CENTER FOR HUMAN SERVICES RESEARCH
UNIVERSITY AT ALBANY State University of New York

ASSESSING AND ADDRESSING THE NEED FOR CHILD AND ADOLESCENT PSYCHIATRISTS IN NEW YORK STATE:

REPORT ON A COUNTY WIDE TELEPHONE SURVEY

JUNE 2008

Assessing and Addressing the Need For Child and Adolescent Psychiatrists in New York State:

Report on a County Wide Telephone Survey

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This report was prepared by Lara Kaye, Cathleen Lewandowski, Rose Greene, Janet Acker and Nancy Chiarella.

The report benefited by the thoughtful feedback from Lynn Warner and Sarah Rain. We would like to acknowledge the efforts of Dorothy Baum for assistance with CATI, Chris Papas for assistance with programming report validations, John Heck for assistance with maps, Min Jeong Kang for assistance with formatting data and figures, and Dikla Madera and Denise Carner for formatting and editing the report.

ACKNOWLEDGEMENTS

The Center for Human Services Research (CHSR) thanks the New York State Conference of Local Mental Hygiene Directors (CLMHD), in particular Mary Coppola, for providing ongoing support and cooperation throughout the study, and the study's respondents whose time and consideration made this report possible. Additional input was provided by advisory committee members: Robin Siegal, Kathleen Plum, James Yonai, Brian Hart, Thomas MacGilvray, Maria Baltz, Sherrie Gillette, and Art Johnson all from the County Mental Health Offices, and Janine D. Lounsbery from Families Together of New York. We also express our appreciation for consultation on the development of the instruments to Gregory Fritz at the American Academy of Child and Adolescent Psychiatry, Jean Jacque Breton at the University of Montreal, Brigette Courtot for Embry Howell at the Urban Institute, Jean Moore at the Center for Health Workforce Studies University at Albany, and Ira Cohen at Psychiatric Advisory Group, Inc. as well as David Woodlock, Robert Allen, Allison Campbell, and Kristin Riley at the NYS Office of Mental Health.

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EXECUTIVE SUMMARY

A needs assessment for Child and Adolescent Psychiatry (CAP) and mental health services for children and adolescents in New York State was conducted by the Center for Human Services Research (CHSR) and supported by the New York State Conference of Local Mental Hygiene Directors (CLMHD). The project consisted of a telephone survey of all 58 counties in NYS and the analysis of census and other relevant data sets.

In an effort to provide a comprehensive examination of the need for CAPs, child and adolescent mental health services and needs were also examined. CAP services do not exist in a vacuum but are closely intertwined with existing services and the need for services in the communities. The survey goals were to describe the current status of child psychiatrists providing services in each county, to illustrate the mental health service system in each county as it pertains to child and adolescent psychiatry, to describe the need for child and adolescent mental health services in each county, to explore alternative strategies such as telepsychiatry, and to identify any unique characteristics that impact on the delivery of child and adolescent mental health services.

Background

It is well documented that there is a vast unmet need for child and adolescent mental health services, and in particular, for CAPs (Center for Health Workforce Studies [CHWS], 2006; Costello, Messer, Bird, Cohen, & Reinherz, 1998; Kim 2003; National Association of County Behavioral Health and Developmental Disability Director [NACBHDDD], 2005; U.S. Department of Health and Human Services [USDHHS], 1999). Alternatives to meeting these needs in the face of CAP shortages do exist. They include relying on other professionals to prescribe and or monitor psychotropic medications for children and adolescents (Koppelman, 2004), using telepsychiatry, and training other professionals in child and adolescent psychiatry, in particular psychotropic medication.

Methods

A telephone survey was developed and implemented to gather information on CAPs and child and adolescent mental health services and needs. The study participants were community mental health directors, commissioners, or a party with comparable knowledge in the 58 counties.

Survey questions were developed based on a literature review, similar surveys, consultation with a project advisory committee, and interviews with other professionals knowledgeable on the topic. The survey was made up of five sections: 1) Current Status of CAPs in each County; 2) The Need for CAPs; 3) Alternative Strategies to CAPs; 4) Influences on Child and Adolescent Psychiatric Services; and 5) Respondent Priorities.

Interviews took place from October 2007 through mid December 2007 with a 100% response rate of 58 counties.

Secondary data on county level demographic and mental health service information was included to supplement the telephone survey data.

Findings

Due to the challenge of accurately providing detailed information in the Top 7 most populous counties, some data are reported separately for the Top 7 and the remaining 51 counties.

CAPs: Numbers and Needs

The data represent a snapshot in time of the most accurate information on the number and demographics of CAPs providing services in each of the 58 counties.

Twelve counties had no CAPs and another nine counties had one. The counties who did identify having CAPs reported that many are part-time. Using per capita calculations (based on youth population) and serious emotional disturbances (SED) estimates for the 51 counties, on average each CAP could carry a caseload of 462 youth.

Nearly all counties reported the need for additional CAPs with the Top 7 counties needing a much higher number of CAPs (average of 34) than the remaining 51 counties (average of 2).

Mental Health Services: Waits, Barriers and Coordination

Wait times for child and adolescent mental health services vary greatly throughout the year, based on seasonal factors, bed occupancy and availability, as well as gender, age, and patient needs including clinical severity.

The three greatest barriers counties reported were transportation, mental health workforce capacity including recruiting and retaining staff, and availability of sufficient and flexible public funds.

Coordination of care between mental health and other systems was reported as moderate to good, with child welfare, juvenile justice and education rating higher than primary health care. This may be attributed to the lack of structures to facilitate collaboration between the mental health system and primary health care.

Mental Health and CAP Service Needs

Over one-third of the counties rated school-age children, adolescents, and children and adolescents with special needs with the most significant need for CAP services. Nearly half of the 51 counties reported a significant need for psychiatric assessment. This was followed by nearly one-third of the counties reporting a significant need for medication consultation, medication management and inpatient psychiatry.

Over half the counties reported the need for additional beds for inpatient psychiatry, residential treatment facility (RTF) and long-term state hospitalization. On average between 8 and 24 new or additional beds were needed.

Alternatives

The top four professional groups filling in for CAPs by prescribing and/or monitoring psychotropic medications for children and adolescents were pediatricians, primary care physicians, adult psychiatrists and nurse practitioners. Nearly all counties indicated that relying on other professionals does not adequately meet the county needs and the arrangement places a strain on the other professional groups.

Over one-third of the counties have used telepsychiatry, half through the NYS Office of Mental Health initiative. Where it was used, implementation varied but most often it was a one time event and used for the most difficult cases.

Over half of the counties who used it noted benefits such as access to CAP expertise for treatment and consultation. Drawbacks included time requirements, staff resistance, and scheduling challenges. Counties that were not using telepsychiatry reported that they were somewhat interested in it.

Over one-third of the counties were using other strategies including employing nurse practitioners with advanced certification in child psychiatry, employing locum tenens CAPs, and providing special trainings in child and adolescent psychiatry for other medical professions. Increased capacity was mentioned as a benefit of all three approaches.

Influences and Trends

Few counties reported unique or adverse events that directly impacted the need for or availability of child and adolescent psychiatric services. More often, the counties reported community characteristics that indirectly impacted child and adolescent psychiatric services such as poverty, unemployment and business closings.

Counties reported that over time children presenting with mental health problems are increasingly younger and have more complex problems. This has impacted service delivery and financial structures. There is a notable shift towards more integration of services between systems of care.

Recommendations

The recommendations are divided into those of the telephone survey respondents and our summary recommendations.

Respondents' Priorities and Recommendations

Counties reported that priorities regarding CAP and child and adolescent psychiatric services were to increase the number and availability of CAPS through increased recruitment efforts, developing relationships with residency programs, and coordinating sharing arrangements with other counties or organizations. Recruitment and retention of existing staff and mental health providers and support for other prescribing professionals who are providing services to children and adolescents were also mentioned. Establishing adequate funding and resources for these efforts was a consistent theme.

Summary Recommendations

Based on the literature review, secondary data analysis, telephone survey findings and feedback from our advisory council and attendees at the CLMHD Spring Membership Meeting, we have identified five areas to target for change: increase and maintain capacity; emphasize prevention; support system collaboration; restructure financing; and improve access to care.

1) Increase and Maintain Capacity

Recommendations to increase and maintain CAP capacity include:

Training

- Develop publicity campaigns aimed at attracting students to the CAP specialty
- Develop mentorship opportunities within CAP training programs

- Allocate funding for CAP training programs (SCAA and NYSCLMHD proposal)
- Allocate funding for loan deferment and loan forgiveness
- Re-examine residency training requirements for CAP trainees

Attracting CAPs to NYS and especially to underserved locations

- Develop a publicity campaign to attract CAPs to work in NYS and in rural communities
- Increase salaries and provide other financial incentives
- Offer statewide professional head hunting services to search for and attract CAPs

Maintaining capacity

- Organize regional teams of CAPs to create a network of support
- Develop the infrastructure to stimulate and offer opportunities to grow, such as annual conferences or monthly in-services via remote technology

2) Emphasize Prevention

Another way to reduce the need for services is to emphasize preventive approaches such as:

- Increase screening opportunities for child and adolescents
- Support and integrate mental health prevention services in early childhood programs
- Increase crisis services such as mobile unit and crisis/respite beds in order to prevent the need to use higher levels of care

3) System Integration and Collaboration

System integration approaches can include:

- Establish funding for regional system of care initiatives throughout NYS
- Fund staff positions devoted to fostering system collaboration
- Provide cross system services for children and adolescents with co-occurring disorders
- Develop initiatives to foster collaboration between mental health services and primary care providers

4) Restructure Funding Mechanisms

The lack of funding flexibility, cumbersome funding requirements, and antiquated reimbursement structures and contract rates are key issues for the field. Recommendations related to funding include:

- Revisit contract rates and reimbursement structures: build more flexibility into Medicaid funding and introduce reimbursement that supports good clinical choices
- Collaboration between OMH licensed facilities and health insurance organizations that provide Child Health Plus to ensure providers, and CAPs in particular are willing to accept these plans
- Expand Timothy's Law to cover our most vulnerable families by removing the exceptions to the law for example the Healthy New York and Child Health Plus programs

5) Improve Access to Care

To improve access to care, the following recommendations should be considered:

- Use established techniques for the successful implementation of telepsychiatry
- Utilize technology that patients can access within their homes
- Provide training on prescribing and monitor psychotropic medications to other medical professionals who provide services to children and youth
- Provide travel vouchers to clients who are in financial need

II

INTRODUCTION

This report was prepared by the Center for Human Services Research (CHSR), University at Albany, for a project supported by the New York State Conference of Local Mental Hygiene Directors (CLMHD) to conduct a needs assessment of Child and Adolescent Psychiatry (CAP) and child and adolescent mental health services in New York State.

This study is a comprehensive examination of the current status and need for CAPs in New York State. CAP services do not exist in a vacuum but are closely intertwined with existing child and adolescent mental health services and the need for these services in the counties; therefore we also explored mental health services and mental health needs for children and adolescents.

The goals of the research were to:

- Describe the current status of child and adolescent psychiatry services in NYS
- Examine NYS county mental health systems in relation to child and adolescent psychiatry services
- Describe the need for child and adolescent mental health services in each county
- Identify alternative strategies to address child and adolescent mental health needs including telepsychiatry
- Identify unique characteristics of counties that influence the delivery of child and adolescent mental health services

The major source of data for this project was a statewide telephone survey of county mental health officers in New York State. This was supplemented by an analysis of census and other relevant data sets and a review of documents and literature in the field.

The New York State Conference of Local Mental Hygiene Directors (CLMHD) plans to utilize the findings from this report to inform their efforts to address the needs of children and adolescents affected by mental illness and more specifically to contribute to the Solutions to End Psychiatric Shortages (STEPS) campaign. These efforts include the CLMHDs' interest in working cooperatively with the NYS Office of Mental Health (OMH) and collaborating wherever possible.

This report begins with general background information about the need for child and adolescent mental health services, the availability of CAPs, workforce issues and strategies to address the need for CAPs. This is followed by a review of the methodology used to gather data for this report. The third section reports on the study findings. Most of the findings are reported in aggregate with some breakdowns by rural and urban areas. Appendices present detailed tables of findings for each county. The final sections of the report present conclusions from the study and a series of recommendations.

III

BACKGROUND

Child and Adolescent Mental Health Needs

Since 1980, several studies have documented significant gaps between the need for child and adolescent mental health services and the availability of CAPs. The American Academy of Child and Adolescent Psychiatry Task Force on Work Force Needs (AACAPTF, 2001) projected a 100% increase in service needs among children and adolescents between 1995 and 2000. The US Department of Health and Human Services estimates that one in five youth will develop a mental disorder during the course of a year (1999). Kim (2003) estimates that 12-20% of children and adolescents suffer from mental health problems. Estimates of the prevalence of serious emotional disturbances (SED) for children and adolescents (4-18 years) range from 6-17% (Costello et al. 1998); this window closes to 9-13% for a smaller age range, 9-17 years (Kim, 2003). In this same age range 5-10% suffers of extreme/severe functional impairment (Kim, 2003).

Using these estimates and applying them to New York State Census 2000 data for 9-17 year olds[1], the above figures could translate to up to 475,918 children with mental health problems, 309,347 children with a SED and 237,959 children suffering from extreme/severe functional impairment.

CAP Availability to Address Mental Health Needs

It is estimated that currently there are only approximately 6,300 CAPs to treat the millions of children with mental health conditions in the United States (Kim, 2003). Between 1995 and 2000, a 30% increase in CAPS was projected (AACAPTF, 2001). If a CAP is to treat just the most severely impaired children, each one has to carry a caseload of 750 severely disturbed children at any given time (Kim, 2003).

In 2004, 898 CAPS in New York were responsible for treating one million children. If all of these children were receiving the treatment from CAPs this would translate into potential caseloads of 1,113 children per CAP (Schuyler Center & NYS Conference of Local Mental Hygiene Directors [SCAA & NYSCLMHD], 2008).

For children, unaddressed emotional disorders can result in serious long-term outcomes such as poor academic progress, higher risk for substance use, higher involvement with the correctional system, vocational problems, health problems, and increased incidence of suicide (Substance Abuse and Mental Health Services Administration [SAMHSA], 2003).

Another significant consequence of not providing services to young people at the first onset of mental illness is the long term implications of untreated conditions. Half of all lifetime mental health cases begin by age 14 and three-quarters by age 24 (Kessler et al., 2005). The window of opportunity that bodes well for success in treating children - when there is affective and brain plasticity and while personalities are still developing - is missed when CAP services are not available. These disorders are more intractable and harder to address when allowed to worsen and persist into adulthood (Fritz, 2005). These untreated disorders also often lead to later co-morbidity and more persistent clinical courses (Kessler, 1997; Kessler & Price, 1993).

[1] Based on Census 2000 data for only 9-17 year old for consistency with estimates from literature

Disparities in Child and Adolescent Mental Health Services

The risk of developing a mental health disorder is higher for children and adolescents growing up in poverty (Thomas & Holzer, 2006). Overall, 79% of children and adolescents 6-17 years who are in need of mental health services do not receive them and the unmet need is greatest for Hispanic children and adolescents at 88% and the uninsured at 87% (Kataoka, Zang, & Wells, 2002). African American children and adolescents are significantly less likely to receive treatment than Whites and Hispanics, and the uninsured are also less likely to receive treatment than those with public or private insurance (Olfson, Gameroff, Marcus, & Waslick, 2003).

Psychiatry suffers from a rural-urban disparity more than any other medical specialty (Goldman, 2001). More CAPs are located in metropolitan counties with low percentages of children and adolescents living in poverty. Thomas and Holzer (1999) note that this inequitable distribution of CAPs further decreases the likelihood of children and adolescents living in areas of poverty and in rural areas having access to needed services. In New York State "one quarter of the population lives in areas that are designated as underserved by appropriate health care providers" (SCAA & NYSCLMHD, 2008, p. 8).

Status of Child and Adolescent Psychiatry Workforce in New York State

New York State trains twice as many CAPS as other states, but upon completion of their training half of those CAPS leave to work elsewhere (SCAA & NYSCLMHD, 2008).

In 2004, 39% of New York State's counties did not have any CAPs at all and 71% had fewer than four CAPs in the county (SCAA & NYSCLMHD, 2008). Nearly 90% of the CAPs in the state were in eleven counties: primarily in the NYC metropolitan region, which is geographically distant from most of the rest of the state. Rural counties in NYS suffer disproportionate CAP shortages (SCAA & NYSCLMHD).

In 2001, the median age of psychiatrists was in the mid fifties (Goldman, 2001). In 2005 this trend continued in New York, with 70% of CAPS at age 45 or older and 41% of CAPS at age 55 or older (CHWS, 2006). The potential of a workforce headed toward retirement increases pressure on an already stretched workforce and on CAPS recruitment.

How CAP Training Impacts Workforce Issues

In 1990 Abt Associates reported that the United States needed an additional 3,300 CAPs to add to the 7,000 in practice. With only 300 CAPS completing training each year, meeting the shortage is a daunting challenge (NACBHDDD, 2005).

To understand the shortage of CAPS it is important to first understand the nature of CAP training. After four years of medical school and at least three years of residency training, the CAP specialty requires an additional two years of training. The training consists of specific child and adolescent therapeutic treatment modalities, developmental theory, psychopharmacology, and pediatric neurology as well as how to work with families, schools and the legal system (Fox, 2005).

In spite of the need for CAPS there have been decreases in the number of training programs from 130 in 1980 to 114 in 2002 (Kim, 2003). Programs have closed due to health care financing trends, failures to recruit both faculty and trainees, and decreased academic funding. The

reorganization in the 1980s of NIH and NIMH eliminated funding for CAP training, de-institutionalization brought about the closure of residencies in state operated facilities, managed care brought about reimbursement constraints and the 1997 Balance Budget Act reduced Graduate Medical Education (GME) funding to 50% for subspecialty training (Kim, 2003). GME, a key financial support for both training programs and residents, is not equitable, providing full funding for training in other specialties such as geriatric psychiatry but only partial funding for CAP training (SCAA & NYSCLMHD, 2008).

If one does enroll in CAP training, there are other disincentives to completing training. Private insurance reimbursement rates for psychiatric services are lower than customary charges and most reimbursement rates are the same for adults and children when children require more time and effort to do the necessary consultation with family, school and other providers (Koppelman, 2004).

Two additional years of training increase the educational costs for those who wish to pursue child and adolescent psychiatry to the point of dissuading candidates, especially when reimbursement potential is a disincentive as noted above (Koppelman, 2004). Loan forgiveness programs designed to provide services in health professional shortage areas are available, but they are scarce and underfunded and thus can only help a small number of CAPs (NACBHDDD, 2005).

Financial challenges to obtain CAP education are extraordinary in the face of limited financial support and disparities. Upon program completion these disparities continue as reflected in the evidence that CAP salaries rank 20th among 28 medical specialties (Fritz, 2007).

Alternative Strategies to Address the Need for CAPs

Alternative strategies to address the need for CAPs include using telepsychiatry, providing special trainings for other professionals who serve children and adolescents, granting prescribing rights to non-physicians and using International Medical Graduates (IMG).

Telepsychiatry

Telepsychiatry is a tool to provide psychiatric services via video conferencing. A number of studies on telepsychiatry have demonstrated positive outcomes including patient satisfaction, and collaborative practices (Pesamaa, et.al, 2004). Other studies have determined that telepsychiatry services and face-to-face psychiatry services result in similar assessments, services, and outcomes (O'Reilly et.al., 2007; Singh, Arya, & Peters, 2007). Similar findings have been reported in studies with pediatric populations (Elford et al., 2000; Myers, Sulzbacher, & Melzer, 2004; Myers, Valentine, & Melzer, 2007). Recent studies have also indicated that recipients experience telepsychiatry positively (Cruz, Krupinski, Lopez, & Weinstein, 2005; O'Reilly et al., 2007; Surface, 2007) and at times prefer it to face-to-face provision of services (Hilty, Marks, Urness, Yellowlees, & Nesbitt, 2004). Telepsychiatry can be a powerful tool, particularly in rural settings, bringing services to those hard to reach families.

