supply ratios—the number of professionals per 100,000 population. As described in Table 4, New York State has a total of 259 mental health professionals per 100,000 population statewide. This workforce includes 33 psychiatrists, 59 psychologists, 127 LCSWs, 5 nurse practitioners–psychiatry, and 35 “Other” mental health professionals per 100,000 population.

OMH Region	2006 U.S. Census Est. Population	Percent State Population	Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}	Nurse Practitioners – Psychiatry ³	Total
			<i>Number per 100,000 Population</i>					
Central	1,968,404	10%	14	20	68	4	27	131
Hudson River	3,368,980	17%	36	64	153	6	37	294
Long Island	2,795,377	14%	25	69	165	11	33	303
New York City	8,214,426	43%	46	53	111	2	30	238
Western	2,958,996	15%	15	26	69	5	32	146
Unknown								25
State Total	19,306,183	100%	33	59	127	5	35	259

* Others include Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.

Dramatic differences exist in supply ratios by region. Across these licensed mental health disciplines, supply ratios are highest in the Long Island (303 per 100,000), Hudson River (294 per 100,000) and New York City (238 per 100,000) regions, and lowest in the Western (146 per 100,000) and Central (131 per 100,000) regions. By profession, the New York City region has the highest supply ratio in the State for psychiatrists, and Long Island has the highest supply ratios in the State for

psychologists, LCSWs, nurse practitioners-psychiatry, and mental health professions in the “Other” category. The Central region has the lowest supply ratios in the State across all of the mental health professions.

Mental Health Professional Shortage Areas

These mal-distributions of mental health professionals in New York State are recognized by designated mental health professional shortage areas. Table 5 details New York State counties by region and shortage area designations. In the table, an asterisk next to a county name indicates that the county was designated a Mental Health Regents Physician Shortage Area by the New York State Department of Health as of January 1, 2008.²⁹ A county name in blue font indicates the county was designated a federal Mental Health Professional Shortage Area as of January 2008 by the Bureau of Health Professions at the United States Department of Health and Human Services.³⁰

OMH Region	County	2006 US Census Est. Population	Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}	Nurse Practitioners – Psychiatry ³	Total
Central	Broome	196,269	45	60	235	10	33	378
	Cayuga*	81,243	6	3	30	3	17	59
	Chenango*	51,787	< 5	3	28	2	3	53
	Clinton	82,166	17	11	36	3	42	106
	Cortland*	48,483	5	9	26	1	11	92
	Delaware*	46,977	< 5	5	34	2	8	47
	Essex*	38,649	< 5	14	25		15	49
	Franklin*	50,968	9	4	23	1	18	57
	Fulton*	55,435	5	8	19	1	6	46
	Hamilton*	5,162	< 5	3	4	1		34
	Herkimer*	63,332	< 5	3	30		6	8
	Jefferson*	114,264	15	13	29	1	33	89
Lewis*	26,685	< 5	2	7		6	76	

²⁹ New York State mental health professions shortage areas are counties identified as having less than one-third of the recommended number of mental health professionals and specific areas and facilities designated by the federal government. Retrieved January 3, 2007 from <http://www.highered.nysed.gov/kiap/scholarships/2006Bulletin.pdf>.

³⁰ A geographic area will be federally designated as having a shortage of mental health professionals if certain criteria are met as provided by 42 Code of Federal Regulations (CFR), Chapter 1, Part 5, Appendix C (October 1, 1993, pp. 34-48). See <http://bhpr.hrsa.gov/shortage/hpsacritmental.htm>. These include a population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1. In some cases, practitioners located within an area may not be accessible to the general population of the area under consideration. Practitioners working in restricted facilities will be included on an FTE basis based on time spent outside the facility. Examples of restricted facilities include correctional institutions, youth detention facilities, residential treatment centers for emotionally disturbed or mentally retarded children, school systems, and inpatient units of State or county mental hospitals. In cases where there are mental health facilities or institutions providing both inpatient and outpatient services, only those FTEs providing mental health services in outpatient units or other short-term care units will be counted.