Ongoing concerns in the delivery of telepsychiatry services are security and confidentiality (Greenwood, Chamberlain, & Parker, 2004; Hilty et al., 2004; Nelson, 2007). Difficulties with technology and equipment problems are barriers that hinder comfort and satisfaction with the service for both patient and provider (Cruz et al., 2005; Hilty et al., 2004). Concerns have also been raised about the cultural aspects of telepsychiatry; there is a need for providers to have

familiarity and regular contact with rural communities (Shore, Savin, Novins, & Manson, 2006). And several studies have suggested further investigation of the impact of telepsychiatry on the dynamics of the patient-provider relationship (May et al., 2001; Shore et al., 2006). It has also been noted that something is lost with the use of technology such as the loss of visual cues to emotional communication (Pesamaa et al., 2004).

Another significant concern is how and whether third party reimbursement is instituted. This fiscal challenge is significant in establishing the sustainability of telepsychiatry practice (Nelson, 2007). To address this dilemma California, has enacted Medi-Cal (Medicaid) legislation that does not require face-to-face contact between provider and patient, and therefore allows reimbursement to providers for services that are provided through telepsychiatry (NACBHDDD, 2005).

Prescribing Psychotropic Medication

During the 1990s the development of new medications like SSRI's for the treatment of mental illness triggered significant growth in the rate of psychotropic prescriptions for children and adolescents, with prescription rates tripling between 1987 and 1996 (Koppelman, 2004). CAPS are the only mental health professionals trained in both the psychotherapeutic and the psychopharmaceutical treatment of mental illness in children and adolescents.

Currently pediatricians now prescribe 85% of all psychotropic medications taken by children and most of the prescribing is done without consulting trained psychiatrists (Koppelman, 2004). Most psychotropic medications prescribed to children and adolescents are off-label or unlicensed usage (Durham & England, 2002), and pediatricians do not receive training in psychopharmacology that is comparable to CAPs' training.

Many providers are practicing outside the scope of their practice (specialty and expertise) and do not have the training or support that would provide them with necessary skills (Gahagan & Gahagan, 2006). A 1999 study of North Carolina pediatricians found that only 16% of the respondents felt comfortable treating depression and only 8% reported adequate training in the treatment of depression (Rushton, Clark, & Freed, 2000).

In efforts to support pediatricians and meet the burgeoning need for children's psychiatric care, pediatric training has shifted to incorporate more emphasis on behavior and development, and in 2002 a subspecialty was designated in developmental and behavioral pediatrics (Koppelman, 2004). This training requires an additional two years of residency focusing specifically on the assessment and treatment of developmental and behavioral disorders (American Academy of Pediatrics, 2007).

Twelve states are considering granting prescribing rights to non-physicians who receive special training. New Mexico and Louisiana have already permitted psychologists who complete specialized training the ability to prescribe. While this creates a larger pool of providers who can assess and treat psychological disorders, there are questions about whether they are sufficiently trained in the biology of medication to understand drug interactions, metabolism and adverse effects, and to appropriately monitor the toxicity of medications (Koppelman, 2004).

Recruiting and Training CAPs

Part of the reason that CAP training program recruitment has remained steady over the last several years is due to the recruitment of International Medical Graduates (IMG) (Kim, 2003). Through J-1 visa regulations that waive the requirement that IMGs return to their home country for two years upon completion of their residency, states can recruit up to 30 IMGs to complete their residency within the state and then practice for three years in underserved areas within the state (SCAA & NYSCLMHD, 2008).

Literature on child and adolescent mental health need and CAP availability indicate that a gap exists. Addressing this gap involves CAP training, recruitment and workforce issues as well as mental health service disparities for poor and minority groups. Alternatives to deal with the gap include telepsychiatry and incorporating other professionals through training.

IV

METHODOLOGY

This section describes the methods used to obtain data for this report. The primary source of data was from a telephone survey of all New York State County mental health offices, including New York City. This was supplemented by census data, data from other relevant published data sources and a review of the literature.

Survey Sample

The study respondents were community mental health directors, commissioners, or a party of comparable status in 58 counties. For purposes of this study, NYC is referred to as a county and is defined as the population and area made up of all 5 boroughs (Queens, Kings, Bronx, Richmond, and Manhattan). Mental health directors from this area advised that NYC be interviewed as a whole for its delivery and coordination of mental health services rather than by individual borough.

Development of the Survey Instrument

Survey questions were built from a review of the literature and similar surveys and interviews with experts in the field (see Appendix 1: Questionnaire). We examined over 35 articles and documents on the topic of CAPs and psychiatric services; consulted with an Advisory Committee comprised of representatives from County Mental Hygiene Directors[2] and a family advocate for child and adolescent mental health services; and received advice from the Office of Mental Health, the American Academy of Child and Adolescent Psychiatrists, the Center for Health Workforces Studies at the University at Albany School of Public Health, the Research Unit at HRDP/University of Montreal[3], and the Urban Institute Health Policy Center[4].

There were two versions of the survey. The survey was modified for the 7 most populous counties in NY which are Erie, Monroe, Onondaga, New York (5 boroughs), Westchester, Suffolk, and Nassau. This second survey is referred to as the "Top 7 Survey." The Top 7 survey was a streamlined version of the larger measure. It asked the counties to identify the number of public outpatient CAPs (rather than all CAPs), and eliminated some of the detailed information on CAPS, practice hours in specific settings, and finances. This information was determined to be too difficult and time consuming for respondents in the larger counties. Otherwise, the data gathered from all counties is the same. The instrument contained five sections:

1. *Current Status of CAPs in Each County:* details on the demographics, workforce, and service settings of current CAPs in the county; mental heath budgets; coordination of psychiatric care with other systems; and barriers for delivering psychiatric services.

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[2] Representatives were from Albany County - the Northeast Region, Monroe County - the Western Region, Madison County - the Central NY Region, Chemung County - the Finger Lakes Region, Suffolk County - the Long Island Area and from Clinton County - the North Region

[3] Interview with Jean-Jacque Breton at University of Montreal who completed a study (semi-structured questionnaire to child psychiatry services heads) on child psychiatric services in Quebec's general and specialize hospitals.

[4] Brigette Courtot for Embry Howell at Urban Institute who completed a study (telephone interview with state officials) on child mental health services under Medicaid and SCHIP

2. *The Need for CAPs*: the need for CAPs and additional psychiatric services to meet the current demand for services. To gauge need, the survey inquired about wait times and wait lists for services, the need to leave the county to access services, and which professionals other than CAPs were treating youth with mental health needs.

3. *Alternative Strategies to CAPs*: specific strategies employed by counties (such as telepsychiatry) to meet the mental health needs of youth as a result of the shortage of CAPs and psychiatric services.

4. *Influences on Child Psychiatric Services:* external trends or changes in the consumers and on the future availability of CAPs for the county.

5. *Respondent Priorities*: respondents' priorities and recommendations for future services.

Once developed, the survey was pretested by two recently retired New York State county mental health directors and a regional director of mental health services in Vermont. The reviewers were asked to focus on the following areas:

- Clarity of the questions (understanding of what is being asked and why)
- The respondent's ability to answer the questions (access to information, time needed for background research)
- Acceptable burden (length of questionnaire, flow, etc.)
- The questionnaire overall (general issues or concerns that had not been addressed)

Feedback from the reviewers was incorporated into the final survey design.

Implementation of the Survey

Prior to administrating the instrument, efforts were made to increase participation and data quality. The CLMHD promoted the study through its membership newsletter and a presentation to members at the STEPS Legislative Roundtable. Project staff sent advance emails to each identified participant announcing the upcoming survey and scheduled a time to complete the survey by phone. Once the interview was scheduled, an electronic copy of the instrument and informed consent were emailed to the participants. Upon the advice of the Advisory Committee, areas of the survey that required preparation were highlighted to assist the counties in obtaining more comprehensive and detailed information. The University's Institutional Review Board (IRB) approved this project requiring data reporting in aggregate with the exception of factual information based on existing services, written reports and databases.

Three interviewers were trained to administer the telephone interview using a computer-assisted telephone interviewing (CATI) system. CATI is a telephone surveying application which provides the flexibility to customize the flow of the questions based on responses as well as information already known about the participant.

Participants were called during regular work hours. In some situations, clinical supervisory staff responded to the surveys but for the most part directors or assistant directors participated. Interviews began with obtaining verbal consent. On average, the interviews took a little over 60 minutes. Interview time was affected by county size, number of persons who participated from the county on the phone call, nuances of each county for each section, and county preparedness. The longest interview took over 2 hours.

Interviews took place October 2007 through mid-December 2007. All 58 counties participated in the survey for a 100% response rate.

Validation Reports

Individual reports were created for every county and sent electronically to participants along with any outstanding questions or clarifications needed. Respondents were asked to review their county survey within five business days. Over half of the counties (N=38) responded to confirm or clarify their original responses. Changes were integrated into the data for each county.

Secondary Data

Secondary data on county level demographic and mental health service information were collected to supplement the telephone survey data. These data are vital to assist in determining demographic trends which impact child and adolescent mental health service needs and the need for CAPs in the near future.

Rural Urban Areas

Economic Research Service created a rural urban continuum. The classification of counties into rural and urban categories is based on population and worker commuting criteria as well as by population size of the metropolitan statistical area for which they are a part (see Appendix 2: Map 3).

Study Limitations

The major limitation to this study was the sample selection. The sample was based on the individual's position and knowledge of child and adolescent mental health services within each county and was mainly comprised of county mental health directors or someone who worked under the county director. The political nature of both the respondent's position and the topics covered may have affected the validity of the data. Self report data is subjective and may be biased. Another limitation to the data is the respondents' inability to respond to a number of the more complex questions given the time allocated for respondents to do background research.

V

FINDINGS

Overview

This section reports the results of the analysis of both the primary and secondary data sources. Unless otherwise specified the data reported represents all valid information from all counties; where indicated results are reported separately for the Top 7 counties and the remaining 51 counties. This section reports data in aggregate. Individual county data findings are presented in Appendix 3.

Current Status

Reporting on the number of CAPs differed for the Top 7 counties because of the challenge of accurately providing this information in such populous areas. Therefore the Top 7 counties were asked to estimate the number of outpatient public CAPs practicing in their county, while the remaining 51 counties were asked to report on the overall number of CAPs practicing in their county. In the following sections we begin with the 51 county findings followed by the 7 county findings.

Number of CAPs

Of the 51 counties, 39 reported having CAPS and 12 reported having no CAPS. NYC used 2006 AACAP data to report that they had a total of 380 public and private CAPS. Additional demographic information on NYC CAPS is unavailable. Thus, the following demographic descriptions for the 51 counties reflect data on the 39 counties who reported having CAPS, and the top 7 county data reflects findings from the 6 counties who were able to provide additional demographic information.

As displayed in Table #1, for the 51 counties, 12 (24%) reported having no CAPs practicing in their county, another 9 counties (18%) reported only 1 CAP and the remaining 30 (59%) reported between 2 and 17 CAPs (see Appendix 2: Map 1). On average (mean) there were 3 CAPs practicing in each county. There were a total of 157 CAPs practicing in the 51 counties. While 12 counties indicated having no CAPs, two of these counties reported having practitioners trained as adult psychiatrists whose specialty and practice focus on the treatment of children and adolescents.

When comparing the number of rural CAPs to the number of urban CAPs in the 51 counties, we find that there are significant differences; a significantly higher number of CAPs practice in urban areas (f=.003).

Out of the Top 7 counties, 6 counties (excluding NYC) reported having between 8 to 31 public outpatient CAPs.

Table #1. Number of Counties with CAPS in Categories: 51 & Top 7 Counties

Number of CAPs	51 Counties	Top 7/Public Outpatient
0	12	0
1	9	0
2	8	0
3	8	0
4-7	7	0
8-10	5	2
11-17	2	2
Over 17	0	3
Total	51	7

CAPs per Youth Population

Using the 2000 census, we calculated the number of CAPs per 100,000 youth for each county (see Appendix 2: Map 2). For the 51 counties there was an average of 13 CAPs per 100,000 youth much higher than the average number of CAPs per county (3).

Using the most conservative estimate of prevalence for youth suffering from serious emotional disorders (6%) (Costello et al., 1998), potentially 6,000 out of 100,000 youth were in need of CAP services. In a county with the highest ratio of CAPs to youth, the best case scenario, each CAP would have a caseload of 100 youth. On average each CAP would have a caseload of 462 youth.

For the Top 7 counties, on average there were 9 public outpatient CAPs per 100,000 youth. Once again the calculations for NYC were based on the total number of CAPs from the AACAP.

Employment Status

Out of the 51 counties who reported having CAPs (N=39), the majority (56%) work part-time. The majority of CAPs were employed by private organizations or in private practice (65%), followed by employment by contract with the county (21%) and then the state (14%). Some CAPS were employed in both the private and public sector and a few respondents did not know the number of hours that CAPs worked in office-based private practice.

Figure #1

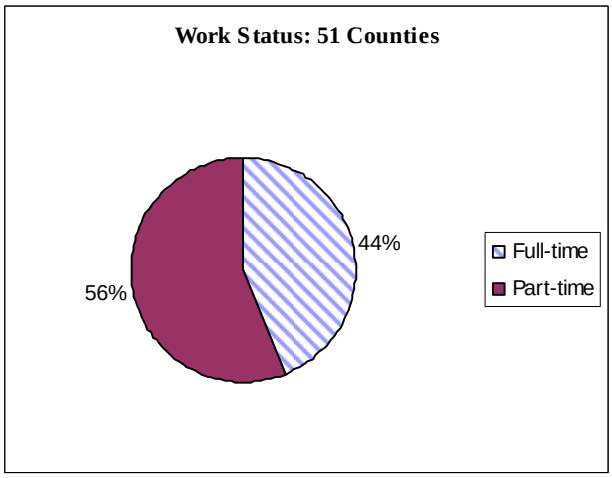
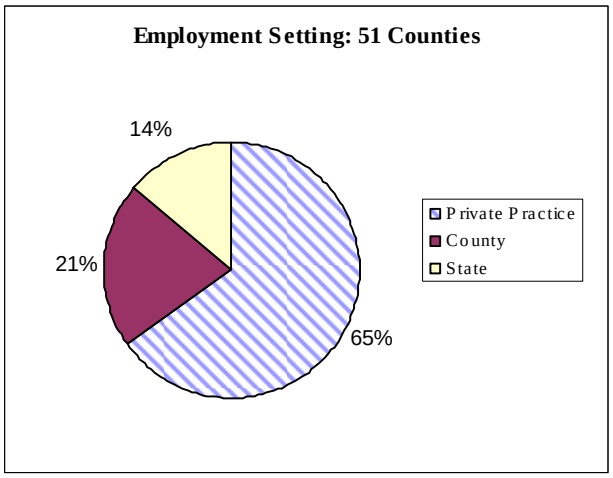
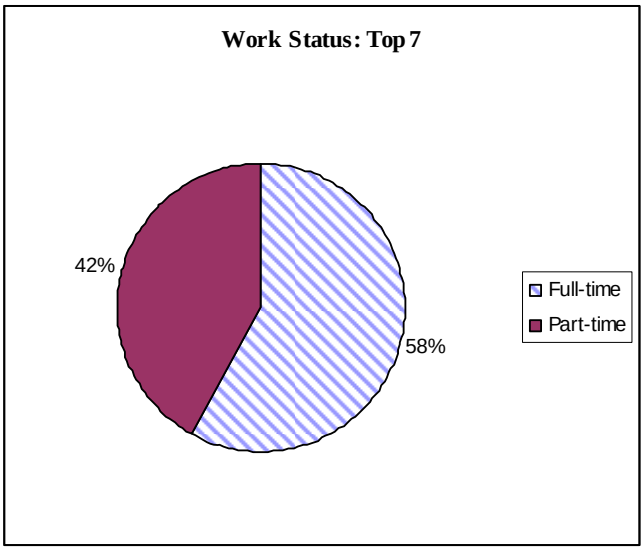


Figure #2



In contrast to the 51 counties where most CAPs are part-time, the majority (58%) of CAPs in the Top 7 counties (n=6) work full-time as compared to part-time.

Figure #3



Demographics

51 County Findings

A majority of the practitioners in counties with CAPs (N=39) were white (69%) and male (58%). Nearly 75% of the counties reported having at least one female CAP. Out of the minority options listed 'Other' was endorsed most (16%), followed by Asian (10%), Black (5%) and Hispanic (4%)[5]. Over 40% of the counties reported having at least one non-white CAP. Counties reported that 20% of CAPs have primary languages other than English (see Table #2).

Nearly 80% of the counties with CAPS had one or more CAPs within 10 years of retirement. In the 38 counties that reported on retirement, slightly under half of the CAPs (41%) are within 10 years of retirement.

In the 36 counties reporting, 47% of the CAPs resided outside the county where they practice. For 28 counties, at least one CAP and anywhere up to 7 resided outside the county where they practice.

7 County Findings

Five of the Top 7 counties reported on retirement and gender; the providers appeared to be younger than in the 51 counties (only 11% are within 10 yrs of retirement) and nearly half were women (49%). Of the 5 counties who were able to provide information on race, a majority of CAPs were White (57%). Of the 6 counties reporting, 30% of CAPs had primary languages other than English. Of the 5 counties reporting, only 6% resided outside the county that they practice in, a marked difference compared to the 47% reported above for the 37 counties.

[5] These add to more than 100 due to overlap in categories.

Table #2: Demographic Information on CAPS

Counties	White	Female	Within 10 years of retirement	Residing outside of the county	Speakers of English as a second language
51	69%	58%	41%	47%	20%
Top7	57%	51%	11%	6%	30%

Wait for Services

One main issues affecting access to child and adolescent mental health services are the length of time children and adolescents wait for the various levels of service. Reporting average wait times for services presented a challenge for many respondents because waits varied based on a number of factors. Seasonal variation in demand for services was expressed across service type and had an impact on the wait for services. In general the waits seemed to be longer in the winter and shorter in the summer. Wait times also varied based on factors such as gender, age, severity of mental health need and special needs such as MRDD. When counties were able to offer the needed services, the wait times seemed to be slightly less of an issue in comparison to counties that did not have those needed services within their borders.

Data were collected on wait times for long-term state hospitalization, day treatment programs, and outpatient services for all counties. While OMH indicates that inpatient and RTF services are regional, wait times were asked separately of those counties who did and did not have that level of service within the county due to the relevance of proximity. Data were not as readily available for wait times when RTF and inpatient services were outside the county. Many counties without RTF and inpatient services expressed a need for these service yet lack the ability (number of kids and resources needed) to support services. The wait times data when inpatient and RTF services were inside the county were not representative of all counties and therefore are not reported.

In addition to asking about wait times for each level of service, we inquired about how many children and adolescents are currently waiting for this level of services. Most often respondents indicated that wait lists are not utilized, partly due to the futility of having one and in some situations due to a sense that this is no longer permissible.

51 County Findings

As displayed in Table #3 below, on average counties reported wait times of just over one month (37 days) for child and adolescent outpatient psychiatric services. For long-term state beds, on average the wait was about one month (34 days). Counties reported on wait times for day treatment programs averaging a 50 day wait.

Table #3. Wait time for Services in 51 Counties

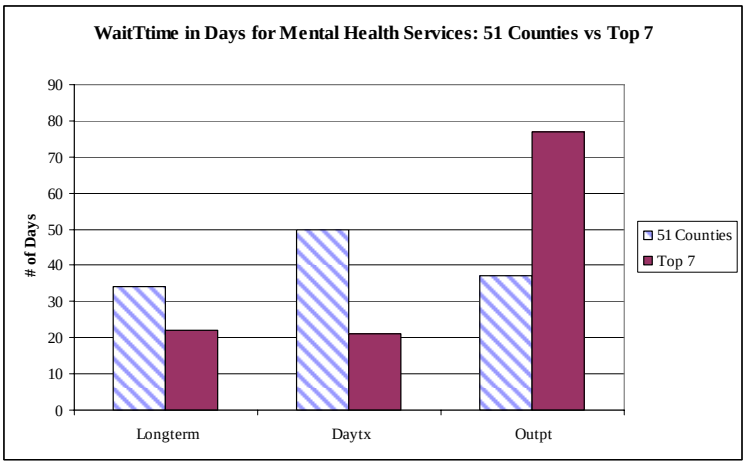
Service	Average Wait	Range
Outpatient	Just over 1 month	No wait – 6 months
Long-term state	Approx 30 days	No wait – 7 months
Day treatment	50 days	No wait – 6 months

7 County Findings

For the five counties who reported wait times to public psychiatric services for children and adolescents, the wait ranged from 42 days to about 4.5 months (133 days), on average 77 days. The wait for day treatment was between no wait and 3 months (90 days), with an average wait of 21 days. Four out of seven counties reported on long-term state beds, the wait ranges from no wait to 60 days, with an average of 21 days.

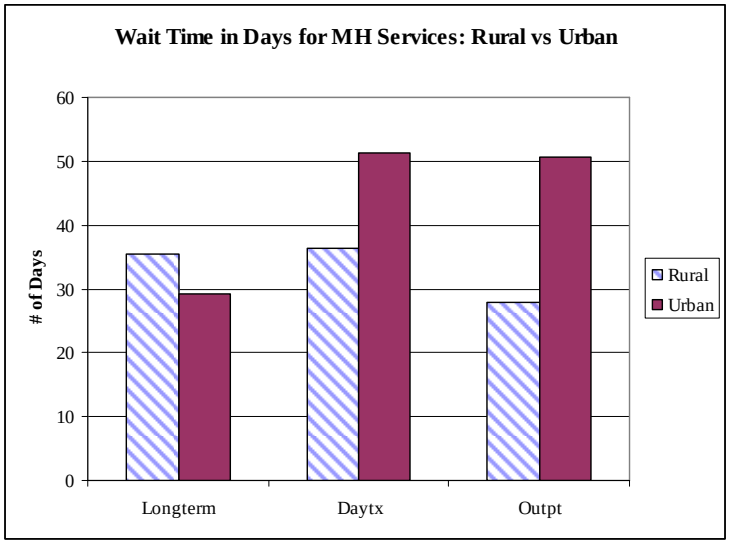
When comparing the 51 counties to the Top 7 counties, there were longer waits for 51 counties for both long-term and day treatment services while there are longer waits for the Top 7 counties for out patient services.

Figure #4.



Comparing all the counties across rural-urban areas for wait time in days, urban counties had longer waits for both day treatment and outpatient services. Rural counties had slightly longer waits for long-term beds.

Figure #5.



Barriers to Services

Counties rated barriers to mental health services on a scale from 1 to 4, where 1 = 'not at all' and 4 = 'a lot'. Transportation was given the top rating, 'a lot' as a barrier by the most counties, followed by 'general mental health workforce capacity' and 'availability of public funds'. The below table (Table #4) displays mean scores and the percents of counties that rated each barrier as 'a lot'. Aspects of services that appear to be functioning well include office hours of mental health service providers, coordination of care across providers and provider follow up on referral.

Table #4. Barriers to Services

Barriers	**Mean**	**Rated 'a lot'**
Transportation	3.65	71.9%
General MH workforce capacity	3.17	44.8%
Availability of public funds	2.93	34.5%
Stigma	3.05	29.8%
Reimbursement procedures	2.81	29.8%
Parent/family knowledge of mental health problems	3.09	28.1%
Available child care	2.93	26.8%
Family or guardian follow-up on referral	2.89	16.1%
Parent/family information about available services	2.75	15.8%
Office hours of mental health services providers	2.12	3.5%
Coordination of care across providers	2.31	3.4%
Provider follow-up on referrals	1.91	0%

In an effort to better understand the most significant barriers we asked respondents to describe the most significant barriers: transportation, general mental health workforce capacity, availability of parent/family knowledge of mental health services, and public funds.

Transportation

Transportation was a considerable problem in a great majority of the counties. Counties reported either no public transit or limited and inconvenient public transit. Poverty also impacts the ability of families to own cars or take taxis or afford to drive cars because of high gas prices. A number of counties indicated that the populations they serve are widely dispersed, and some indicated that distances to satellite service locations can be far in more remote locations.

Mental Health Workforce Capacity

Mental Health Workforce Capacity was another highly rated barrier. The primary reasons are difficulties in recruiting and retaining staff as well as increased need for services. Other factors that impact ability to recruit are low salaries, competition with facilities offering higher pay (state facilities or competition with neighboring counties) and regulations for hiring, including civil service laws and government programs with staff qualifications that are difficult to meet. Retention issues include high staff turnover and staff burnout exacerbated by high caseloads. These issues impact the quality of services including the fact that in some situations clients weren't seen at clinically appropriate levels. Counties also indicated that there was an increased need for services in general and for specialization of services. A few reported that some practitioners are selective about payment (for example private practitioners who will only take

cash payments) and that the high cost of homes impacted the ability to recruit new practitioners to the area.

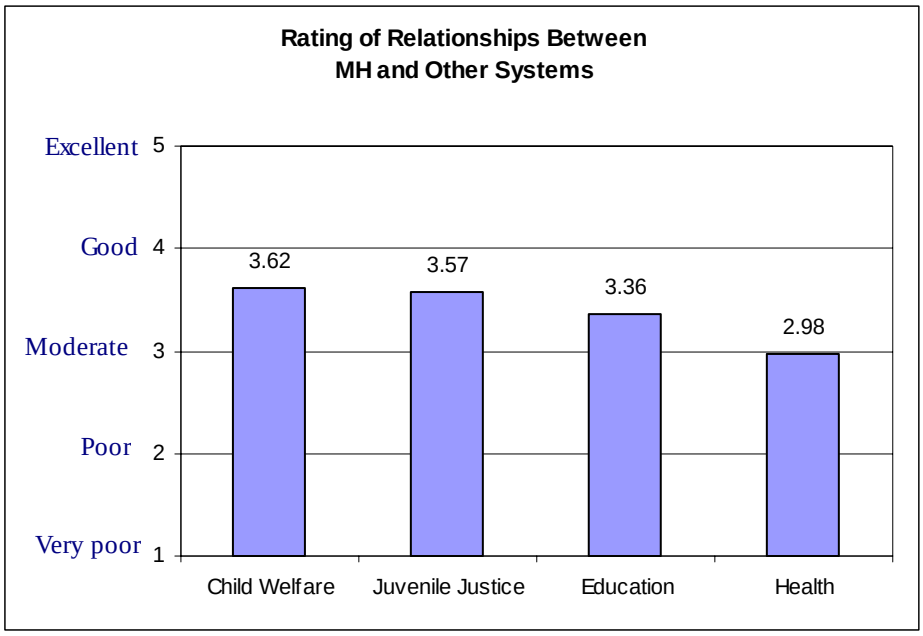
Availability of Public Funds

Availability of Public Funds was reported as an issue primarily in relation to low reimbursement rates of Medicaid. Counties also indicated that funding mechanisms are not flexible enough to meet the service needs. Counties reported that the lack of public funds impacts staffing and existing programs.

Coordination of Care

Care coordination across providers was not considered a significant barrier by respondents but varied somewhat by type of system. Counties rated the quality of coordination between the child and adolescent mental health system and four other systems of care on a scale from 1 to 5 where 1 = very poor, 2 = poor, 3=moderate, 4= good and 5 = excellent. Child welfare and juvenile justice received higher ratings (3.62 and 3.57 respectively) than education and primary health care (3.36 and 2.98) (see figure #6. below).

Figure #6.



Mental Health System and Primary Health Care

Out of the four, the relationship between mental health and primary health care seemed to be the least developed. It appears that there were few incentives or programs to foster collaboration between mental health and primary health care. When coordination between mental health and primary care provider (PCP) was reported positively it seemed to be related to two factors: (1) smaller, more rural counties allowed for better communication and (2) the mental health system placed special emphasis on fostering communication through policies and practices. There were a few mechanisms that have been implemented that fostered collaboration:

- Shared paperwork (e.g. releases are sent to PCPs)
- Mental health system provides outreach to the medical community (e.g. CAPs meets with or provide phone consults to medical providers)

- Medical community integrating into mental health system (e.g. PCPs on mental health boards and nurses employed in MH sites to deal with PCP offices)

The structural gaps expressed were mainly time constraints on the part of both systems. Also mentioned were a lack of clear policies, structure, or procedures to foster communication and referrals between systems. Others cited a shortage of PCPs and no reimbursement for collateral contacts. On a more individual level (but related to the structure of the health care system) was a sense that PCPs were unwilling to communicate. Some expressed that the PCPs waited for a crisis to contact mental health or only make contact when parents were frustrated. Some PCPs were not willing to prescribe; some lacked knowledge about mental health resources. However, others admitted there was a lack of initiative on both sides, and that the mental health system needs to do more to reach out to PCPs.

The Mental Health System and Education System

Communication and coordination has been helped by collocating mental health services in schools, especially through Child and Family Clinic Plus. Other practices noted included:

- Mental Health presentations in schools
- Releases which facilitate communication with schools
- Involving education in SPOA, education involved in wraparound meetings and in interagency groups
- School superintendent on the Community Service Board

There appears to be a willingness of schools to collaborate. There were some concerns over the size of some educational systems (many districts in one county) which makes coordination difficult. Time was a factor: scheduling with teachers was difficult because of the structure of school day. Other barriers include schools' misunderstanding of the confidentiality requirements of mental health workers and unwillingness to collaborate because of different missions and philosophies. A new federal regulation disallowing billing for guidance counselors may have a negative impact on working together.

Mental Health System and Juvenile Justice

In general, communication was good. There were lots of structural mechanisms including interagency groups (juvenile justice task force, juvenile justice service teams, etc). There was also significant involvement of juvenile justice through SPOA. Other practices noted included:

- Probation is host site for Clinic Plus
- Mental health/juvenile justice staff who straddle both systems
- Collocation of staff

There were isolated counties who reported not working well with Juvenile Justice.

Mental Health and Child Welfare

Most counties reported good working relationships between the mental health and child welfare systems. Similar to juvenile justice, there were many mechanisms and structures that have fostered communication. There were a number of collaborative practices noted including cross system training, multi disciplinary teams, SAMHSA support, cross systems groups, meetings, collocation, structures in place (CCSI and SPOA) and a shared philosophy about coordination of care.

Yet counties also reported that child welfare has a different orientation and philosophy than other systems; child welfare was more adversarial and more reactive, and needs to address crises. Child welfare workers have high case loads which was also a factor that hinders collaboration. Other barriers noted included:

- Child welfare does not consistently identify mental health issues or bring them to the resources available
- Child welfare staff turnover
- Mental health doesn't respond fast enough for child welfare – they have to respond immediately and mental health doesn't always work that fast

Referral Sources

Counties ranked the number of children and adolescents referred to mental health services. The most common referral source was 'family' with 31 counties endorsing it as the top ranking. This was followed by 'education and 'primary health care. The mental health system received fewer referrals from child welfare and juvenile justice. Self referrals were reported to be the least common referral source. A few counties indicated that family referrals may actually represent an indirect referral from a primary care provider or the school, since often families are directed to seek mental health services by their pediatricians or teachers.

Family Groups or Associations

Nearly two thirds of the counties (65.5%) indicated that there are family groups or associations that influence the provision of child and adolescent psychiatric services in their county. These organizations serve a number of different purposes. Respondents noted that groups advocate for families to obtain needed services, support families to effectively navigate systems, provide direct services such as respite and transportation, and conduct political advocacy. Some family associations and support groups provide training, education and awareness in the community and help dispel the stigma attached to mental health treatment.

Overall counties that have family groups and associations indicated that they enriched the quality of care for families. One county said the family organization ensures that "we keep families at the center of treatment." Family support groups were also reported to help push systems to do more outreach. One county commented that parent involvement brought creativity to problem solving and helped identify low cost solutions to service provision problems.

Need for CAP and Child and Adolescent MH Services

Need for CAPs

51 County Findings

Counties expressed a great need for additional CAPS (see Table #5). Of the 51 counties, nearly all the counties (92%) reported that they needed additional CAPs. Counties reported needing 2 CAPs on average. Three out of the four counties that indicated no need for additional CAPs were rural counties. Urban counties expressed that they needed a slightly greater number of CAPs as compared to rural counties (2.2 versus 1.9).

Top 7 County Findings

The Top 7 counties were asked about their need for additional outpatient public CAPs. All six of the Top 7 counties who responded expressed a need. These counties reported needing between 3 and 147 CAPs, on average 34 CAPS.

Table #5. Number of Counties in Need of CAPs in Categories

Number of CAPs	51 Counties	Top 7 Counties
1 Full or Part-time	19	0
2 Full or Part-time	11	0
3-4	14	1
5-9	3	2
10-21	0	2
Over 21	0	1
Total	47	6

How the Need for CAPs Impacts Counties

51 County Findings

Both rural and urban areas reported that the most common impact of needing more CAPs was long waits and the consequences of those waits on families and communities. This often leads to children needing higher levels of more costly care (for example the emergency room or inpatient hospitalization)

Differences were reported between rural and urban counties. Rural counties reported needing to rely on reluctant PCPs, and having to refer families outside the county for CAP services such as in-depth assessments or specialized services. This is both inconvenient and costly. Meanwhile urban counties more frequently reported kids not getting served at all and as a result of the high demand and low supply, a lack of choice in CAPs. A few stated that pediatricians and PCPs sometimes handle more difficult cases.

Top 7 County Findings

Regarding the Top 7 counties, all 6 who reported needing additional outpatient public CAPs also indicated that this need significantly impacted their county. Similar to the 51 county responses, the most frequent impact was long waits for services including initial consultations and medication reviews. One county mentioned that emergency cases are an exception to this wait. Lack of capacity and lack of access was mentioned many times; an unrealistic demand is placed on CAPs and there are too few part-time CAPS to serve large school districts and large counties. The lack of access leads to children and adolescents without medication, without prevention services, and systems unable to meet certain standards such as CAP seeing patients within 30 days of discharge from residential care. One county mentioned the PCPs' reluctance to work with children and adolescents with higher needs. Another county described the difficulty that families faced when they can not arrange appointments with anyone on their insurance lists.

Shortage Causes Strain on Other Professionals

51 County findings

Nearly all the counties indicated that the shortage of CAPs resulted in a strain on other professionals providing mental health services, especially for PCPs and pediatricians. These providers are prescribing beyond their comfort level or are not prescribing at all. Urban counties

also mentioned that PCPs have larger caseloads and are managing more difficult cases including SED children, children on multiple medications, and younger children needing medication.

The shortage of CAPs also places strain on adult psychiatrists, mental health clinicians, social workers, and staff in other systems of care who feel unequipped to handle the mental health needs of children and adolescents. However, rural counties reported the strain on ER/hospitals and adult psychiatrists with more frequency than urban counties, while urban counties report the strain on nurse practitioners with more frequency.

Some general comments regarding the strain on professionals included high caseloads, clients with complicated medications, challenging behaviors, and the desire for back up and validation.

Consistent with the 51 counties, 6 of the Top 7 counties responded that there was a strain on other professional disciplines providing mental health services and for similar reasons. One additional point was the need for more consultation with CAPs for PCP and nurse practitioners. These practitioners were seen as 'holding back the dyke'. Also mentioned were the strains on social workers, adult psychiatrists, other outpatient service providers and the educational system. Schools were left handling problems that they are not equipped to manage.

Populations in Need of CAP Services

Respondents rated the need for CAP services in different populations on a scale of 1 to 5 where, 1 = most significant need; 2= great need; 3=some need, 4= little need; and 5 = no need at all. 'School age children (6-12 yrs)' and 'adolescents with special needs' were considered to have the 'most significant need' by the greatest number of counties (38%). This was followed by 'adolescents (13-17 yrs)' and 'children with special needs' (36%), 'children and adolescents in the child welfare system' (17%) and lastly 'preschool children' (9%). On average all the populations received a rating of 'great need' except for preschool children with an average of 'some need'.

Almost one-third of the counties mentioned additional populations with CAP needs -- children and/or adolescents with dual/co-occurring diagnosis; adolescents with substance abuse issues and both children and adolescents with a developmental disability (particularly autism). This was followed by adolescents and children as young as 10 yrs old involved in the juvenile justices system. Three counties mentioned the need for mental health services for transitional aged youth.

Some unique responses relating to special populations included the following:

- Children under 12 with SED
- Children with parents with mental health issues
- Adolescent sexual perpetrators
- Severe behavior disorders/conduct disorder
- Bilingual needs

Setting in Need of CAP Services

Respondents rated the need for types of CAP services using a scale where 1 = most significant need; 2= great need; 3=some need, 4= little need; and 5 = no need at all. On average there is 'great need' for CAP psychiatric assessment, medication consultation, medication management, services in inpatient psychiatry, and services in crisis care. There is 'some need' for CAP

services in RTF and day treatment and there is 'little need' for CAP services in individual mental health counseling and family therapy.

Results for the Top 7 counties were similar excepting the need for cap services in inpatient psychiatry which was between 'some need' and 'little need'.

Other settings in need of CAP services were mentioned by a number of counties. The most frequent was consultation for other professional and clinical staff, including pediatricians and therapists with a CAP. This was followed by CAPs in schools and in the community, making home visits. Some counties mentioned the need for respite services, community mental health residences, intensive outpatient programs (in particular access to this care for Medicaid patients) and tele-psychiatry. A couple of counties mentioned specific treatments that they are in need of including anger management (for families or child) and evidence based treatments such as Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Behavior Management and Family Therapy.

Mental Health Beds and Services in Need

While the NYS Office of Mental Health (OMH) does identify that inpatient and RTF services are regional, we distinguished whether or not counties have these two levels of care in their county. This was done because of the relevance of proximity to these services. If counties did have these services located within the county, we asked about the need for any additional beds, if they did not we asked about the need for this level of service in their county. For long-term state hospitalization we asked all counties about the need for additional beds. For crisis care we asked all counties if this was a need and if so to describe it.

Inpatient Psychiatry for Children and Adolescents

Twenty counties have inpatient psychiatric services for children and adolescents within their county. Out of the 20, over half (N=14) expressed a need for additional inpatient psychiatric services for children and adolescents. Of the remaining 38 counties that do not have inpatient psychiatric services for children and adolescents, over half expressed a need for inpatient child and adolescent psychiatric services within the county. Several counties (N=7) that indicated that they did not need this level of service in their county, said they could not sustain it. One county reported that a regional inpatient unit should be considered. The number of additional beds needed ranged from 2 to 30 with an average of 10 beds.

One county noted that while there was not a consistent need, that there were specific times of the year when a bed can not be found. Others mentioned the need for more beds for certain age groups -- three counties expressed the need for beds for younger children, under 11 yrs old. Also other levels of service were mentioned such as crisis beds and beds for children and adolescents waiting for placement in another level of care.

Residential Treatment Facilities (RTF)

Of the 14 counties that have RTF services for children and adolescents in their counties, 10 indicated that they do need additional RTF services. Out of the 44 counties who do not have this level of service, 19 indicated a need for this level of service. The number of beds needed ranged from 3 to 250 beds with an average of 24; just a few counties reported needing a lot of beds inflating the average. A better indicator in this case is the median of 8 beds.

Counties expressed the same issue for RTFs as they did for inpatient services; those without this level of service did not think that they were able to support an RTF due to costs and too few children. While OMH reported that RTF services are regional, a few counties requested that RTF services be regional, more specifically that RTF services be shared with other counties within a limited driving distance.