Table 5. Number of Licensed Mental Health Workers by NYS Region and County

OMH Region	County	2006 US Census Est. Population	Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}	Nurse Practitioners – Psychiatry ³	Total
	Madison*	70,197	< 5	18	45	1	21	15
	Montgomery	49,112	7	2	21	2	9	85
	Oneida	233,954	56	36	183	18	30	317
	Onondaga	456,777	107	162	410	16	186	875
	Oswego*	123,077	< 5	14	30	1	23	774
	Otsego*	62,583	13	11	57	4	14	99
	St. Lawrence*	111,284	11**	19	57	2	49	137
	Total Region	1,968,404	285+	400	1,329	69	530	2,586
Hudson River	Albany	297,556	101	209	417	18	110	856
	Columbia*	62,955	13	28	70	6	12	127
	Dutchess	295,146	82	146	480	27	97	827
	Greene*	49,822	5	11	44	1	12	68
	Orange	376,392	88	83	382	5	96	654
	Putnam	100,603	18	49	179	8	49	297
	Rensselaer*	155,292	11	35	138	14	42	236
	Rockland	294,965	146	195	527	14	111	1,001
	Saratoga	215,473	11	83	232	18	79	438
	Schenectady	150,440	26	52	172	7	72	326
	Schoharie*	32,196	25	3	22	2	5	32
	Sullivan	76,588	12	17	81	3	33	141
	Ulster	182,742	41	98	347	12	111	607
	Warren	66,087	15	32	51	6	27	130
	Washington*	63,368	< 5	6	29	1	6	42
Westchester	949,355	602	1,103	1,993	53	370	4,117	
Total Region	3,368,980	1196+	2,150	5,164	195	1,232	9,899	
Long Island	Nassau	1,325,662	387	1,125	2,414	109	535	4,544
	Suffolk	1,469,715	322	795	2,201	200	393	3,924
	Total Region	2,795,377	709	1,920	4,615	309	928	8,468
New York City	Bronx	1,361,473	350	174	767	14	152	1,429
	Kings	2,508,820	489	634	1,880	31	517	3,500
	New York	1,611,581	2,387	2,964	4,588	77	1,251	11,074
	Queens	2,255,175	432	435	1,466	36	448	2,792
	Richmond	477,377	105	111	424	15	93	751
	Total Region	8,214,426	3,763	4,318	9,125	173	2,461	19,546
Western	Allegany*	50,267	< 5	12	11	1	17	41
	Cattaraugus*	81,534	6	6	29	3	31	69
	Chautauqua*	135,357	12	9	46	1	59	128
	Chemung	88,641	21	13	65	4	22	125
	Erie	921,390	148	267	721	19	276	1,414
	Genesee*	58,830	5	9	29	1	13	52
	Livingston*	64,173	< 5	9	31	2	11	53
	Monroe	730,807	189	299	577	82	324	1,451
	Niagara*	216,130	14	12	73	4	40	141

Table 5. Number of Licensed Mental Health Workers by NYS Region and County

OMH Region	County	2006 US Census Est. Population	Psychiatrists ⁴	Psychologists ³	LCSWs ³	Others ^{3,*}	Nurse Practitioners – Psychiatry ³	Total
	Ontario	104,353	19	27	88	12	36	199
	<i>Orleans*</i>	43,213	< 5	5	13		9	27
	<i>Schuyler*</i>	19,415	< 5	2	16		2	20
	<i>Seneca*</i>	34,724	< 5		25	1	7	38
	<i>Steuben*</i>	98,236	8	19	54	4	14	99
	Tioga	51,285	< 5	10	40	3	9	62
	Tompkins	100,407	24	55	165	3	36	285
	<i>Wayne*</i>	92,889	< 5	5	33	3	31	77
	<i>Wyoming*</i>	42,613	< 5		16	1	4	21
	<i>Yates*</i>	24,732	< 5	2	6	1	5	14
	Total Region	2,958,996	446+	761	2,038	145	946	4,316
	Unknown		N/A	1,834	2,161	147	701	4,843
	Statewide Total	19,306,183	6,439	11,383	24,432	1,038	6,798	50,090

Note: Italicized font indicates county was designated a federal Mental Health Professional Shortage Area as of 01/2008* "Others" includes Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.

** St. Lawrence: 2006 OMH State Psychiatric Center Data.

Notes: In psychiatrist column, "< 5" indicates fewer than 5 psychiatrists in county in 2006. The psychiatrist totals for the Central, Hudson River, and Western Region are therefore estimates. Total psychiatrist value for State includes actual values for counties with less than 5 psychiatrists. Data

Table 6 summarizes New York State counties designated as mental health shortage areas by OMH region. As of January 2008, 31 of New York's 62 counties (50%) are designated as shortage areas and 12% of the State's population lives in those areas. Overall, 2,275,872 people in the State live in designated federal and/or state mental health shortage areas.