Long-term State or Regional Services

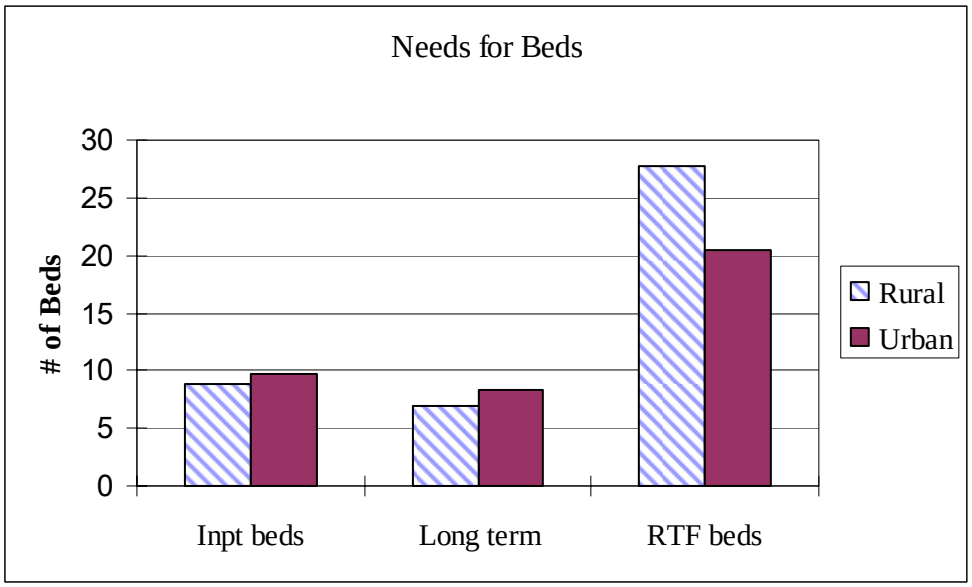
Since all counties are identified within a catchment area for a state psychiatric center through OMH, all counties were asked if they needed additional long-term state beds. Over half (32) indicated that they needed between 1 to 20 additional beds with an average of 8.

This level of care seems to elicit more complex responses related to the nature of long-term hospitalization on a whole and the management of the regional system. For example, one county mentioned the need to deal more creatively with issues in the community rather than using regional beds. Others were concerned about the "back end" and discharge planning, in addition to the lack of access to regional beds due to lack of coordination between agencies.

Bed Need in Urban vs. Rural Areas

Only slight differences are noted when comparing rural and urban areas for the need for both inpatient and long-term beds. The need for rural RTF beds was also higher than urban RTF beds.

Figure #7



Crisis Care

Counties reported a need for additional child and adolescent crisis psychiatric services (85%). They described gaps in the availability of crisis services from a number of vantage points. The most common response was the lack of appropriate beds for children when they are in crisis, described as either child psychiatric ER beds or short term observation and placement beds. Counties also commented frequently that the shortage of CAPS hinders the ability of the system to quickly, accurately and completely assess and respond to the needs of children in crisis.

Counties commented on the need for 24/7 services. Crisis by its nature can occur at any time, but some mobile crisis units and home-based crisis intervention programs are only available during business hours and weekdays. Mobile units, CPEP units and crisis respite beds are commonly needed. Counties see these as valuable resources to prevent ER use and hospitalizations. They again noted the need for CAPS to be available for consultation with these services to improve the quality of services and promote better outcomes for children.

Alternative Strategies

Varieties of alternatives have been identified or have naturally evolved to address the shortage of CAPs within counties. By default physicians or nurse practitioners have filled in for CAPs by prescribing and/or monitoring psychotropic medications for children and adolescents. Therefore, one set of alternatives to meet the need for the CAP shortage has been directed toward developing the expertise of other professionals in child and adolescent mental health issues and in prescribing medications. Some of these programs include providing nurse practitioners with advanced certification in child psychiatry and training developmental behavioral pediatricians. Other approaches have been directed toward recruiting and training more CAPs. Finally, tele-psychiatry has been promoted nationally and in New York State. Each of these approaches is discussed below.

Strategies to Train or Hire Other Professionals to Meet the Need for CAPs

Counties were asked which, if any professional groups are responsible for prescribing and/or monitoring psychotropic medication for children and adolescents in addition to or instead of CAPs. Consistent with the literature, pediatricians commonly prescribe and monitor medications (93% of the counties). This was followed by primary care physicians (89%), adult psychiatrists (78%) and nurse practitioners (78%). One county noted that adult psychiatrists will treat adolescents 16 and older and another that they filled this role only in a crisis. Some counties indicated that neurologists and developmental behavioral pediatricians were also playing this role (22% and 21%, respectively). Few counties reported that psychiatry residents, CAP fellows, international medical graduate psychiatry residents are prescribing and or monitoring in addition to or in place of CAPs (10%, 9%, and 3%, respectively).

Overall, counties reported that while relying on other professionals has been helpful, they do not adequately meet the mental health needs of children and adolescents. Mental health treatment is time consuming because of the requirements for prescribing, monitoring, follow-up and collateral contacts. Doctors with busy practices in their primary fields do not have adequate time or capacity to sufficiently bridge the gap. Some counties noted that this has negatively impacted on the quality of assessments, follow-up and monitoring.

The lack of availability of CAPS to act in consultation with these health professionals was noted. Professionals felt they required more expertise on medication side effects, differences in dosages for children, how to make medication adjustments, and multiple medication management. Counties reported that if some of these professionals could have consultation with CAPS, they would have more confidence and professional support, but this kind of CAP time is largely unavailable.

In New York State, a Primary Care Physician-Child Psychiatry Collaborative has been developed between an HMO (CDPHP) and a psychiatric facility (Four Winds Hospital) to increase the knowledge and comfort of pediatricians and PCPs when they are treating mental and

emotional difficulties. About 30 network pediatricians received specialized training from Four Winds Psychiatric staff through a computer program, four annual training sessions, and two hours of consultation with Four Winds Psychiatrists. The program received good feedback and has been expanded to a capacity of 60 pediatricians (NACBHDDD, 2005).

About 28% of the counties reported providing special training in child and adolescent psychiatry to other medical professions. Most counties reported that the trainings increased the ability and comfort level of pediatricians and PCPs in prescribing and monitoring psychotropic medications. They indicated that training builds capacity by allowing providers to serve more children and families. They also reported training increased coordination, consultation, and networking between providers and CAPs. And they reported that pediatricians and PCPs are the first and most comfortable point of contact for families as a relationship already exists; providing mental health services in the larger context of health services. This allows for improved continuity of care and a more holistic approach. Additional benefits of training were increased communication, better knowledge about current research, and more accurate or appropriate referrals.

Most counties saw no drawbacks or limitations to these programs. A few reported that poor attendance is an issue. Three counties discussed not having enough CAP time to provide training (there is a more critical need for them to provide services). Two counties reported cost as a drawback. Two other counties indicated that the training was inadequate and might give the impression that medication is the only answer and other clinical options may be overlooked.

Nurse Practitioners with Advanced Certification in Child Psychiatry

Close to half of the counties (48%) utilized nurse practitioners with advanced certification in child psychiatry to supplement the child and adolescent psychiatry workforce. In New York in 2006, the University of Rochester, School of Nursing established a training program to provide in-depth education for nurse practitioners. Nurses trained in the Child/Adolescent Psychiatric Mental Health Nurse Practitioner program (C/A NPP) program can provide psychiatric assessment, diagnosis, treatment planning, psychotherapy, medication management including prescribing and monitoring, and education services. Under New York State law, while they must establish collaborative practice agreements with physicians, they are not required to obtain co-signatures for orders, prescriptions and progress notes (URSON, Brown & DeSocio, 2007).

The most frequent benefit mentioned by counties is the cost effectiveness of utilizing this option; nurse practitioners with advanced certification cost less than CAPs. This is followed by the increased capacity that they provide, reducing or eliminating wait times, in addition to having the ability to prescribe medications when CAPs are not available. Counties commented on the high quality of their work. Counties also reported that nurse practitioners are more accessible and have more time. Overall counties reported that they are easier to recruit and are a stable workforce. They also spoke highly of their knowledge of medications and medication management, and their motivation to stay up-to-date with current practice.

The most frequent drawback mentioned was that nurse practitioners with advanced certification require supervision by a CAP and can not sign off on some paperwork. This creates additional paperwork for CAPs and in at least one case there is no CAP to supervise the nurse practitioner. This was followed by the perception by both CAPs and families that nurse practitioners provide a lower level of care. Also pointed out is that in actuality they do have less training and less expertise than CAPs.

While many counties reported that availability was a benefit, an equal number reported a lack of availability and difficulties in recruiting. Two counties mentioned that they have high salary expectations. Another drawback is that they can not conduct court-ordered evaluations.

Locum Tenens CAPs

About 36% of the counties reported that they employ locum tenens CAPs. Locum Tenens are physicians who fill needed positions temporarily. Most counties reported that this provides coverage and reduces wait times but has little else to offer. Three counties mentioned that the position allows counties to meet standards and be in compliance with regulations (e.g. face-to-face when a physical hold is used and patient/Dr. ratio). One county reported that there were no benefits to this approach.

Cost topped the list of drawbacks for this strategy. The second most reported concern was the temporary nature of the strategy which impacts on the continuity of care. Lastly counties reported that these providers do not know the local system, local resources, and the community culture. One county mentioned that parents did not like these providers.

Other creative possibilities exist on the local level. Wyoming, Genesee and Orleans counties are in collaboration with the New York State Rochester Psychiatric Center to create a fellowship in child psychiatry where the fellow would spend half their time in urban Rochester and the other half of their time in the three rural counties (NACBHDDD, 2005).

Telepsychiatry

Telepsychiatry is a unique method to bridge the gap in services. The New York State OMH has offered telepsychiatry for general psychiatric services for nearly a decade and in 2007 implemented a program to serve children and adolescents utilizing CAPS at Columbia University. At the end of 2007, 14 counties used this telepsychiatry service. Columbia CAPs provide consultations to clinical teams (general psychiatrist, clinicians, PCP and case managers) working with young people who are being served at OMH licensed outpatient clinics (SCAA & NYSCLMHD, 2008). In addition to the OMH initiative, private organizations offer telepsychiatry within some counties.

Our data indicate that a total of 21 counties have used telepsychiatry to supplement the child and adolescent psychiatry workforce and slightly more than half indicated the program is through the OMH initiative. Of the 37 counties who reported not using telepsychiatry, 26 (70%) were interested in using it. Almost half (43%) of the 21 counties who reported using telepsychiatry indicated that it has been a positive experience. Another 19% said using telepsychiatry was somewhere in between positive and negative, and only 5% reported the experience as negative. Seven of these 21 counties (33%) indicated they did not know how the telepsychiatry was working in their county.

According to the telephone survey, there are a number of different ways telepsychiatry has been used. A few counties reported telepsychiatry is relied on for more difficult cases. Protocols varied by county. Three counties discussed a whole team (teacher, primary therapist, case manager and family) approach, others indicated that it is used for individual consults for helping professionals or for outpatient medication consults and others described a format where the time is split among consults with staff, family and clients, and then feedback on cases. Most counties

reported using telepsychiatry as a one time event in contrast to on-going services for a particular patient and family. A couple of counties spoke about the regular use of telepsychiatric services, weekly and monthly.

Following is a description of the benefits and drawbacks of telepsychiatry.

Benefits

Over half (12, or 60%) of the counties reported benefits to using telepsychiatry. Having access to CAPs' expertise and assistance on diagnosis, treatment and medication recommendations was reported most often. This access offered a different perspective and new information in addition to developing professional staff's diagnostic skills and enhancing their knowledge of evidence-based diagnostic tools.

Other benefits are as follows:

- Increasing parental participation
- Parents' feeling they were getting a lot of attention
- Technology was not as awkward as initially anticipated; ease of equipment
- Having a second opinion for challenging cases
- Increasing confidence of adult psychiatrists prescribing medications for children
- Direct billing; no extra costs to county with multiple practitioner being an exception
- Removing transportation as a barrier to accessing services

Drawbacks

Initial reports find that while consumers are satisfied with services being provided through telepsychiatry, the service is underutilized in New York State (NACBHDDD, 2005).

Over half of the counties reported drawbacks to using telepsychiatry. The amount of time required to set up the equipment and prepare materials was mentioned most frequently. Other reported drawbacks reported by a few counties are as follows:

- Staff resistance to being filmed and feeling threatened because they need to reach out to other experts (may be more prevalent in start-up phase)
- Scheduling, as there are limited times to schedule a consult
- Reimbursement, (e.g. no reimbursement for a 2nd psychiatrist or pediatrician)
- Getting started with telepsychiatry was difficult
- Telepsychiatry was redundant and was not adding any new ideas
- Parents and youth do not like it, especially when there is a crisis
- Staff would prefer to build a relationship with one CAP (currently being addressed)

It was also reported that some psychiatrists may be unwilling to prescribe without a face-to-face interview. Most noteworthy, OMH requires only psychiatrist-to-psychiatrist consultation (NACBHDDD, 2005) which makes telepsychiatry consults inaccessible to other service providers, such as primary care physicians, pediatricians, and nurse practitioners.

Cost

Respondents knew very little about the cost for telepsychiatry. Most counties were under the impression that OMH plans to continue funding telepsychiatry, and that there was no cost to the county. A majority of counties (11 of 21) expressed that telepsychiatry is economically viable, another 7 were unsure and only two counties indicated that it was not viable as it was not used much. To explain, one county suggested that telepsychiatry might be more viable if consults could take place without families. Some suggested that providers can bill Medicaid for their involvement, and be reimbursed. One county mentioned that they were unable to be reimbursed when multiple practitioners were in the room at one time.

Where Counties Could Benefit from Additional Information

Options that few counties utilized were collaborating with CAP training programs (19%), developmental behavioral pediatricians (17%), International Medical Graduates (IMG) (16%), and Limited Permit CAPs (10%). Further exploration of these strategies could help counties identify the viability of each for their particular needs. This especially pertains to recent changes in policy such as the availability of IMG on J1 visa and scholarships for CAPs in training.

Influences and Actions

Direct and Indirect Impacts on Services

Only a few counties reported outstanding events that directly impacted the need for or availability of child and adolescent psychiatric services. These included lawsuits which affected services and/or the communities and the closing of services or a CAP training program. Other counties discussed the impact of the war and deployment of troops, natural disasters, and suicides in the community.

Over half of the counties reported on things that happened in recent years that indirectly impacted child and adolescent psychiatric services. The most commonly reported were poverty and unemployment followed by business closings. Some related reports included the loss of high paying jobs, the increased cost of homes and/or loss of homes and the loss of insurance. Other notable trends mentioned were high migrant and/or immigrant populations who are in need of Spanish-speaking services, no services expansions, an increase in the population overall, and populations without insurance. Two counties also mentioned changes in PINS Laws which create more referrals; two others mentioned the impact of 9/11.

Individual counties reported the impact of labeling on children's antidepressants, increased substance abuse in families, MICA, teen parents, child abuse, and violence related to parents serving in the war. Comments related to professional staff included trends in hiring limited permit (certain restrictions apply) CAPs, retirement of CAPs, mental health position cuts and changes in state psychiatric systems effecting employment.

Pending Changes

New York State budgetary and legislative decisions will impact county mental health services, and in particular those services for children and adolescents. While each recommendation and each piece of legislation alone will not solve the problem of CAP shortages and the need for child and adolescent mental health services in the state, together there is the possibility that these changes will have a positive impact.

The NYS OMH has delineated a number of budgetary recommendations for 2008-2009. Most central to CAP and child and adolescent mental health are the following three recommendations: 1) Improving access and decreasing fragmentation in the children's community mental health systems 2) Enhancing the ability to recruit and retain a qualified workforce to ensure the deliver of quality care and 3) Reforming Medicaid rate structures to rationalize provider reimbursement.

More specifically, OMH is requesting new funding for family support services within the Child and Family Clinic Plus program, expanding the number of clinics that serve children with Medicaid managed care, and expanding Children's Rural Telepsychiatry initiative, adding 10 more counties. OMH also recommends continued funding of Achieving the Promise Initiative and expansion of Home and Community Based Services waiver slots. Counties express concerns about the roll out of Child and Family Clinic Plus and its impacts, such as increased numbers of kids who are identified then needing services.

Where requested funding would impact recruitment and retaining of CAPS as well as other mental health services providers, OMH recommends funding for cost of living adjustments and targeting salary enhancements to allow the state to offer more competitive salaries for certain clinical positions. If CAPs are included in these clinical positions, this would address a central barrier mentioned by counties, maintaining and increasing the mental health workforce, in particular CAPs, by providing more competitive salaries.

Two pieces of legislation are related to Medicaid reform. The first plans to update Article 28 hospital rates for inpatient psychiatric care and the second to remove reimbursement inequalities by eliminating specialty rates for certain outpatient programs. Yet, the need for broader changes was expressed by the study's respondents. Nearly one third of the counties reported on the impact of changes in Medicaid regulations (movement towards Medicaid managed care and away from Community Reinvestment dollars) and the lack of flexibility associated with Medicaid funding streams. For counties where becoming Medicaid certified is a problem due to small and sparse population, Community Reinvestment was a critical resource in providing services. Several counties noted the burden that Medicaid funding puts on providers who are overwhelmed with reporting requirements and concerns about audits, expressing that this concern diverts resources from serving children and families. One county described high regulation forcing treatment decisions based on Medicaid payment rather than clinical judgment, and potentially not being able to provide services. Counties report that Medicaid Managed Care, mandated in some counties, has limited access, increased wait times for CAPS and other services, and sometimes brings about more frequent hospitalization due to brief insufficient outpatient treatment.

Another piece of legislation under consideration is 'An Act to Amend the Mental Hygiene Law, in Relation to Establishing the Child Psychiatry Access Demonstration Project'. This bill would establish no less that three regional child psychiatry access demonstration projects made up of a team of service providers (a social worker, a care coordinator and a child psychiatrist) designed to provide PCPs with timely access to child psychiatric consultations. These services would be free of charge and regardless of the patient's insurance status.

The NYS Department of Health (DOH) has presented a few policy recommendations with the potential to impact on child and adolescent psychiatric services. One is the Doctors Across New York program which provides funding for medical school loan repayment for those who practice

in medically underserved communities, in addition to funds for start up and recruitment to new physicians practicing in shortage areas. Other recommendations include enhanced Medicaid rates to those practicing in underserved communities and reallocating inpatient dollars to outpatient settings.

Federal legislation (S1572 and HR2073) was introduced in 2005 and then again in 2007 and is now in committee in both the House and the Senate (the first step in the legislative process). This legislation would set up a loan forgiveness program and restore GME funding for CAP training programs removing some of the most significant barriers to CAP recruitment (NACBHDDD, 2005).

Currently, four counties in NYS receive and one has graduated from the SAMHSA federally funded Child Mental Health Initiative more commonly known as the 'System of Care.' SAMHSA has allocated 19 new awards for 2008 FY. Several counties in NYS have submitted applications for this award. Respondents reported that the system of care programs, Coordinated Children's Services Initiative (CCSI), wrap around and SPOA (Single Point of Access) helped to improve collaboration, coordination of care and cross system service delivery.

Trends in Child and Adolescent Mental Health Service Needs and Access to CAP: Rural and Urban Differences

There are four broad areas that participants mentioned as affecting child and adolescent mental health service needs and access to child psychiatrists. These include the increase in severity of children's and adolescents' presenting problems, increased diversity among children and their families, changes in the service delivery system, and cost and reimbursement issues. Rural areas were more likely to mention an increase in the severity of children's and adolescents' presenting problems, while urban areas were more likely to mention increased diversity, changes in the service delivery system, and cost and reimbursement concerns.

Children Being Served: An Evolving Population

Most of the rural counties reported that children were reporting with more complex problems and were coming for services at an earlier age. Often, children were already on psychotropic medication. Both urban and rural counties reported that they were seeing more children with substance abuse concerns. The urban counties reported a similar pattern, but with somewhat less frequency. Some urban counties also indicated that they were serving a larger number of children who spoke Spanish, and children with developmental disabilities. Rather than providing services to children with what may be considered classical mental health issues, some respondents indicated that children's and adolescents' main concerns were coping with trauma, violence, abuse, and gang activity. Some were presenting with PTSD as a result.