OMH Region	Number of Counties	Counties Designated Mental Health Shortage Areas	Percent of Total	2006 US Census Est. Population	Population in Designated Counties	Percent of Region Total
Central	20	13	65%	1,968,404	950,126	48%
Hudson River	16	5	31%	3,368,980	363,633	11%
Long Island	2	0	0	2,795,377		
New York City	5	0	0	8,214,426		
Western	19	13	68%	2,958,996	962,113	33%
Total	62	31	50%	19,306,183	2,275,872	12%

Approximately 84% of counties designated as mental health shortage areas are located in the Central and Western regions. In each of these regions, approximately two-thirds of all counties have been designated shortage areas. One-third of the population in the Western region lives in a designated mental health shortage area and nearly half (48%) of the population in the Central region lives in a shortage area. In the Hudson River region five counties are designated as mental health shortage areas and 11% of the population in the region lives in those areas. No county in New York City or Long Island is designated a shortage area.

Supply and Distribution of Child & Adolescent psychiatrists in New York State

Child and adolescent psychiatry is the only board-certified medical specialty that trains physicians to treat the emotional and behavioral disturbances of children and adolescents. According to the American Academy of Child and Adolescent Psychiatry, there were approximately 7,000 child and adolescent psychiatrists in the United States in 2006, and only 300 child and adolescent psychiatrists complete training each year. In 2000, the Bureau of Health Professions at HRSA projected that between 1995 and 2020, the use of child and adolescent psychiatrists will increase by 100%, with general psychiatry's increase at 19%.

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Tables 7–9 describe the distribution of child and adolescent psychiatrists in New York State by region and county. Among the 898 child and adolescent psychiatrists in the State, 47% are located in New York City, 23% in the Hudson River region, 18% in Long Island, 8% in the Western region and 5% in the Central region.

OMH Region	2006 U.S. Census Est. Total Population	Percent State Population	2004 U.S. Census Est. Population Ages 19 and Under	Percent State Population Age 19 and Under	Total Psychiatrist*	Percent of NYS Total	Total Child & Adolescent psychiatrist**	Percent of NYS Total
Central	1,968,404	10%	519,223	10%	285	4%	42	5%
Hudson River	3,368,980	17%	901,509	18%	1196	19%	207	23%
Long Island	2,795,377	14%	758,418	15%	709	11%	158	18%
New York City	8,214,426	43%	2,119,501	42%	3,763	58%	423	47%
Western	2,958,996	15%	790,047	16%	446	7%	68	8%
NYS TOTAL	19,306,183	100%	5,088,698	100%	6,439	100%	898	100%

*Armstrong DP and Forte GJ. *Annual New York Physician Workforce Profile, 2007 Edition*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany: December 2007.
 **Staats, M. *Improving Access to Child Psychiatric Services*, 2005. The National Association of County Behavioral Health and Developmental Disability Directors.

These data indicate a serious mal-distribution of child psychiatric services in New York State, with children in the more rural Central and Western areas having significantly reduced access. While 10% of the State’s population ages 19 years and younger lives in the Central region, only 5% (n=42) of all child and adolescent psychiatrists practice there. The Western region has 15% of the population ages 19 years and younger, but only 8% of child and adolescent psychiatrists statewide (n=68). In contrast, 47% of child and adolescent psychiatrists in the State practice in New York City, where 42% of the population ages 19 years and under lives; 23% practice in the Hudson River region where 17% of the population lives; and 18% of practice in Long Island where 14% of the population lives.

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The supply ratio (number per 100,000 population) of child and adolescent psychiatrists in both the Central and Western regions is 2, the lowest in the State (Table 8). In comparison, the Hudson River and Long Island regions have the highest supply ratios in the State with 6 child and adolescent psychiatrists per 100,000 population. New York City is second highest with a supply ratio of 5.