An Evolving Service Delivery System

While not mentioned by every respondent, the evolving nature of children's and adolescents' presenting concerns may in part, explain the increase in the amount of interface county mental health systems are having with child welfare and with juvenile justice. Because child and adolescent mental health concerns were a consequence of trauma and on occasion, gang activity, children are being caught between child welfare and the juvenile justice system. Families are also experiencing environmental and cultural stress that is impacting their children.

Counties reported children end up being more impaired when they come out of the child welfare or juvenile justice system. Schools, child welfare, and juvenile justice systems then look to the mental health system to solve children's and adolescent's problems that are largely social and environmental. To further complicate the need, hospitals were keeping children for shorter durations meaning that they were coming to the clinic with more severe concerns. Increased public awareness of child and adolescent mental health issues may also be impacting the number of children who were brought for mental health services.

Cost and Reimbursement

In terms of negative trends, cost and reimbursement issues were mentioned most often by both urban and rural respondents. Managed care, the liability and risk, and the impact of OMH financial restructuring were mentioned by urban respondents. Both urban and rural respondents mentioned the pending retirements of the CAPS that were currently serving their communities. Finally, both urban and rural counties suggested that the national shortage was affecting New York.

Population and Community Trends: Potential Impact on Access to CAPS

Both urban and rural counties indicated that it was easier for them to attract CAPS because of their attractive community and the quality of life that their community could offer. On the other hand, some urban and rural respondents indicated that their location negatively impacted their ability to recruit CAPS.

Population trends may be important to take into account when developing strategies to meet the needs for CAPs across the state. To that end, Census data were examined to assess county population trends and by regions. County populations were compared at two points in time, 2000 and 2007 population estimates to examine whether there was an increase or decrease in population. Overall, the Hudson Valley, the Capital District, and the New York Area are increasing in population, while all other regions of the state are decreasing in population. There are a few exceptions to these general trends. In the Mohawk Valley, Madison County has experienced an increase in population, and Fulton County is essentially unchanged. Columbia County is the only county in the Capital Region that experienced a decrease in population. Ontario and Seneca Counties experienced an increase in population, in contrast to all other Finger Lake counties which experienced a decrease since 2000.

VI

CONCLUSIONS

CAPS: Numbers and Needs

Published sources of data on the number of CAPs practicing in New York State have limitations. While the New York State Education Department, Office of Professions licenses psychiatrists, they do not keep a record of specialty information. Although the American Medical Association reports on the specialty and lists CAPs by county, the specialty is self-designated and does not necessarily mean that the physician has training or competence in the specialty. The data do not distinguish between currently practicing practitioners and those who are inactive or retired and the location listed could be the practitioner's home or office address. Thus our data provide a meaningful contribution by offering a snapshot in time of the number and demographics of CAPs practicing in each of the 58 counties in NYS.

About 20% of the counties in NYS have no CAPs providing services within their county. Another nine counties report only one CAP providing services. Using per capita (based on youth population) calculations and SED estimates for the 51 counties, on average each CAP could carry a caseload of 462 youth.

Out of all 58 counties, nearly all (53) reported the need for additional CAPs. The Top 7 counties reported needing a much higher number of CAPs than the remaining 51 counties. Of the counties who expressed a need for more CAPs, almost all reported that this need significantly impacts the county and indicated that there is a strain on other professionals providing mental health services as a direct result of the shortage of CAPs (51).

Our data reinforced findings in the literature on national CAP shortages and detailed the specifics of status and need in NYS counties. Current estimates of the prevalence of mental health disorders in children and adolescent (Costello et al., 1998; Kim 2003; and USDHHS, 1999), the rates with which current CAPs will be retiring in the next 10 to 20 years (CHWS, 2006) and the rate that new CAPs are entering the fields (NACBHDDD, 2005) draw a picture of colossal unmet need in the near future.

Mental Health Services: Waits, Barriers and Coordination

Gathering data on wait times for child and adolescent mental health services was a difficult task. This was primarily due to the fact that wait times varied throughout the year. This variation was based on seasonal factors, the school calendar, bed occupancy and bed availability, as well as gender, age, and special needs including clinical severity of the patient. Additionally, some counties did not track wait times and or wait lists.

Average waits times for outpatient services were just over a month, ranging from no wait to 180 days of waiting. The average wait time for long-term state beds was about one month, ranging from no wait to over 7 months. For day treatment services there was an average wait of 50 days and a range between no wait to 6 months. Wait times for the Top 7 counties were slightly longer for outpatient, around the same for day treatment services, slightly shorter for long-term beds.

The three greatest barriers counties reported were transportation, general mental health workforce capacity, and availability of public funds. Transportation was described as a result of poor public systems for transportation, in conjunction with spread out rural areas and communities living in poverty which impacts their ability to travel to services. Capacity was a barrier because of the difficulties inherent in recruiting and retaining qualified staff and the existing demand for services outweighing the current supply of service providers. The availability of public funds was a barrier due to low Medicaid reimbursement, lack of flexible public funds including no funding for existing programs, the limited tax base of counties and the high cost of mental health services. Other factors that are barriers to care are stigma, reimbursement procedure, parent/family knowledge of mental health services and available child care.

Overall coordination of care is moderate to good between mental health and the four other central systems serving children and adolescents. Coordination with child welfare and juvenile justice rated higher than education, and even more so than primary health care. This can be attributed to the lack of structures in place in primary health care that would help facilitate coordination by allocating time, resources and expectations to work collaboratively. These structures include state and federally-funded initiatives (including NYS CCSI and SAMHSA System of Care), institutionalized interagency groups and collaborative case management (e.g., wraparound), and in some cases collocation of services.

Mental Health and CAP Service Needs

Over a third of the counties rated school-age children, adolescents, and children and adolescents with special needs as having a most significant need for CAP services. Other populations markedly in need of CAP services were children with dual/co-occurring diagnosis, especially adolescents with substance abuse and children and adolescents with developmental disabilities, children and adolescents in the juvenile justice system and transitional aged youth. Of the 51 counties, close to half of the counties (43%) reported psychiatric assessment as having a most significant need. This was followed by nearly a third of the counties rating the need for CAP services in medication consultation, medication management and in inpatient psychiatry as a most significant need. The Top 7 counties reported similar needs except for inpatient psychiatry. Other types of service needs for CAPs described are consultation with other professional and clinical staff, followed by CAP services in the schools and community, such as making home visits.

Over half the counties expressed the need for additional (or any if they currently have none within the county) beds for inpatient psychiatry, RTF and long-term state hospitalization. On average anywhere between 8 and 24 new or additional beds were needed. While OMH inpatient and RTF services are considered regional, counties suggested establishing regional inpatient beds and RTF beds for counties with low utilization; most often the regional boundaries were indicated to be within adjacent counties or within limited driving distances. At the same time another county mentioned the need to deal more creatively within the community rather than using regional beds at least for long-term hospitalization. Bed availability was variable and dependent on time of year and age of the patient; in particular it is difficult to find inpatient beds for younger children.

Alternatives

The top four other professional groups filling in for CAPs by prescribing and/or monitoring psychotropic medications for children and adolescents were pediatricians, primary care physicians, adult psychiatrists and nurse practitioners. Nearly all of those counties reported that these other professionals do not adequately meet the needs. This practice was seen as a stop gap measure which puts other professionals into the position of practicing beyond their scope of practice and training therefore offering less than ideal services. This placed a strain on other professionals providing mental health services including being time consuming and causing practitioners to feel uncomfortable.

Telepsychiatry

Over a third of the counties have used telepsychiatry to supplement the child and adolescent psychiatry workforce and more than half of them indicated the program is through the OMH initiative. A few counties indicated they either didn't use it at all or much or had used it in the past. Implementation varies, counties reported that it is either a whole team approach, individual medication consults or consults with other professionals, or a mix of above. It has been used for difficult cases, and generally is a one time event.

Close to half of the counties reported that their experience with telepsychiatry was positive. One county did report that it was a failure. Half of the counties who used telepsychiatry could see its benefit in increasing access to CAPs' expertise for treatment and consultation. Staff, parents, and clients seemed pleased with telepsychiatry and were enthusiastic about services and the knowledge consultants could provide. Some of the drawbacks reported include time requirements, staff resistance, and scheduling challenges. Counties who are not currently using telepsychiatry did express some interest in it.

One outstanding concern is the under utilization in those counties where telepsychiatry is set up and is in place. Our findings concur with statewide reports indicating that the services are underutilized (NACBHDDD, 2005). Whether it is due to the difficulties identified in this survey, such as scheduling, billing, time commitments and staff resistance, needs further exploration.

Other Strategies

Other strategies used by counties include employing nurse practitioners with advanced certification in child psychiatry, employing locum tenens CAPs, and providing special trainings in child and adolescent psychiatry for other medical profession. About one-third of respondents indicated using some of these strategies. The greatest benefit for using nurse practitioners with advanced certification in child psychiatry is cost effectiveness. Conversely the biggest drawback for using locum tenens is the high cost associated; cost is also mentioned as a drawback in terms of special trainings for other professionals. Increased capacity was mentioned as a benefit for all three approaches but in particular for nurse practitioners with advanced certification who are thought to offer quality care where locum tenens are seen as a 'warm body'. While few counties identified any drawbacks associated with special trainings, some mentioned low attendance at trainings in addition to their cost.

Influences and Trends

Direct and Indirect Impacts on Services

Few counties reported outstanding events that directly impacted child and adolescent psychiatric services; these impacts were lawsuits and the closing of services or a CAP training program. Over half the counties reported things that happened in recent years that indirectly impacted child and adolescent psychiatric services. The most commonly reported were poverty and unemployment followed by business closings; these findings reinforce the strong link between health disparities, mental health in particular, and poverty.

Pending Changes

A number of recommendations and pieces of legislation have been presented to impact child and adolescent mental health services and CAP availability. Should these initiatives be funded changes will be seen in service delivery, reimbursement, and CAP availability (both via increased opportunities for trainees- loan forgiveness and increased funding of training programs- and consultation).

As this report goes to print we received word that the state budget passed with resources allocated towards health care enhancement, including increases in health insurance coverage for uninsured children and reforms to the state reimbursement system which will shift more money from inpatient care to effective primary and preventive care.

Trends in Child and Adolescent Mental Health Service Needs and Access to CAP

Counties reported that children presenting with mental health problems tend to be younger and to have more complex problems. Service delivery needs are impacted by these changes and the shift towards integrating services between systems of care has begun. Institutionalizing these changes and meeting the needs of these patients lay ahead for most counties. Funding issues underlie the issues; while trends in population and services are shifting, funding also needs restructuring in order to realistically support the current and future mental health service needs.

VII

RECOMMENDATIONS

The recommendations are divided into two sections. The first section describes the priorities and recommendations of the telephone survey respondents. The second section describes our summary recommendations. These summary recommendations are based on the literature, secondary data, telephone survey results, and our discussions with the project's advisory council.

Respondents' Priorities and Recommendations

Improving Overall Functioning: CAPS and Child/Adolescent Psychiatric Services

About 60% of all counties believed that increasing the number and availability of CAPS, either part-time or full-time was a priority. Specifically, they identified recruitment, developing relationships with residency programs, and organizing sharing arrangements with other counties or organizations as strategies. Recruitment and retention of mental health providers were also priorities for all counties.

Rural counties perceived that the support, training, and recruitment of other providers is essential to provide a full complement of service to children and adolescents, as CAPS were even less available in rural counties. While all counties mentioned that finding ways to support and train alternative providers was important, rural counties mentioned this more frequently. The alternative providers that were mentioned included nurse practitioners, pediatricians and other psychiatrists.

Regardless of whether counties were in urban or rural areas, counties see a need for more services for children and adolescents. Building capacity and improving availability of services was the third most frequent response for rural providers, while urban counties mentioned improving use and access to existing services, followed by .the need to build capacity.

Improved collaboration and integration as well as telepsychiatry were other priorities mentioned by both rural and urban counties. Collaboration and integration would improve coordination of services across systems. In addition to consultation, some expressed an interest in using telepsychiatry for training with alternative prescribers. Others wanted to explore how to make better use of telepsychiatry. Some that didn't have access to telepyschiatry were interested in seeing how telepsychiatry could be used in their counties.

Other responses of both urban and rural counties are as follows:

- Collaborate with other health services to obtain a mobile clinic
- Provide adequate outpatient services to prevent placement
- Maintain or increase the number of treatment facility beds
- Provide services close to children and families' homes

Improving Overall Functioning: Child and Adolescent Mental Health Services

Both rural and urban counties agreed that it is essential to increase funding and access to services for the entire family. Suggestions related to funding were to: relax funding regulations, increase funding sources, restructure pay scales and revise reimbursement structures. One rural county

indicated that at times, current funding structures were obstacles for providing services, due to the inability of small regions to qualify to accept Medicaid.

Family support and involvement are central to achieving positive outcomes, and may require family treatment and other services.

Wraparound services and strategies that foster collaboration were important for urban counties. Rural areas mentioned innovative programs such as Clinic Plus and school-based mental health programs more frequently, though they viewed wraparound and collaboration as also important. The benefits of these programs are that they seem to provide early access and assessment so that interventions are timelier and logistically convenient to families.

Training in evidence-based practice including realistic mechanisms to implement these practices was also recommended by both rural and urban counties.

Since children and adolescents with a dual diagnosis or whose cases are complex are becoming more prevalent, both urban and rural counties noted that it is critical to find ways to better respond to their situations and improve outcomes.

Unique responses from both rural and urban counties:

- Address added administrative costs when new initiatives are implemented
- Consider other options beside the psychiatric medical model
- Enhance crisis and respite care services
- Base treatment on clinical judgment rather than funding mechanisms

Summary Recommendations

Based on the literature review, secondary data, telephone survey results, and discussions with the project's advisory council and attendees at the CLMHD Spring Membership Meeting, we have identified five potential target areas for change: increase and maintain capacity, emphasize prevention, support system collaboration, restructure financing and improve access to care.

Increase and Maintain Capacity

This report adequately demonstrates the need for increased capacity in CAPs. While the shortage extends to other mental health professions, those mentioned in our findings are social workers, nurse practitioners with advanced certification and those mental health clinicians with qualifications to meet the requirements of federal and/or state policies, the focus of our recommendations below is on CAPs. The goal of increasing capacity is imperative for the stability of mental health services; by increasing the number of CAPs we can increase the ability to provide special trainings in child and adolescent psychiatry, CAP telepsychiatry services, and one on one consults with CAPS in addition to the immediate need of providing CAP services to children and adolescents with mental health needs.

Training

- Develop publicity campaigns in an effort to increase applications, admissions, and graduation to CAP training programs by focusing the message to college students and k-12 students
- Develop mentorship opportunities within cap training program to support the completion of the program
- Allocate funding to develop new CAP training programs
    - Support the SCAA and NYSCLMHD proposal to develop a CAP training program in Albany and expand existing programs in Buffalo, Rochester, and Syracuse
- Funding for students to pay for education (student loan deferment, loan forgiveness)
- Reassess residency training requirements for CAP trainees in an effort to decrease the burden (number of years and tuition expenses).

Attracting CAPs to NYS and especially to underserved locations

- Develop a publicity campaign around the value, rewards, and opportunities specific to work in NYS and in rural communities.
    - Benefits of rural living (outdoors activities, access to smaller city cultural opportunities, rural community)
- Increase salaries and provide other financial incentives (bonus, moving expenses, house search, spousal job search)
- Offer statewide professional head hunter services to attract CAPs by networking with medical schools, CAP training programs, the pool of CAP graduates in addition to supporting and guiding the counties on how best to increase their ability to attract individuals to their locale.

Maintaining Capacity

- Organize regional teams of CAPs to create a work community and a network of support for caps in remote areas.
- Develop the infrastructure to stimulate and offer opportunities to grow (annual NYS conferences or, monthly in-service such as grand rounds via remote technology for all CAPs in the state)

Emphasize Prevention

While increasing CAP capacity is an imperative recommendation, it is also unrealistic in face of the current and estimated future need for services for children and adolescents. Reducing this need and more specifically the severity of the cases that are in need, we can hopefully find a balance where the capacity to serve matches the mental health needs of our children and adolescents.

Respondents indicated that the lack of preventive services, has led to an increased use of higher levels of services and therefore more costly services. These costs include finances, time, and space needed to serve others. By shifting the resources to preventive services, more children and adolescents should receive services at earlier on and therefore be able to avoid more intensive services later. This shift has begun with Child and Family Clinic Plus for example with the school wide screenings; counties report on the comprehensive nature of the screenings and the ability to identify problems early on.

- Continue and increase screening opportunities for children and adolescents in schools, primary health care, juvenile justice/courts, DSS/foster care
- Support and integration of mental health prevention services in early childhood through parent training in the community. Prenatal services, early infancy family support, toddler and family groups, preschool education.
- Increase crisis services such as mobile unit and crisis/respite beds in order to prevent the need to use higher levels of care

System Integration and Collaboration

Counties value services that are based on systems integration and collaboration, such as SAMHSA System of Care, CCSI and other wraparound services, and evidenced based services. They express a need for and training in these services, and see the potential for positive results are associated with these efforts. In particular counties remark that the Child and Family Clinic Plus Initiative has impacted services, increasing resources and capacity for example by allowing counties to provide home based services and expand support staff.

Counties expressed that the children they are currently seeing are involved in a number of systems and are plagued with a number of problems such as substance abuse, family and community violence, and extreme poverty; trends indicate an increase in children and adolescents with co-occurring disorders. Trying to provide individual child and adolescent mental health services in a vacuum more often than not is a set up for failure. The myriad of problems need to be addressed which include the individual, family, community and other service systems involved.

- Establish funding for regional system of care initiatives through out NYS (e.g. SAMHSA Grants) and/or increase the number of counties with funding for systems of care
- Attract and fund qualified staff to implement these multi system approaches as well as the management needed to oversee and support staff in their efforts to accurately implement the needed services
- Support the Child Psychiatry Access Demonstration Project, which would establish regional child psychiatry teams (a social worker, a care coordinator and a child psychiatrist) to provide timely consultations to PCPs
- Provide cross system services for children and adolescents with co-occurring disorders
- Develop initiatives to foster collaboration between mental health services and primary care providers including supporting and consulting with medical professionals on prescribing and monitor psychotropic medications for children and adolescents

Restructure Financing

Reimbursement structures and contract rates of managed care entities underlie some of the key issues that relate to the current inadequate funding of child and adolescent mental health care. Contract rates for CAPS and other MH providers are too low; they do not support the level of care and coordination required, consult with schools, physicians and family, when working with children. They act as a disincentive for CAPS and other providers to work within the public and private health care system or to accept insurance payments for service. Koppleman (2004), explains that changes in the financing of mental health care, with the rise of managed care and the accompanying bureaucracy, has also brought about the trend of CAPS leaving insurance panels and going to private pay arrangements.

Many counties report fiscal difficulties when trying to implement state and federal policies. Funding is based on medical regulations not necessarily on clinical decisions. HIPAA and Child and Family Clinic Plus are two programs often cited due to unrealistic fiscal models. Frequently, the funding behind a mandate is insufficient to support the increased workload or staffing requirements for implementation. For example, several counties pointed to inflexible Medicaid requirements, including the inability to bill for a therapy appointment and a medical appointment such as psychiatry, on the same day, which creates an enormous burden for families to bring their child twice in the same time frame, often over great distances.

- Revisit contract rates and reimbursement structures
- Build more flexibility into Medicaid funding (e.g. to reduce negatively influencing clinicians to provide care based on funding rather than need) and introduce reimbursement that supports good clinical choices (e.g. face-to-face services with two clinicians in the same day and consultation between professionals via telepsychiatry)
- Collaboration between OMH licensed facilities and health insurances organizations that provide CHP to ensure providers, and CAPs in particular, in the area are willing to accept these plans
- Expand Timothy's Law to cover our most vulnerable families by removing the exceptions to the law for example the Healthy New York and Child Health Plus programs (http://www.ins.state.ny.us/timothy.htm).