OMH Region	2006 U.S. Census Est. Population	Percent State Population	Total Psychiatrist	Total Child & Adolescent Psychiatrist
			Number per 100,000 Population	
Central	1,968,404	10%	14	2
Hudson River	3,368,980	17%	36	6
Long Island	2,795,377	14%	25	6
New York City	8,214,426	43%	46	5
Western	2,958,996	15%	15	2
State Total	19,306,183	100%	33	5

Table 9 examines the number of child and adolescent psychiatrists per 100,000 of the population ages 19 and younger by region. Overall, the supply ratios of child and adolescent psychiatrists range from lows in the Central and Western regions of 8 and 9 respectively to a high of 23 in the Hudson River region. Supply ratios in Long Island and New York City are 21 and 20 respectively.

OMH Region	2004 U.S. Census Est. Population Ages 19 and Under	Percent State Population	Total Child & Adolescent Psychiatrist	Total Child & Adolescent Psychiatrist
				<i>Number per 100,000 Population Ages 19 and Under</i>
Central	519,223	10%	42	8
Hudson River	901,509	18%	207	23
Long Island	758,418	15%	158	21
New York City	2,119,501	42%	423	20
Western	790,047	16%	68	9
State Total	5,088,698	100%	898	18

Across regions, child and adolescent psychiatrist supply ratios for the population ages 19 years and younger are lower than psychiatrist supply ratios for the population as a whole. For example, the Central region has 14 psychiatrists per 100,000 total population (Table 8), but only 8 child and adolescent psychiatrists per 100,000 population ages 19 years and younger (Table 9). Likewise, New York City's supply ratio of all psychiatrists is 46 compared to a supply ratio of 20 for child and adolescent psychiatrists. As described in Table 10, there are striking variations in child and adolescent psychiatrist supply ratios across counties within regions. In the Central region, county supply ratios range from 0 to 23 and average 8. Forty percent (n=8) of the Central region's counties have no child and adolescent psychiatrist. Similarly, child and adolescent psychiatrist supply ratios in the Western region range from 0 to 19 and average 9. Nearly two-thirds (63%, n=12) of the counties in the Western region have no child and adolescent psychiatrist.

OMH Region	County	2004 US Census Est. Population Ages 19 and Under	**Child & Adolescent Psychiatrist	Child & Adolescent Psychiatrist per 100,000 population
Central	Broome	50,441	6	12
	Cayuga*	20,739	0	0
	<i>Chenango*</i>	13,552	0	0
	Clinton	19,899	3	15
	Cortland*	13,444	1	7
	<i>Delaware*</i>	11,621	0	0
	<i>Essex*</i>	8,764	2	23
	Franklin*	11,883	2	17
	Fulton*	14,079	0	0
	Hamilton*	1,027	0	0
	<i>Herkimer*</i>	15,771	0	0
	Jefferson*	31,454	1	3
	<i>Lewis*</i>	7,293	0	0
	Madison*	19,538	1	5
	Montgomery	12,584	2	16
	Oneida	59,383	2	3
	Onondaga	127,389	18	14
	<i>Oswego*</i>	34,614	0	0
	<i>Otsego*</i>	29,669	1	3
	<i>St. Lawrence*</i>	16,079	3	19
Total Region		519,223	42	8
Hudson River	Albany	75,531	13	17
	Columbia*	15,656	0	0
	Dutchess	78,767	9	11

Table 10. Supply of Child & Adolescent Psychiatrists by Region and County				
OMH Region	County	2004 US Census Est. Population Ages 19 and Under	**Child & Adolescent Psychiatrist	Child & Adolescent Psychiatrist per 100,000 population
	<i>Greene*</i>	12,154	0	0
	Orange	111,872	5	4
	Putnam	27,186	0	0
	<i>Rensselaer*</i>	39,926	1	3
	Rockland	87,316	26	30
	Saratoga	54,353	11	20
	Schenectady	38,684	2	5
	<i>Schoharie*</i>	8,455	2	24
	Sullivan	19,616	2	10
	Ulster	44,782	3	7
	Warren	15,872	3	19
	<i>Washington*</i>	15,642	0	0
	Westchester	255,697	130	51
	Total Region	901,509	207	23
Long Island	Nassau	350,855	100	29
	Suffolk	407,563	58	14
	Total Region	758,418	158	21
New York City	Bronx	441,051	31	7
	Kings	708,914	66	9
	New York	301,973	253	84
	Queens	544,338	64	12
	Richmond	123,225	9	7
	Total Region	2,119,501	423	20
Western	<i>Allegany*</i>	14,394	0	0
	<i>Cattaraugus*</i>	22,877	0	0
	<i>Chautauqua*</i>	35,987	1	3
	Chemung	23,289	2	9
	Erie	241,135	23	10
	<i>Genesee*</i>	15,737	0	0
	<i>Livingston*</i>	17,048	0	0
	Monroe	201,931	33	16
	<i>Niagara*</i>	56,242	3	5
	Ontario	27,022	5	19
	<i>Orleans*</i>	11,742	0	0
	<i>Schuyler*</i>	5,011	0	0
	<i>Seneca*</i>	8,546	0	0
	<i>Steuben*</i>	26,096	0	0
	Tioga	13,954	0	0
Tompkins	25,577	1	4	

OMH Region	County	2004 US Census Est. Population Ages 19 and Under	**Child & Adolescent Psychiatrist	Child & Adolescent Psychiatrist per 100,000 population
	<i>Wayne*</i>	26,114	0	0
	<i>Wyoming*</i>	10,339	0	0
	<i>Yates*</i>	7,006	0	0
	Total Region	790,047	68	9
	Statewide Total	5,088,698	898	18
<p>Note: Italicized font indicates county was designated a federal Mental Health Professional Shortage Area as of 01/2008. An asterisk next to a county name indicates that the county has been designated a mental health regents Physician shortage area as of 01/2008. ** Staats, M. <i>Improving Access to Child Psychiatric Services</i>. (2005). Washington, DC: National Association of County Behavioral Health and Developmental Disability Directors.</p>				

In the Hudson River region, supply ratios of child and adolescent psychiatrists range from 0 to 51 and average 23. Four counties (25%) in the Hudson River region have no child and adolescent psychiatrist.

Overall, 24 of the 57 counties in New York State (not including New York City) have no child and adolescent psychiatrist. Statewide, 368,198 individuals ages 19 or younger live in a county with no child and adolescent psychiatrist. Forty-nine percent (n=178,864) are in the Western region, 32% are in the Central region (n=118,696), and 19% are in the Hudson River region (70,638).

Variations in child and adolescent psychiatrist supply ratios across New York City's counties are the largest in any region in the State, with supply ratios ranging from 7 each in Bronx and Richmond counties to 84 in New York county (Manhattan). On Long Island, the supply ratio is 14 in Suffolk county and 29 in Nassau county, while the population ages 19 and younger is 16% larger in Suffolk than in Nassau.

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III. Demographics of the Mental Health Workforce

Aging

The licensed mental health workforce in New York State is aging. Table 11 describes age groups among psychologists, LCSWs, nurse practitioners – psychiatry, and the category “Other”, which includes Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.

Age Group	Psychologist		LCSWs		Nurse Practitioner - Psychiatry		Others*		Total	
	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof
< 30	83	1%	187	1%	12	1%	181	3%	463	1%
31 - 38	1,656	15%	3,023	12%	89	9%	1,214	18%	5,982	14%
39 - 50	2,832	25%	6,137	25%	275	26%	1,671	25%	10,915	25%
51 - 61	3,950	35%	9,333	38%	513	49%	2,401	35%	16,197	37%
62 - 75	2,303	20%	5,137	21%	143	14%	1,177	17%	8,760	20%
> 75	555	5%	598	2%	5	0%	151	2%	1,309	3%
Unknown	4	0%	17	0%	1	0%	3	0%	25	0%
Total	11,383	100%	24,432	100%	1,038	100%	6,798	100%	43,651	100%

*"Other" includes Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.
Data Source: Office of the Professions, NYS Education Department, January 2008.

On the statewide level, these data show that 60% of mental health practitioners are over 50 years of age, 23% are of retirement age (62 years and older) and only 15% are under the age of 39. The difference in the size of the retirement population compared to the population under the age of 39 speaks to recruitment issues. Aging issues are of greatest concern among psychologists and psychiatrists, with 25% of psychologists (Table 7) and at least 25% of psychiatrists (Table 12) ages 62 years and older. More than half (52%) of psychiatrists in the State are ages 55 and older.