Improve Access to Care

Counties indicated that the greatest barrier to mental health services is transportation. The lack of adequate public transport, poverty and dispersed populations all contribute to families' difficulties in getting to clinics. While telepsychiatry can improve the counties access to CAPs, the difficulty of getting patients to the telepsychiatry equipment still remains. Some counties report that patients have difficulty even getting to remote/satellite clinics that have been established.

- Use established successful techniques for design and implementation of telepsychiatry for e.g. designing the service with providers' needs in mind, such as ease of use and incentives (Whitten & Mackert, 2005)
- Utilize technology that patients can access within their homes such as email and or telephone consultations. Safe websites for CAPs consultation (something similar currently exists for primary care)
- Provide training for medical professionals providing services to children and adolescents on prescribing and monitoring psychotropic medications
- Provide travel vouchers to clients who are in financial need

In conclusion this report represents the most accurate available data on CAP and child and adolescent mental health services in the 58 counties of NYS. Practice and policy recommendations include increasing CAP capacity to serve children and adolescents with mental health problems as well as increasing prevention of mental health illness and the prevention of exacerbating existing illnesses. Other recommendations include improving the quality of care by integrating evidenced based models that are systemic and collaborative, restructuring finances in order to fund equitably and to reinforce the systems of care that are needed and lastly, better access to mental health and CAP services especially for families in poverty and in rural areas.

VIII

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Appendix 1

Respondent's Name: _____ Date: _____ Code number: _____

County Wide Survey on Child and Adolescent Psychiatric Services in NYS

Introduction: The purpose of this interview is to gather information at the county level regarding child and adolescent psychiatric services. The survey is made up of five sections and should take approximately 45 to 60 minutes. Section one inquires about the current status of child and adolescent psychiatric services. Section two inquires about the need, if any, for child and adolescent psychiatric services. Section three inquires about any efforts to address this need including alternative methods such as tele-psychiatry. Section four inquires about influences on child and adolescent psychiatric services and section five inquires about the respondent's mental health service priorities. Unless otherwise specified, we ask that your responses include any and all information on child and adolescent psychiatric services in all settings and operations to the best of your knowledge. Throughout this survey we inquire about child and adolescent psychiatrists, for ease of the survey we will use the term, 'CAPs' in its place.

Sect. I	**CURRENT STATUS OF CHILD AND ADOLESCENT PSYCHIATRY AND PSYCHIATRIC SERVICES IN YOUR COUNTY**	**KEY**
1	a. ___ Please estimate the overall number of **CAPs** practicing in your county? b. Can you estimate how many of those CAPs practice full time (30 or more hours a week) versus how many practice part time (less than 30 hours a week) in your county. How many hours of CAP services are available in each of the following settings per week in your county? c. ___ Inpatient facilities d. ___ Outpatient service organizations e. ___ Office based only	If 0 skip to Q5
2	Please tell us a little more about the **demographics and employment status** of CAPs in your county. How many are? a. ___ Within 10 years of retirement b. ___ Female c. Race/ethnicity i. ___White ii. ___Black iii. ___Hispanic iv. ___Asian v. ___ Other d. ___ Speakers of English as a second language e. ___ Residing outside of the county f. ___ Employed by private organizations or in private practice g. ___ Employed by contract by county h. ___ Employed by contract by state	
3	Please indicate which if any of the following **services are provided by CAPs** in your county? And approximately how many CAPS perform each of the following services.	

	a. ___ Psychiatric assessment (by CAP) b. ___ Medication consultation (by CAP) c. ___ Medication management(by CAP) d. ___ Individual mental health counseling (by CAP) e. ___ Family therapy (by CAP)	
4	The next few questions are about coordination between child and adolescent mental health system and other related systems. First we are interested in **referral sources**, please rank referral sources based on how many children and adolescents are referred for mental health services in your county from the following: 1=majority of referrals, up to as many as apply. a. ___Primary health care b. ___Education/Special Ed c. ___Juvenile justice system d. ___Child welfare services e. ___Family f. ___Self referral by child/adolescent g. ___Other please describe _____	1=majority of referrals, 2= second place for most referrals 3= third place for number of referrals, etc.
5	Please rate the **quality of coordination of care** between the child and adolescent mental health system and other systems of care using the response options very poor, poor, moderate, good, and excellent. a. ___Mental health and Primary health care b. ___Mental health and Education/Special Ed c. ___ Mental health and Juvenile Justice d. ___ Mental health and Child Welfare	1=very poor, 2=poor, 3=moderate, 4=good, 5= excellent
6	a. Please tell us what makes the coordination with primary health care BLANK? b. What makes the coordination with education/special education BLANK? c. What makes the coordination with Juvenile Justice BLANK? d. What makes the coordination with Child Welfare BLANK?	BLANK response from 5 a-d. Memo
7	a. Are there any organized **family groups** or associations that influence the provision of child and adolescent psychiatric services in your county? Yes------ No ----- b. If yes, what are these groups? c. In what ways have they had influence?	If no, skip to next Q
8	The next few questions are about **mental health policy**. a. Have federal or state mental health policies or initiatives impacted your county's child and adolescent mental health services in recent years? Yes------ No ----- b. If so, how have they impacted services?	Skip f/u ? if no
9	a. Has it been difficult to implement federal or state policies at the county level? Yes------ No ----- b. If so why?	Skip f/u ? if no
10	Now we are going to ask about child and adolescent mental health system payment sources. Please indicate which of the following **payment sources** are typically used for outpatient child and adolescent services in your county and the percent of revenue from each. a. ___Medicaid ___% i Fee-for-service ___%	

	ii Managed Care ___% If yes to managed care, then is there a Carve out for MH services? Yes------ No ----- b. ___Child Health Plus ___% c. ___Other public insurance ___% d. ___Private health insurance ___% i ___ Fee for services ___% ii___ Managed care ___% e. ___Out-of-pocket ___% Are there sliding fee scales? Yes------ No ----- f. ___Other, please describe _____	
11	Now we are going to ask about **other funding sources** for your county's child and adolescent mental health services. a. Are there any federal and state supplemental sources? b. If so, what are they? c. Please tell us about any restrictions on how this money can be used? d. Does the county fund any child and adolescent mental health services? Yes------ No ----- i If so, what part of the county budget does this money come from? e. Please tell us about any other funding sources that your county utilizes? f. Have there been innovative attempts to merge funding from other service sectors, such as juvenile justice, child welfare, education, perhaps health or substance abuse? Yes------ No ----- i If so, please tell me about it? _____	2 skips here (c and e)
12	I am going to read a list of **<u>barriers</u>** to child and adolescent mental health services. Please tell me the extent to which each one is a barrier in your county. The responses options are "not at all, a little, somewhat, a lot" a. ___ General mental health workforce capacity b. ___ Care coordination across providers c. ___ Provider follow up on referrals d. ___ Family or guardian follow up on referrals e. ___ Reimbursement procedures f. ___ Availability of public funds	For data entry 1=not at all, 2=a little, 3=somewhat, 4=a lot

	g. ___ Transportation h. ___ Office hours of mental health service providers i. ___ Available child care j. ___ Parent/family knowledge of MH problems k. ___ Parent/family information about available services l. ___ Stigma m. ___ Are there any other barriers I haven't mentioned? please describe them _____	
13	Where the barrier was 'a lot', please give us examples of the nature of the barrier? _____	Ask if <=3 flagged '4=a lot'
14	Please identify the top three barriers to child and adolescent mental health services. For each of the 3, give us examples of the nature of the barrier _____ _____ _____	> 3 flagged a lot then ask, if not skip Space for 3 responses
Sect. II	**CHILD AND ADOLESCENT PSYCHIATRIC NEEDS IN YOUR COUNTY**	
15	a. Does your county need any additional CAPs? Yes------ No ----- b. If so how many? c. How did you arrive at this number? d. Does this need significantly impact your county? Yes------ No ----- e. If so, how? f. Has there been a strain on other professional disciplines providing mental health services in your county as a direct result of this shortage? Yes------ No ----- g. Please tell us about the strain _____	if no to a skip to next Q if no to d skip to f if no to f skip to next Q
16	Please rate the **need for CAP services for the following populations** in your county (most significant need; great need; some need, little need; and no need at all). a. ___ Preschool children (0-5 yrs) b. ___ School age (6-12yrs) c. ___ Adolescents (13-17 yrs) d. ___ Children with special needs (developmental or physical) e. ___ Adolescents with special needs (developmental or physical) f. ___ Children and adolescents in the child welfare system g. ___ Other, please describe _____	1 = most significant need; 2= great need; 3=some need, 4= little need; and 5 = no need at all
17	Please rate the following types of **CAP psychiatric services based on need** in your county. (most significant need; great need; some need, little need; and no need at all).	1 = most significant need;

	a. ___ Services in inpatient psychiatry program (by CAPs) b. ___ Services in crisis care (by CAPs) c. ___ Services in residential treatment facilities (by CAPs) d. ___ Services in child day treatment program (by CAPs) e. ___ Psychiatric assessment (by CAP) f. ___ Medication consultation (by CAP) g. ___ Medication management(by CAP) h. ___ Individual mental health counseling (by CAP) i. ___ Family therapy (by CAP) j. ___ Any other services, please describe _____	2= great need; 3=some need, 4= little need; and 5 = no need at all
18	What are the typical **<u>wait times and numbers</u>** of names on wait list for services for the following child and adolescent mental health services inside your county? a Inpatient child and adolescent psychiatric hospital beds (not long term or RTF): _____ wait time in ER; _____ # on wait list b. Long term state child and adolescent psychiatric hospitalization beds for your region: _____ wait time; _____ # on wait list c. Residential treatment facility beds _____ wait time; _____ # on wait list d. Day treatment program _____ wait time; _____ # on wait list e. Outpatient psychiatric services (CAPs) _____ wait time; _____ # on wait list f. Do any other specific psychiatric services, such as diagnostic assessment, initial medication consultation, on-going medication management, or therapy have wait times or wait lists? Yes------ No ----- g. If yes please share which ones? _____ wait time; _____ # on wait list	Skip each if no service in county F needs space for 4 possible response
19	a. Would a child or adolescent ever have to go **<u>outside of the county for inpatient</u>** psychiatric hospitalization (not long term or RTF)? Yes------ No ----- b. If yes, what is the typical reason? c. If so, where do the majority of children and adolescents have to go for inpatient services? _____ d. And how long does it take to get there? _____	Pre-program skip to c if no level of care
20	a. Would a child or adolescent ever have to go **<u>outside of the county's regional facility for long term state</u>** psychiatric hospitalization? Yes------ No ----- b. If yes, what is the typical reason? c. If so, where do the majority of children and adolescents have to go for long term state inpatient services? _____ d. And how long does it take to get there? _____	If 20a is no skip to next Q
21	Would a child or adolescent ever have to go **<u>outside of the county for placement in a residential</u> <u>treatment facility</u>**? Yes------ No ----- b. If yes, what is the typical reason?	Pre-program skip to c

	c. If so, where do the majority of children and adolescents have to go for residential services? _____ d. And how long does it take to get there? _____	if no level of care
22	Do children and adolescents in need of **outpatient** psychiatric services ever have to go **outside of the county** in order to receive services? Yes------ No ----- b. If yes, what is the typical reason? c. If so, where do the majority of children and adolescents have to go for outpatient services? _____ d. And how long does it take to get there? _____	If no skip to next Q
23	**No Inpt**: a. Do you think there is a need for inpatient child and adolescent psychiatric services located within your county? Yes------ No ----- **Yes Inpt**: b. Do you think there is a need for additional inpatient child and adolescent psychiatric services? Yes------ No ----- c. If so, approximately how many beds _____	Pre-pro OMH licensed Both answer c
24	**State Long Term Care**: a. Do you think there is a need for additional beds at your county's regional long term inpatient child and adolescent psychiatric facility? Yes------ No ----- b. If so, approximately how many beds _____	
25	**No RTF:** a. Do you think there is a need for residential treatment programs for child and adolescent located within your county? Yes------ No ----- **Yes RTF**: b. Do you think there is a need for additional residential treatment programs for child and adolescent? Yes------ No ----- c. If so, approximately how many beds _____	Pre-prog as above
26	**Crisis Care**: a. Do you think there is a need for additional child and adolescent crisis psychiatric services (assessment, observation, and placement)? Yes------ No ----- b. If so please describe? _____	
Sect. III	**ALTERNATIVE STRATEGIES TO DEAL WITH CHILD AND ADOLESCENT MENTAL HEALTH NEEDS FOR PSYCHIATRIC SERVICES**	
27	In addition to, or instead of CAPs, which professional groups are responsible for **prescribing and/or monitoring psychotropic medications** for children and adolescents in your county out of the following? a.___ Adult psychiatrists b.___ Primary care physicians c.___ Pediatricians d.___ Nurse practitioners e. ___ Developmental behavioral pediatricians f. ___ Neurologists g. ___ Psychiatry residents, if so are they from programs in your county? i_____ ii. ___ International medical graduate psychiatry residents with J-1 visa h. ___ CAP psychiatry fellows, if so are they from programs in your county? i_____ ii. ___ International medical graduate psychiatry fellows with J-1 visa	Ask j. only if there are more than three endorsed in the list of a-i. If a-i are not endorsed skip j, k

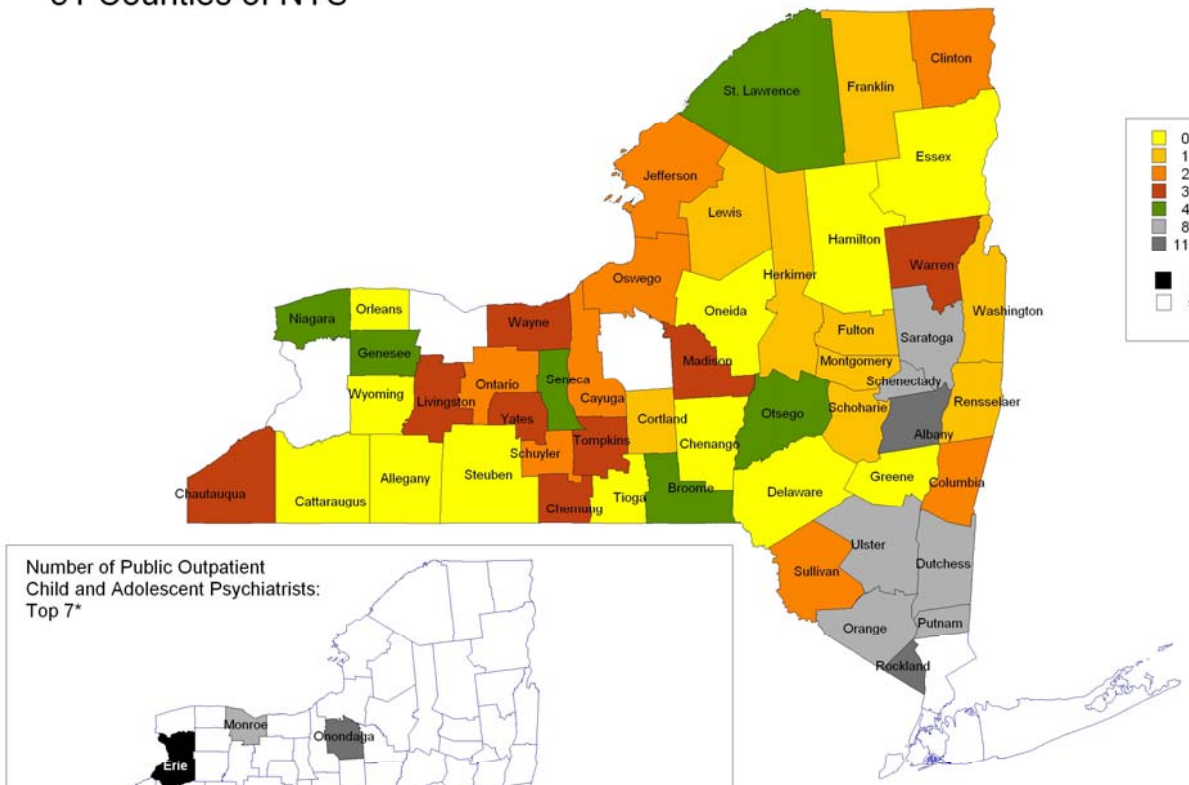
	i. ___ Other, please specify_____ j. Which are the top three professional groups primarily responsible for prescribing and/or monitoring? k. Have the services provided by other professions adequately met the needs for children and adolescents? Yes------ No ----- l. If not, please explain _____	and l
28	Has your county employed any of the following **strategies or practitioners or trainings** to supplement the child psychiatry workforce? a. ___ Tele-psychiatry b. ___ Locum tenens (temporary employment for physicians) CAPs c. ___ Limited permit (certain restrictions apply) CAPs d. ___ Nurse practitioners with advanced certification in child psychiatry e. ___ Developmental behavioral pediatricians f. ___ Collaborating with CAP training program, please describe _____ g. ___ International graduate medical residents with J-1 Visas or waivers h. ___ Special training in Child and Adolescent psychiatry for i. ___Pediatricians ii. ___Primary Care Physicians iii. ___ Adult Psychiatrist iv. ___Other, please describe _____ i. ___Any other strategies, please describe_____	if no to a skip 29a1-6; yes, skip 29a7, If no to each of b-h skip 30, if yes skip 31; if 28i is ask 30, if no skip to 32
29a 1	a. Tell us more about how tele-psychiatry is being implemented and used in your county (i.e Which agencies/organizations are involved, who provides services, who receives consults, and under what circumstances).	
29a 2	Who else is participating in tele-psychiatric services? And approximately how many consultations have taken place for each to date? a. ___Preschool (0-5) b. ___ Child (6-12) c. ___ Adolescent (13-17) d. ___Parents e. ___ Other, please describe _____ f. Generally, is it a one time event or an on-going relationship? _____	
29a 3	a. Has your county experienced any benefits as a result of using tele-psychiatry? Yes------ No ----- b. If so what are they?_____	
29a 4	a. Has your county experienced any drawbacks to using tele-psychiatry? Yes------ No ----- b. If so what are they? _____	
29a 5	What has the overall experience been like, positive/successful or negative/failure or somewhere in between? Please describe? _____	Circle one
29a 6	a. What is the approximate total cost per year for this program? b. Is it economically viable to continue services? c. And how is it currently being funded? d. Are there any plans for continuity of these services including funding?	If no to d skip to next Q

	Yes------ No ----- If so, what are they? _____	
29a 7	Detail for **Tele-psychiatry If Not**: a. Is tele-psychiatry something that you think your county would be interested in using? Yes------ No ----- b. If not, why? c. If so, how interested? (Extremely interested, Very interested, Somewhat interested) d. What do you see as the role of tele-psychiatry in providing psychiatric and/or mental health services to children in your county	If yes to a skip to c 1=Extremely interested, 2=Very interested, 3=Somewhat interested If b skip to next Q
30	a. What are the benefits to employing BLANK? b. What are the limitations or drawbacks to employing BLANK?	SP -ask of all in 28 as yes
31	What, if anything has prevented you from employing BLANK to supplement child and adolescent psychiatry workforce?	SP ask of all in 28 as no
32	a. Are any efforts currently in place to **attract more CAPs** to your county? Yes------ No ----- b. If not, what might be done to attract CAPs to your area? c. If so, what are they? d. What else might be done to attract CAPs to your area?	If yes to a skip to c After b skip to next Q
Sect. IV	**INFLUENCES ON CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**	
33	a. Have any **outstanding events** (for e.g. law suits, advocacy, or accidents) **directly impacted** child and adolescent psychiatric services in your county? Yes------ No ----- b. If so can you tell me about them and their impact?	Skip f/u ? if no
34	a. Has anything happened in your county in recent years that has **indirectly impacted** child and adolescent psychiatric services or child and adolescent psychiatry (e.g. unemployment increases- local business closing, crisis events, migration/immigration)? Yes------ No ----- b. Please tell us about it. _____	
35	a. Are there any **trends or changes** in the children and adolescents who are currently receiving psychiatric services as compared to children and adolescents who were receiving psychiatric services over the previous years? Yes------ No ----- i. If so what sort of trends or changes have you witnessed? _____ ii. When did these changes begin to occur? b. Are there any current trends or changes that might influence the availability of CAPs in your county? Yes------ No ----- i. If so, Please describe_____	If no to a skip to b If no to b skip to next Q

Sect. V	RESPONDENT'S ROLE AND PRIORITIES	
36	What is your current job title and what are your main responsibilities? Title_____ Capacity_____	
37	a. How many years have you worked in this position? _____ b. And in this community/county? _____	
38	What are your current priorities regarding CAP and child and adolescent psychiatric services in your county?	
39	What are your recommendations to improve mental health services to children and adolescents?	
40	Is there anything you would like to add regarding child and adolescent mental health services and child and adolescent psychiatry?	