Age Group	Psychiatrists	
	N	Percent
< 35	250	4%
35-44	1086	17%
45-54	1752	27%
55-64	1738	27%
> 65	1602	25%
Unknown	11	0%
Total	6439	100%

Aging trends in New York State’s licensed mental health workforce are further demonstrated by looking at years since degree for licensure. Statewide, 41% of the mental health professions described in the Table 13 are 20 or more years from their degree for licensure. This includes 44% of LCSWs, 40% of psychologists, 36% of the mental health professions in the “Other” category (e.g., marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists), and 10% of nurse practitioners in psychiatry.

Group of Years Since Degree	Psychologist		LCSWs		Nurse Practitioner - Psychiatry		Others		Total	
	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof	N	Pct of Prof
< 10	2,934	26%	4,069	17%	566	55%	2,027	30%	9,596	22%
10 - 19	3,070	27%	8,609	35%	274	26%	2,182	32%	14,135	32%
20 - 29	2,843	25%	6,905	28%	67	6%	1,492	22%	11,307	26%
30 and Over	1,748	15%	3,890	16%	38	4%	966	14%	6,642	15%
Unknown	788	7%	959	4%	93	9%	131	2%	1,971	5%
Total	11,383	100%	24,432	100%	1,038	100%	6,798	100%	43,651	100%

*"Other" includes Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, and Creative Arts Therapists.
Data Source: Office of the Professions, NYS Education Department, January 2008.

Race and Ethnicity

U.S. Mental Health Workforce

Complete race and ethnicity data are unavailable for members of the New York State mental health workforce who are not employed by OMH. Race and ethnicity data for the U.S. mental health workforce and OMH psychiatric center licensed direct patient care staff can provide insight into the mental health workforce in New York State. Table 14

³¹ Armstrong DP and Forte GJ. *Annual New York Physician Workforce Profile, 2007 Edition*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany: December 2007.

describes the U.S. mental health workforce by race and ethnicity. Figures from the 2005 U.S Census estimate are used to provide an overall comparison population.

Race/Ethnicity	2005 U.S. Census Estimate*	Disciplines					
		Psychiatrists 2002 (N=24,932)	Psychologists 2004 (N=84,883)	Social Workers 2004 (N=103,128)	MH Counselors 2004 (N=100,533)	Advanced Practice Psych Nurses 2003 (N=8,751)	Hospital-based Psych RNs 2003 (N=33,891)
White	80.2%	75.0%	93.1%	86.8%	81.9%	80.6%	82%
Black	12.8%	2.5%	2.2%	4.5%	4.1%	3.2%	12%
Asian	4.3%	10%	1.7%	1.2%	0.8%	1%	
American Indian	1%	0.1%	0.3%	0.2%	0.5%	0.5%	
Other race/multiracial	1.5%						7%
Race not specified		7.8%	0%	2.5%	10.7%	12.2%	
Hispanic	14.4%	4.4%	2.6%	2.9%	2%	2.5%	N/A

Data for psychiatrists, psychologists, social workers, counselors and advanced practice psychiatric nurses: SAMHSA, Mental Health, United States, 2004. Data for hospital-based psychiatric registered nurses: Hanrahan, N.P., & Gerolamo, A.M. (2004). Profiling the Hospital-Based Psychiatric Registered Nurse Workforce. *Journal of the American Psychiatric Nurses Association*, 10(6), 282-289.
U.S. Census data retrieved July 11, 2007, from <http://quickfacts.census.gov/qfd/states/00000.html>

These data describe a national mental health workforce that is overwhelmingly White and where minorities are under-represented across disciplines. Table 15 compares minorities in the U.S. population to the percent of minorities in mental health disciplines nationally. Except for Asian psychiatrists, minorities are under-represented across mental health disciplines. Both Blacks and Hispanics are dramatically under-represented in mental health disciplines compared to their proportion of the general population.

Race/Ethnicity	2005 U.S. Census Estimate	U.S. Mental Health Disciplines	Percent Minority
Black	12.8%	social workers	4.5%
		counselors	4.1%
		advanced practice psych nurses	3.2%
		psychiatrists	2.5%
		psychologists	2.2%
Asian	4.3%	psychiatrists	10%
		psychologists	1.7%
		social workers	1.2%
		advanced practice psych nurses	1%
		nurses	0.8%

Table 15. In the U.S. Minorities are Under-Represented across Mental Health Disciplines			
Race/Ethnicity	2005 U.S. Census Estimate	U.S. Mental Health Disciplines	Percent Minority
		counselors	
American Indian	1%	counselors advanced practice psych nurses psychologists social workers psychiatrists	0.5% 0.5% 0.3% 0.2% 0.1%
Hispanic	14.4%	psychiatrists psychologists social workers advanced practice psych nurses counselors	4.4% 2.6% 2.9% 2.5% 2%

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Race and Ethnicity of the NY State Psychiatric Center Mental Health Workforce

Table 16 compares race and ethnicity in New York’s State psychiatric center direct patient care workforce to State and national demographics. These data show that New York State is more racially and ethnically diverse than the nation, and that our State psychiatric center workforce is generally more diverse than the comparable national workforce. In New York State in 2005, 17.4% of the general population was Black compared to 12.8% nationally, 6.8% was Asian compared to 4.3% nationally, and 16.1% was Hispanic compared to 14.4% nationally. Black, Asian, and Hispanic minorities working in New York State psychiatric centers are proportionally larger than those in the national mental health workforce. For example, 18% of hospital-based psychiatric nurses in the State psychiatric centers are Black compared to 12% nationally; 33% of psychiatrists are Asian compared to 10% nationally, and 9% of social workers are Hispanic compared to 2.9% nationally.

Table 16. Comparison of Minority Populations in U.S., NYS, and NYS OMH Psychiatric Center Mental Health Disciplines					
Race/Ethnicity	2005 U.S. Census Estimate	2005 NYS U.S. Census Estimate*	OMH State Psychiatric Centers MH Disciplines	U.S. (2002-2004, see Table 16)	NYS Psychiatric Center (11/2007)
				<i>MH Workforce Percent Minority</i>	
Black	12.8%	17.4%	hospital-based psychiatric nurses psychiatrists psychologists social workers	12% 2.5% 2.2% 4.5%	18% 6% 4% 23%
Asian	4.3%	6.8%	hospital-based psychiatric nurses psychiatrists psychologists social workers	N/A 10% 1.7% 1.2%	15% 33% 4% 5%
American Indian	1%	0.5%	hospital-based psychiatric nurses psychiatrists psychologists social workers	N/A 0.1% 0.3% 0.2%	0.41% 0.40% 0.20% 0%
Hispanic	14.4%	16.1%	hospital-based psychiatric nurses psychiatrists psychologists social workers	N/A 4.4% 2.6% 2.9%	3% 5% 6% 9%
*Source: U.S. Census, retrieved July 11, 2007 from http://quickfacts.census.gov/qfd/states/36000.html NYS Data: OMH State Psychiatric Center Licensed Direct Patient Care Workforce Data: November 2007					

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Table 17 describes race and ethnicity of inpatients served in New York State psychiatric centers compared to the same demo-graphics for the licensed direct patient care staff serving them. According to these data, minorities are under-represented in New York's State psychiatric center workforce compared to Black and His-panic inpatients served; e.g., 37% of inpatients were Black compared to 14% of direct patient care staff, while 15% of inpatients were Hispanic compared to 4% of staff.³² At the same time, Asians comprised 16% of the State psychiatric center workforce compared to 2% of inpatients served.

Table 17. OMH State Facilities Licensed Direct Patient Care Workforce by Race & Ethnicity							
Race/Ethnicity	NYS Census, 2005 U.S. Census Estimate	State PC Inpatients, 2005	OMH State Psychiatric Center Licensed Direct Patient Care Workforce				
			All Staff	Psychiatric Nurses	Psychiatrists	Psychologists	Social Workers
White	73.8%	44%	54%	53%	44%	74%	56%
Black	17.4%	37%	14%	18%	6%	4%	23%
Asian	6.8%	2%	16%	15%	33%	4%	5%
American Indian	0.5%	0.30%	0.37%	0.41%	0.40%	0.20%	0%
Other race/ multiracial	1.50%	1%	N/A	N/A	N/A	N/A	N/A
Race unknown	N/A	0.21%	11%	12%	12%	13%	7%
Hispanic	16.1%	15%	4%	3%	5%	6%	9%

*Source: U.S. Census, retrieved July 11, 2007 from <http://quickfacts.census.gov/qfd/states/36000.html>
 NYS Data: OMH State Psychiatric Center Licensed Direct Patient Care Workforce Data: November 2007

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³² These data should be interpreted with caution given race is unknown for 11% of the State psychiatric center licensed direct patient care workforce.