Appendix 2

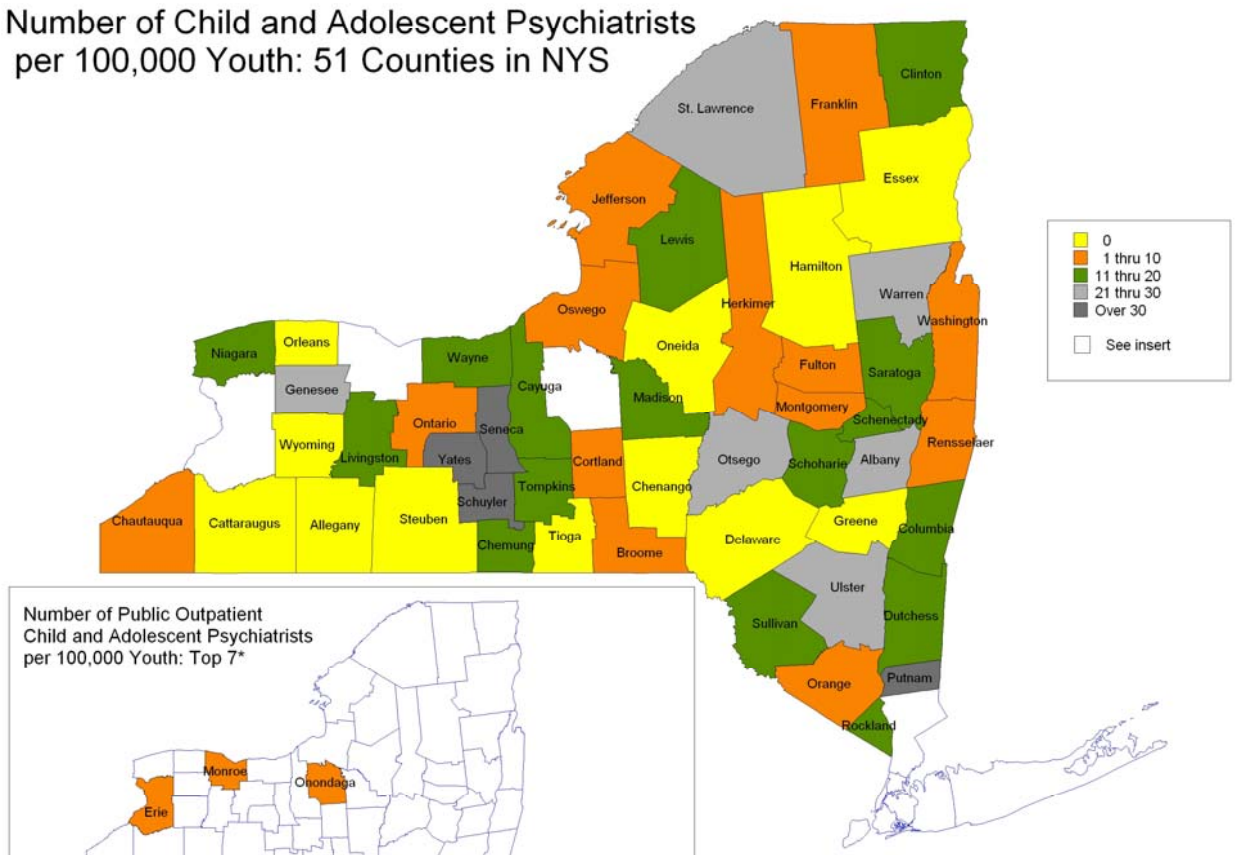
Number of Child and Adolescent Psychiatrists: 51 Counties of NYS



Number of Public Outpatient Child and Adolescent Psychiatrists: Top 7*

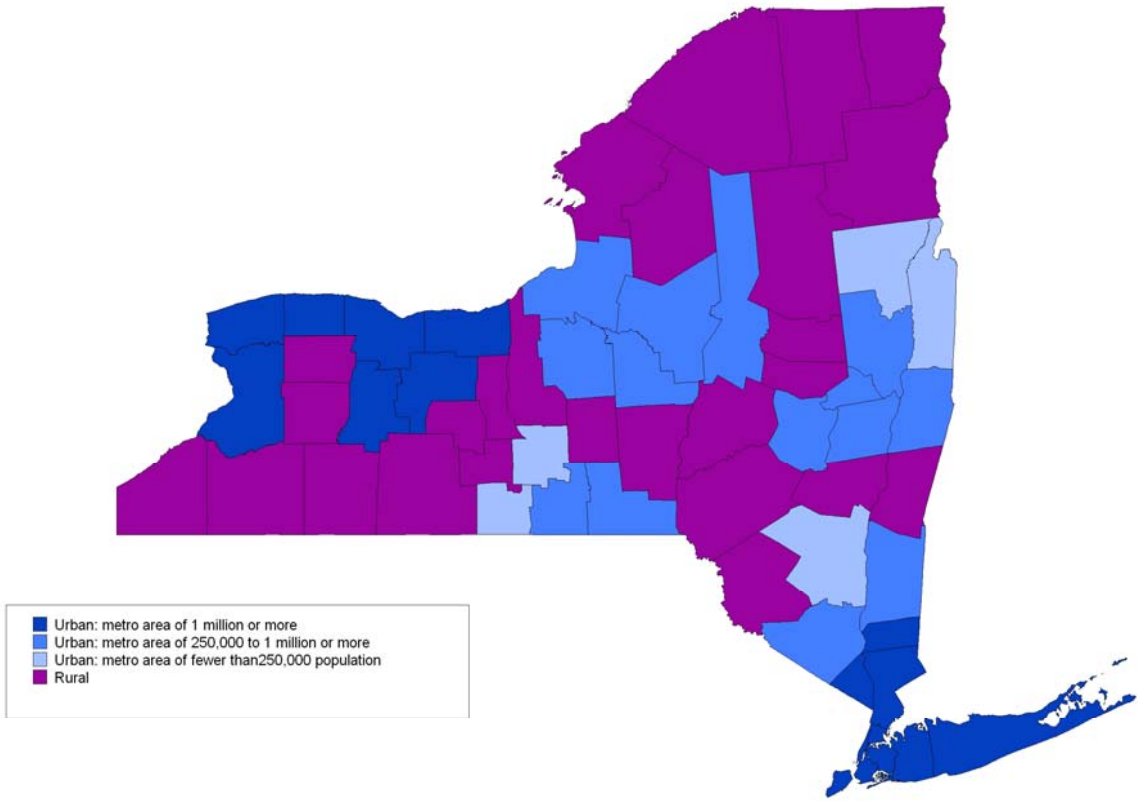
*NYC is excluded because they reported on 2006 data which was not limited to public outpatient CAPs

Map 1


Number of Child and Adolescent Psychiatrists per 100,000 Youth: 51 Counties in NYS
St. Lawrence
Franklin
Clinton
Essex
Jefferson
Lewis
Hamilton
Warren
Washington
Herkimer
Oswego
Oneida
Saratoga
Fulton
Niagara
Orleans
Wayne
Cayuga
Madison
Montgomery
Schenectady
Genesee
Ontario
Seneca
Wyoming
Livingston
Yates
Cortland
Otsego
Schoharie
Albany
Rensselaer
Tompkins
Chenango
Schuyler
Chautauqua
Cattaraugus
Allegany
Steuben
Chemung
Tioga
Broome
Delaware
Greene
Columbia
Ulster
Sullivan
Dutchess
Orange
Putnam
Rockland
0
1 thru 10
11 thru 20
21 thru 30
Over 30
See insert
Number of Public Outpatient Child and Adolescent Psychiatrists per 100,000 Youth: Top 7*
Monroe
Onondaga
Erie
Westchester
Suffolk
Nassau
*NYC is excluded because they report on 2006 data which was not limited to public outpatient CAPs

Map 2

Rural and Urban Areas in NYS*



*USDA Economic Research Service: 2003 Rural-Urban Continum Codes for New York
Rural Counties Collapsed

Map 3

Appendix 3

County Name: Albany

Current Status			
Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	17	Census population under 18 yrs[6]	61,392
Practice full time	5.00	CAPs per 100,000 youth	27.69
Practice part time	12.00		
Reside outside of the county		**Hours of CAP services per week:**	
Employed by private organizations or in private practice	16.0	Inpatient facilities	0.00
Employed by contract by county	0.0	Outpatient service organizations	215.00
Employed by contract by state	1	Office based only	85.00
Within 10 years of retirement	13.00	**Number of CAPs (AMA data):**	
Female	7	In 2005	13
White	15	In 2006	16
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Family United Network through Parsons Child and Family Center, Families Together in Albany Co- which has been developed through the systems of care which is a partnership between family and the county.	
Hispanic	0		
Asian	0		
Other	2		
Speakers of ESL			

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	297,556	Families w/related children <18[7] yrs	33,678
Total Number of Females	154,635	Families w/children <18 yrs living in poverty[2]	4,237
Total Number of Males	142,921	Children and youth 0 to 17 yrs living below poverty[8]	9,248
Median Age	37.8	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	2
White	240,538	Suicide Mortality Rate 10-19 in 2001-03	3.9
Black	34,826	Suicide Mortality 10-19 in 2003-05	2
American Indian and Alaskan Native	724	Suicide Mortality Rate 10-19 in 2003-05	3.9
Asian	12,517	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	533.21
Other	5,147	Population Density per sq mile	562.7
Disabilities[1]		Housing Density per sq mile of land area	248.3
Total population 5 to 15 yrs w/disability	41,692	**Economics[1]:**	
With a mental disability	2,407	Median Family Income	68,314
		Number unemployed	8,055

[6] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[7] U.S. Census Bureau; Census 2000
[8] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	4	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Great need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other: Consultation and support with PCP	Most significant need
Other, please describe			

Access to services			**Need for the following services**		
Service	**Wait time in Days**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		45 min avg.	Inpatient psychiatric services	Yes	15
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility	98	90 min	Additional residential treatment beds	Yes	7
Outpatient psychiatric services	35	90 min	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	90	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents. Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Developmental behavioral pediatricians, Collaborating with CAP training program, Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians and Adult Psychiatrists, and Other: Dr. Seigel spoke about the STEPS campaign CLMHD and partnership with Schuyler regarding expanding debt reduction and expanding residency opportunities and additional use of nurse practitioners and use of tele psychiatry in the planning process.

County Name: Allegany

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[9]	12,194
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	
Outpatient service organizations	
Office based only	
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: N/A

Additional Secondary County Data

Population[1]:	
Total	49,927
Total Number of Females	24,985
Total Number of Males	24,942
Median Age	35
Race[1]:	
White	48,444
Black	361
American Indian and Alaskan Native	139
Asian	358
Native Hawaiian and Pacific Islander	2
Other	183
Disabilities[1]	
Total population 5 to 15 yrs w/disability	7,795
With a mental disability	436

Families:	
Families w/related children <18[10] yrs	5,681
Families w/children <18 yrs living in poverty[2]	1,020
Children and youth 0 to 17 yrs living below poverty[11]	2,181
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	0.0
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	1,034.42
Population Density per sq mile	48.5
Housing Density per sq mile of land area	23.8
Economics[1]:	
Median Family Income	38,586
Number unemployed	2,127

[9] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[10] U.S. Census Bureau; Census 2000
[11] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Little need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Some need
Adolescents w/special needs (developmental or physical)	Some need
Children and adolescents in the child welfare system	Great need
Other, please describe	

Need for services by CAPS for:	
Inpatient psychiatry program	No need at all
Crisis care	No need at all
Residential treatment facilities	No need at all
Child day treatment program	No need at all
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		45 min avg.
Long term state psychiatric hospitalization	15	
Placement in a residential treatment facility		90 min
Outpatient psychiatric services	35	90 min
Day treatment services	0	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	Yes	3
Additional child and adolescent crisis psychiatric services	No	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioner

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Nurse Practitioners

County Name: Broome

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	4	Census population under 18 yrs[12]	40,451
Practice full time	2	CAPs per 100,000 youth	10
Practice part time	2		
Reside outside of the county	0	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	3	Inpatient facilities	40
Employed by contract by county	1	Outpatient service organizations	7
Employed by contract by state	1	Office based only	40
Within 10 years of retirement	2	**Number of CAPs (AMA data):**	
Female	3	In 2005	6
White	3	In 2006	7
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** SPOA comes together to recommend services and includes Parent Partners. CCSI - Tier 2, local administrators, but parents are involved in this group. MH/MR task force has been in place for 4 years which looks at access to psychiatry for families.	
Hispanic	0		
Asian	1		
Other	0		
Speakers of ESL	1		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	196,269	Families w/related children <18[13] yrs	22,797
Total Number of Females	101,717	Families w/children <18 yrs living in poverty[2]	3,531
Total Number of Males	94,552	Children and youth 0 to 17 yrs living below poverty[14]	7,529
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	174,996	Suicide Mortality Rate 10-19 in 2001-03	4.5
Black	8,344	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	371	Suicide Mortality Rate 10-19 in 2003-05	4.6
Asian	6,901	**Density[2]**	
Native Hawaiian and Pacific Islander	50	Total Area per sq mile	715.46
Other	2,294	Population Density per sq mile	283.7
Disabilities[1]		Housing Density per sq mile of land area	125.7
Total population 5 to 15 yrs w/disability	29,410	**Economics[1]:**	
With a mental disability	2,020	Median Family Income	57,098
		Number unemployed	5,599

[12] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[13] U.S. Census Bureau; Census 2000
[14] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	4	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Little need
Need for CAP services by population group:		Child day treatment program	Some Need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Great need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other: MH/MR kids. The former Dr. who specialized in this population left the county.	
Other: Under age of 12 and SED hard to find services			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		Range 1 hr at the least	Additional psychiatric services	Yes	10
Long term state psychiatric hospitalization		1 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	
Placement in a residential treatment facility		1/2 hr	Residential treatment programs	No	
Outpatient psychiatric services	0		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Other: Trying to recruit CAPs, put ads out, the only calls from locum tenens a service we can't afford.

County Name: Cattaraugus

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[15]	18,632
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	0
In 2006	0
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	81,534
Total Number of Females	41,790
Total Number of Males	39,744
Median Age	39
Race[1]:	
White	76,793
Black	1,163
American Indian and Alaskan Native	2,207
Asian	613
Native Hawaiian and Pacific Islander	0
Other	77
Disabilities[1]	
Total population 5 to 15 yrs w/disability	13,963
With a mental disability	845

Families:	
Families w/related children <18[16] yrs	10,282
Families w/children <18 yrs living in poverty[2]	1,780
Children and youth 0 to 17 yrs living below poverty[17]	3,681
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	5.0
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	5.2
Density[2]	
Total Area per sq mile	1,322.25
Population Density per sq mile	64.1
Housing Density per sq mile of land area	30.4
Economics[1]:	
Median Family Income	46,168
Number unemployed	2,719

[15] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[16] U.S. Census Bureau; Census 2000
[17] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of CAPs needed	1	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Little need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Some need	Medication management	Great need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Some need
Children and adolescents in the child welfare system	Some need	Other: MH/MR kids. The former Dr. who specialized in this population left the county.	Most significant need
Other, please describe			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1 hr	Inpatient psychiatric services	Yes	3
Long term state psychiatric hospitalization	45		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		1.5 hr	Residential treatment programs	Yes	5
Outpatient psychiatric services	0	Depends, but about 20 min for those near the county line.	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Nurse practitioners w/advanced cert. in child psychiatry

County Name: Cayuga

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	2
Practice full time	0
Practice part time	2
Reside outside of the county	2
Employed by private organizations or in private practice	1
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	1
Female	0
White	2
Black	0
Hispanic	0
Asian	0
Other	
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[18]	17,870
CAPs per 100,000 youth	11
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	20
Office based only	20
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Partnership for Results, NAMI, Parents as Partners Program, and a Group at the MH Center which hosts monthly meetings.

Additional Secondary County Data

Population[1]:	
Total	81,243
Total Number of Females	41,182
Total Number of Males	40,061
Median Age	40
Race[1]:	
White	75,703
Black	3,009
American Indian and Alaskan Native	296
Asian	472
Native Hawaiian and Pacific Islander	0
Other	578
Disabilities[1]	
Total population 5 to 15 yrs w/disability	13,068
With a mental disability	828

Families:	
Families w/related children <18[19] yrs	9,971
Families w/children <18 yrs living in poverty[2]	1,333
Children and youth 0 to 17 yrs living below poverty[20]	3,009
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	2.8
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	5.7
Density[2]	
Total Area per sq mile	863.64
Population Density per sq mile	118.2
Housing Density per sq mile of land area	51.2
Economics[1]:	
Median Family Income	54,114
Number unemployed	2,447

[18] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[19] U.S. Census Bureau; Census 2000
[20] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed		Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?		Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?		Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	No need at all
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Some need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Great need
Children and adolescents in the child welfare system	Great need	Other: MH/MR kids. The former Dr. who specialized in this population left the county.	
Other: Full time CAP to serve in an inpatient unit - missing in entire state, need long term beds for children. Now overwhelmed and people go elsewhere to have their needs met. Misdiagnosed or given wrong medications given by Dr. When they can't receive MH services from a MH professional, they go to their primary DR.			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		Varies	Inpatient psychiatric services	Yes	12
Long term state psychiatric hospitalization	1	6 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	18
Placement in a residential treatment facility	540	4 hr	Additional Residential treatment beds		250
Outpatient psychiatric services	42	45 min	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	180	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Limited permit CAPs and Collaborating with CAP training program

County Name: Chautauqua

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	3
Practice full time	3
Practice part time	0
Reside outside of the county	0
Employed by private organizations or in private practice	2
Employed by contract by county	2
Employed by contract by state	0
Within 10 years of retirement	0
Female	2
White	1
Black	0
Hispanic	0
Asian	0
Other	2
Speakers of ESL	2

CAPS per Youth:	
Census population under 18 yrs[21]	29,657
CAPs per 100,000 youth	10
Hours of CAP services per week:	
Inpatient facilities	40
Outpatient service organizations	80
Office based only	0
Number of CAPs (AMA data):	
In 2005	1
In 2006	2

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: NAMI, Group RAD - parents whose children have been diagnosed with reactive attachment disorder. County employs a large number of parent advocates through out the system to advocate for children.