Summary Highlights

Size of the Mental Health Workforce

- In New York State, the licensed mental health workforce includes psychiatrists, psychologists, psychiatric-mental health nurses, LCSWs, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists. It is not possible to identify the statewide population of nurses specializing in psychiatric–mental health because all nursing specialties are combined in the State licensing data and in data collected by professional nursing organizations.
- The estimated size of the licensed mental health workforce, not including nurses, is in excess of 50,090. LCSWs make up the largest proportion statewide (49%), followed by psychologists (23%), others³³ (14%), psychiatrists (13%), and nurse practitioners–psychiatry (2%).
- There are only 898 child and adolescent psychiatrists in New York State, reflecting the severe shortage of child and adolescent psychiatrists nationally. Overall, 24 of the 57 counties in New York State (not including New York City) have no child and adolescent psychiatrists.

Distribution of the Mental Health Workforce

- By OMH region, 76% of these licensed mental health workers practice in the New York City (39%), Hudson River (20%) and Long Island (17%) regions. Fourteen percent practice in the more rural Western (9%) and Central (5%) regions.
- Dramatic differences exist in supply ratios by region. Across all licensed mental health disciplines (excluding nurses), supply ratios are highest in Long Island (303 per 100,000), the Hudson River region (294 per 100,000) and New York City (238 per 100,000), and lowest in the Western (146 per 100,000) and Central (131 per 100,000) regions.
- Licensed mental health workers in New York State tend to cluster in urban and suburban areas, leaving rural and inner-city areas understaffed. For example, 58% of psychiatrists and 38% of psychologists practice in New York City, where 43% of the State’s population resides. In contrast, 11% of both psychiatrists and psychologists practice in the more rural Central and Western regions, where 26% of the State’s population resides.
- New York’s shortage of child and adolescent psychiatrists is compounded by a serious mal-distribution of child and adolescent psychiatrists in both rural and urban areas.

³³ Because of their small numbers, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists are combined in an "Other" category in this analysis.

- Overall, 24 of the 57 counties outside of New York City have no child and adolescent psychiatrist. Statewide, 368,198 individuals ages 19 or younger live in these counties. Forty-nine percent (n=178,864) live in the Western region, 32% (n=118,696) live in the Central region, and 19% (n=70,638) live in the Hudson River region.
 - In New York City, variations in child and adolescent psychiatrist supply ratios between counties are the largest for any region in the State. In the population ages 19 and younger, supply ratios range from 7 per 100,000 in both Bronx and Richmond counties to 84 per 100,000 in New York county.
- As of January 2008, 31 of New York's 62 counties (50%) are designated as Mental Health Professional Shortage Areas and 12% of the State's population lives in those areas. Overall, 2,275,872 people in the State live in designated federal and/or state mental health shortage areas.
- Approximately 84% of counties designated as mental health shortage areas are located in the Central and Western regions. In each region, approximately two-thirds of all counties have been designated as shortage areas. One-third of the population in the Western region lives in a designated mental health shortage area and nearly one-half (48%) of the population in the Central region lives in a shortage area.

Demographics of the Mental Health Workforce

- Statewide, 60% of psychologists, LCSWs, nurse practitioners—psychiatry, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists are over 50 years of age, 23% are of retirement age (62 years and over) and only 15% are under the age of 39. These issues are of greatest concern among psychologists and psychiatrists. Statewide, 25% of psychologists and at least 25% of psychiatrists are of retirement age. More than half (52%) of psychiatrists in the State are ages 55 and older.
- Complete race and ethnicity data are unavailable for members of the New York State licensed mental health workforce. Race and ethnicity data for the U.S. mental health workforce and OMH psychiatric center (PC) licensed direct patient care staff can provide insight into the mental health workforce in New York State.
- Available national data describe a national mental health workforce that is overwhelmingly White and where minorities are generally under-represented across disciplines. Except for Asian psychiatrists, minorities are under-represented across mental health disciplines. Both Blacks and Hispanics are dramatically under-represented in mental health disciplines compared to their proportion of the general population.
- According to OMH data, minorities are under-represented in New York's State psychiatric center workforce compared to Black and Hispanic inpatients served; e.g., 37% of inpatients were Black compared to 14% of direct patient care staff, while

15% of inpatients were Hispanic compared to 4% of staff. At the same time, Asians comprised 16% of the State psychiatric center workforce compared to 2% of inpatients served.