Additional Secondary County Data

Population[1]:	
Total	135,357
Total Number of Females	68,974
Total Number of Males	66,383
Median Age	39
Race[1]:	
White	128,474
Black	2,841
American Indian and Alaskan Native	184
Asian	847
Native Hawaiian and Pacific Islander	0
Other	610
Disabilities[1]	
Total population 5 to 15 yrs w/disability	21,712
With a mental disability	1,645

Families:	
Families w/related children <18[22] yrs	16,608
Families w/children <18 yrs living in poverty[2]	2,978
Children and youth 0 to 17 yrs living below poverty[23]	6,738
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	1.6
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	6.5
Density[2]	
Total Area per sq mile	1,500.02
Population Density per sq mile	131.6
Housing Density per sq mile of land area	61.1
Economics[1]:	
Median Family Income	46,755
Number unemployed	5,179

[21] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[22] U.S. Census Bureau; Census 2000
[23] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	4	Additional Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Little need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	No need at all
Children and adolescents in the child welfare system	Most significant need	Other: Consultation with other professionals and with clinical staff, need to get knowledge out to staff	Great need
Other, please describe			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0	1.5 hr-8 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	0	1.5-8 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		About 1.5 hr, they could go farther if special needs	Residential treatment programs	Yes	7
Outpatient psychiatric services	42		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Nurse practitioners w/advanced cert. in child psychiatry, International graduate medical residents with J-1 Visas or waivers and Other: Redesigned how we do things within our own organization. While many children get a psych assessment upfront, as soon as they become stable they move to the MedClinic where most of the work is done by RNs who make sure they are doing well on medications and are stable and check if they have any questions allowing the CAP to spend a shorter time with these kids.

County Name: Chemung

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	3	Census population under 18 yrs[24]	19,399
Practice full time	3	CAPs per 100,000 youth	15
Practice part time	0		
Reside outside of the county		**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	80
Employed by contract by county	0	Outpatient service organizations	0
Employed by contract by state	2	Office based only	50
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	1	In 2005	2
White	0	In 2006	2
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** NAMI ; Finger Lakes Parent Network	
Hispanic	0		
Asian	0		
Other	3		
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	88,641	Families w/related children <18[25] yrs	10,876
Total Number of Females	44,605	Families w/children <18 yrs living in poverty[2]	1,840
Total Number of Males	44,036	Children and youth 0 to 17 yrs living below poverty[26]	4,074
Median Age	39	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	79,659	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	4,186	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	374	Suicide Mortality Rate 10-19 in 2003-05	8.0
Asian	1,132	**Density[2]**	
Native Hawaiian and Pacific Islander	70	Total Area per sq mile	410.79
Other	625	Population Density per sq mile	223.1
Disabilities[1]		Housing Density per sq mile of land area	92.5
Total population 5 to 15 yrs w/disability	14,087	**Economics[1]:**	
With a mental disability	1,119	Median Family Income	48,185
		Number unemployed	3,532

[24] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[25] U.S. Census Bureau; Census 2000
[26] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Little need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Great need
Other, please describe	

Need for services by CAPS for:	
Inpatient psychiatry program	Great need
Crisis care	Little need
Residential treatment facilities	Little need
Child day treatment program	No need at all
Psychiatric assessment	Most significant need
Medication consultation	Great need
Medication management	Great need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		Between 20 min and 5.5 hr depending.
Long term state psychiatric hospitalization	5	1 hr
Placement in a residential treatment facility		Rochester - 2 hr Philadelphia area - 5.5 hr
Outpatient psychiatric services	35	
Day treatment services	0	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services		
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	No	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Limited permit CAPs, and Nurse practitioners w/advanced cert. in child psychiatry

County Name: Chenago

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	0	Census population under 18 yrs[27]	13,461
Practice full time	N/A	CAPs per 100,000 youth	0
Practice part time	N/A		
Reside outside of the county	N/A	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	N/A	Inpatient facilities	N/A
Employed by contract by county	N/A	Outpatient service organizations	N/A
Employed by contract by state	N/A	Office based only	N/A
Within 10 years of retirement	N/A	**Number of CAPs (AMA data):**	
Female	N/A	In 2005	0
White	N/A	In 2006	1
Black	N/A	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	N/A		
Asian	N/A		
Other	N/A		
Speakers of ESL	N/A		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	51,401	Families w/related children <18[28] yrs	6,480
Total Number of Females	26,092	Families w/children <18 yrs living in poverty[2]	1,184
Total Number of Males	25,309	Children and youth 0 to 17 yrs living below poverty[29]	2,352
Median Age	38	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	50,191	Suicide Mortality Rate 10-19 in 2001-03	4.3
Black	422	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	141	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	146	**Density[2]**	
Native Hawaiian and Pacific Islander	11	Total Area per sq mile	898.70
Other	112	Population Density per sq mile	57.5
Disabilities[1]		Housing Density per sq mile of land area	26.7
Total population 5 to 15 yrs w/disability	8,787	**Economics[1]:**	
With a mental disability	699	Median Family Income	39,711
		Number unemployed	1,342

[27] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[28] U.S. Census Bureau; Census 2000
[29] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of CAPs needed	1	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Little need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Great need
School age (6-12 yrs)	Most significant need	Medication consultation	Great need
Adolescents (13-17 yrs)	Most significant need	Medication management	Some need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other: MH/MR kids. The former Dr. who specialized in this population left the county.	
Other, please describe			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		About 1hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	2	1-6 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	5
Placement in a residential treatment facility	21		Additional Residential treatment programs		4
Outpatient psychiatric services	21	About 1.5 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Special training in Child and Adolescent psychiatry for: Pediatricians and Primary Care Physicians

County Name: Clinton

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	2	Census population under 18 yrs[30]	16,099
Practice full time	1	CAPs per 100,000 youth	12
Practice part time	1		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	2	Inpatient facilities	40
Employed by contract by county	0	Outpatient service organizations	16
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	1	In 2005	3
White	2	In 2006	3
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** NAMI	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	82,166	Families w/related children <18[31] yrs	9,407
Total Number of Females	40,176	Families w/children <18 yrs living in poverty[2]	1,398
Total Number of Males	41,990	Children and youth 0 to 17 yrs living below poverty[32]	2,758
Median Age	37	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	76,886	Suicide Mortality Rate 10-19 in 2001-03	2.8
Black	2,370	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	0	Suicide Mortality Rate 10-19 in 2003-05	5.6
Asian	612	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	1,117.61
Other	707	Population Density per sq mile	76.9
Disabilities[1]		Housing Density per sq mile of land area	31.9
Total population 5 to 15 yrs w/disability	11,954	**Economics[1]:**	
With a mental disability	806	Median Family Income	56,772
		Number unemployed	2,494

[30] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[31] U.S. Census Bureau; Census 2000
[32] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Little need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Little need
Other, please describe	

Need for services by CAPS for:	
Inpatient psychiatry program	Little need
Crisis care	Great need
Residential treatment facilities	Some need
Child day treatment program	Some need
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Great need
Individual mental health counseling	Some need
Family therapy	No need at all
Other:	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization	0	2.5 hr-7 hr away
Long term state psychiatric hospitalization	30	
Placement in a residential treatment facility		Franklin-1.5 hr Albany-2.5 hr
Outpatient psychiatric services		About 1 hr
Day treatment services		N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Additional Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Special training in Child and Adolescent psychiatry for: Pediatricians and Adult Psychiatrist

County Name: Columbia

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	2	Census population under 18 yrs[33]	15,184
Practice full time	0	CAPs per 100,000 youth	13
Practice part time	2		
Reside outside of the county	2	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	5
Employed by contract by county	1	Outpatient service organizations	15
Employed by contract by state	0	Office based only	10
Within 10 years of retirement	2	**Number of CAPs (AMA data):**	
Female	1	In 2005	0
White	2	In 2006	1
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Small NAMI group	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	63,094	Families w/related children <18[34] yrs	7,418
Total Number of Females	31,700	Families w/children <18 yrs living in poverty[2]	824
Total Number of Males	31,394	Children and youth 0 to 17 yrs living below poverty[35]	1,944
Median Age	41	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	58,105	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	2,850	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	132	Suicide Mortality Rate 10-19 in 2003-05	3.7
Asian	507	**Density[2]**	
Native Hawaiian and Pacific Islander	20	Total Area per sq mile	648.27
Other	568	Population Density per sq mile	99.2
Disabilities[1]		Housing Density per sq mile of land area	47.5
Total population 5 to 15 yrs w/disability	9,570	**Economics[1]:**	
With a mental disability	534	Median Family Income	49,357
		Number unemployed	1,329

[33] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[34] U.S. Census Bureau; Census 2000
[35] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed		Inpatient psychiatry program	No need at all
Does this need significantly impact your county?		Crisis care	No need at all
Has there been a strain on other professions as a result of this shortage?		Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	No need at all
School age (6-12 yrs)	Most significant need	Medication consultation	No need at all
Adolescents (13-17 yrs)	Most significant need	Medication management	No need at all
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other: County notes that for day treatment, RTF, and inpatient, they go outside the county where needs are met.	
Other, please describe			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-2 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	2
Placement in a residential treatment facility		about 2 hr	Residential treatment programs	No	
Outpatient psychiatric services		about 1 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	90	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Other: From time to time we have offered doing a consultation for another MD, having CAP meet with patient and offer that when there is another MD involved already who is not a CAP. Because we recognize that others are prescribing. Not sure if it has happened but we have offered that.

County Name: Cortland

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	1
Practice full time	0
Practice part time	1
Reside outside of the county	0
Employed by private organizations or in private practice	1
Employed by contract by county	0
Employed by contract by state	0
Within 10 years of retirement	1
Female	0
White	1
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[36]	11,506
CAPs per 100,000 youth	9
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	2
Office based only	1
Number of CAPs (AMA data):	
In 2005	1
In 2006	1

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Loose knit group of families on the MHA board of directors that seek to advocate for services.

Additional Secondary County Data

Population[1]:	
Total	48,599
Total Number of Females	25,120
Total Number of Males	23,479
Median Age	34
Race[1]:	
White	47,115
Black	416
American Indian and Alaskan Native	133
Asian	201
Native Hawaiian and Pacific Islander	5
Other	154
Disabilities[1]	
Total population 5 to 15 yrs w/disability	7,285
With a mental disability	467

Families:	
Families w/related children <18[37] yrs	5,645
Families w/children <18 yrs living in poverty[2]	836
Children and youth 0 to 17 yrs living below poverty[38]	1,781
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	4.2
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	4.2
Density[2]	
Total Area per sq mile	501.52
Population Density per sq mile	97.3
Housing Density per sq mile of land area	40.3
Economics[1]:	
Median Family Income	42,204
Number unemployed	2,094

[36] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[37] U.S. Census Bureau; Census 2000
[38] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	4
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Little need
Adolescents w/special needs (developmental or physical)	Little need
Children and adolescents in the child welfare system	Great need
Other, please describe	

Need for services by CAPS for:	
Inpatient psychiatry program	No need at all
Crisis care	Some need
Residential treatment facilities	No need at all
Child day treatment program	Little need
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Little need
Family therapy	No need at all
Other:	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		20-45 min
Long term state psychiatric hospitalization		1.5 hr
Placement in a residential treatment facility		30 min
Outpatient psychiatric services		20-45 min
Day treatment services	0	N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	4
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians, Adult Psychiatrist, and Other: Consultative office rounds for pediatricians provided by SUNY Upstate

County Name: Delaware

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	0	Census population under 18 yrs[39]	11,084
Practice full time	N/A	CAPs per 100,000 youth	0
Practice part time	N/A		
Reside outside of the county	N/A	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	N/A	Inpatient facilities	N/A
Employed by contract by county	N/A	Outpatient service organizations	N/A
Employed by contract by state	N/A	Office based only	N/A
Within 10 years of retirement	N/A	**Number of CAPs (AMA data):**	
Female	N/A	In 2005	0
White	N/A	In 2006	0
Black	N/A	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	N/A		
Asian	N/A		
Other	N/A		
Speakers of ESL	N/A		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	48,055	Families w/related children <18[40] yrs	5,415
Total Number of Females	24,395	Families w/children <18 yrs living in poverty[2]	865
Total Number of Males	23,660	Children and youth 0 to 17 yrs living below poverty[41]	1,815
Median Age	41	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	46,346	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	568	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	149	Suicide Mortality Rate 10-19 in 2003-05	4.8
Asian	257	**Density[2]**	
Native Hawaiian and Pacific Islander	6	Total Area per sq mile	1,468.04
Other	254	Population Density per sq mile	33.2
Disabilities[1]		Housing Density per sq mile of land area	20.0
Total population 5 to 15 yrs w/disability	7,066	**Economics[1]:**	
With a mental disability	518	Median Family Income	42,204
		Number unemployed	1,376

[39] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[40] U.S. Census Bureau; Census 2000
[41] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of CAPs needed	0.07	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	No	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	No	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	No need at all
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	No need at all
School age (6-12 yrs)	Great need	Medication consultation	No need at all
Adolescents (13-17 yrs)	Most significant need	Medication management	No need at all
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Little need
Children and adolescents in the child welfare system	Most significant need	Other:	
Other, please describe			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		Range of 1-2 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	0		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	3
Placement in a residential treatment facility		1-2 hr	Residential treatment programs	No	
Outpatient psychiatric services	0		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	0	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians and Adult Psychiatrists, and Other: Hired nurse practitioner about 5 years ago.

County Name: Dutchess

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	8
Practice full time	2
Practice part time	6
Reside outside of the county	4
Employed by private organizations or in private practice	8
Employed by contract by county	0
Employed by contract by state	0
Within 10 years of retirement	1
Female	7
White	3
Black	1
Hispanic	2
Asian	2
Other	0
Speakers of ESL	1

CAPS per Youth:	
Census population under 18 yrs[42]	66,807
CAPs per 100,000 youth	12
Hours of CAP services per week:	
Inpatient facilities	40
Outpatient service organizations	87
Office based only	
Number of CAPs (AMA data):	
In 2005	9
In 2006	11

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Both the Aster Home for Children and the MHA have very active consumer advisory boards that meet monthly and just last month they put on their own conference for families. Mental Hygiene Board has children and youth subcommittee and they are very active and most of them have children with MH needs. They are pressing MH and county to do more about outreach to families for services. Also have NAMI.

Additional Secondary County Data

Population[1]:	
Total	295,146
Total Number of Females	146,772
Total Number of Males	148,374
Median Age	38
Race[1]:	
White	234,385
Black	26,097
American Indian and Alaskan Native	609
Asian	7,048
Native Hawaiian and Pacific Islander	88
Other	6,626
Disabilities[1]	
Total population 5 to 15 yrs w/disability	44,788
With a mental disability	2,374

Families:	
Families w/related children <18[43] yrs	34,315
Families w/children <18 yrs living in poverty[2]	2,831
Children and youth 0 to 17 yrs living below poverty[44]	6,493
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	2.3
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	3.0
Density[2]	
Total Area per sq mile	825.38
Population Density per sq mile	349.5
Housing Density per sq mile of land area	132.4
Economics[1]:	
Median Family Income	77,079
Number unemployed	8,575

[42] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[43] U.S. Census Bureau; Census 2000
[44] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	4	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Some need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Little need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other: Transition age of 16-25 years old we need clinicians comfortable working with this age group, need a bridge of services			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0	1-2 hr	Additional inpatient psychiatric services	Yes	8
Long term state psychiatric hospitalization	60	5-6 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility	126	1-2 hr	Additional Residential treatment programs		20
Outpatient psychiatric services	60		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	180	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry, Collaborating with CAP training program, Special training in Child and Adolescent psychiatry for Pediatricians, and Other: Trying to recruit more NP with higher salaries

Top 7- County Name: Erie

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	20	Census population under 18 yrs[45]	206,125
Practice full time	18	CAPs per 100,000 youth	10
Practice part time	2		
Reside outside of the county		**Number of CAPs (AMA data):**	
Within 10 years of retirement		In 2005	23
Female	16	In 2006	24
White	2		
Black	1	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic			
Asian	1		
Other	3		
Speakers of ESL	20		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	921,390	Families w/related children <18[46] yrs	112,900
Total Number of Females	442,707	Families w/children <18 yrs living in poverty[2]	18,417
Total Number of Males	478,683	Children and youth 0 to 17 yrs living below poverty[47]	39,994
Median Age	39.7	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	5
White	780,942	Suicide Mortality Rate 10-19 in 2001-03	3.8
Black	123,529	Suicide Mortality 10-19 in 2003-05	4
American Indian and Alaskan Native	5,755	Suicide Mortality Rate 10-19 in 2003-05	2.8
Asian	13,835	**Density[2]**	
Native Hawaiian and Pacific Islander	223	Total Area per sq mile	1,226.89
Other	13,499	Population Density per sq mile	910.0
Disabilities[1]		Housing Density per sq mile of land area	398.3
Total population 5 to 15 yrs w/disability	146,874	**Economics[1]:**	
With a mental disability	7,698	Median Family Income	58,838
		Number unemployed	26,682

[45] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[46] U.S. Census Bureau; Census 2000
[47] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:		Need for services by Outpatient Public CAPS for:	
Number of additional CAPs needed	20	Inpatient psychiatry program	No need at all
Does this need significantly impact your county?	Yes	Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	No need at all
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	No need at all
Children and adolescents in the child welfare system	Most significant need	Other:	
Other, please describe			

Access to services			Need for the following services		
Service	**Wait time in Days**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0		Additional inpatient psychiatric services	No	
Long term state psychiatric hospitalization	0	About 1 hr-2 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility	0	About 2.5- 3 hr	Additional Residential treatment programs		
Outpatient psychiatric services	133		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	14	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, Psychiatry residents, and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, Collaborating with CAP training program, and Special training in Child and Adolescent psychiatry for Pediatricians, Primary Care Physicians and Adult Psychiatrists

County Name: Essex

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[48]	8,858
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	2
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Families First, a not for profit and they are very strong advocates.

Additional Secondary County Data

Population[1]:	
Total	38,851
Total Number of Females	18,710
Total Number of Males	20,141
Median Age	39
Race[1]:	
White	36,848
Black	1,092
American Indian and Alaskan Native	122
Asian	160
Native Hawaiian and Pacific Islander	26
Other	267
Disabilities[1]	
Total population 5 to 15 yrs w/disability	5,809
With a mental disability	379

Families:	
Families w/related children <18[49] yrs	4,385
Families w/children <18 yrs living in poverty[2]	590
Children and youth 0 to 17 yrs living below poverty[50]	1,252
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	12.6
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	6.6
Density[2]	
Total Area per sq mile	1,916.50
Population Density per sq mile	21.6
Housing Density per sq mile of land area	12.9
Economics[1]:	
Median Family Income	41,927
Number unemployed	1,215

[48] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[49] U.S. Census Bureau; Census 2000
[50] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of CAPs needed	0.5
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Great need
Adolescents w/special needs (developmental or physical)	Great need
Children and adolescents in the child welfare system	Most significant need
Other, please describe	

Need for services by CAPS for:	
Inpatient psychiatry program	Most significant need
Crisis care	Some need
Residential treatment facilities	Some need
Child day treatment program	Some need
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Little need
Family therapy	Some need
Other: Staff consultation with a CAP.	Most significant need

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		30-70 min
Long term state psychiatric hospitalization	0	Minimum of 3 hr up to 10 hr
Placement in a residential treatment facility		4 hr
Outpatient psychiatric services	70	On average 1 hr
Day treatment services	0	N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	Yes	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	5
Residential treatment programs	Yes	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Psychiatry residents and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry

County Name: Franklin

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	1
Practice full time	0
Practice part time	1
Reside outside of the county	0
Employed by private organizations or in private practice	1
Employed by contract by county	0
Employed by contract by state	0
Within 10 years of retirement	1
Female	1
White	1
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[51]	11,645
CAPs per 100,000 youth	9
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	12
Office based only	0
Number of CAPs (AMA data):	
In 2005	2
In 2006	1

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: The MH Association in Franklin Co. and Family Champions.

Additional Secondary County Data

Population[1]:	
Total	51,134
Total Number of Females	23,067
Total Number of Males	28,067
Median Age	36
Race[1]:	
White	42,970
Black	3,389
American Indian and Alaskan Native	3,171
Asian	194
Native Hawaiian and Pacific Islander	0
Other	1,056
Disabilities[1]	
Total population 5 to 15 yrs w/disability	7,580
With a mental disability	511

Families:	
Families w/related children <18[52] yrs	5,780
Families w/children <18 yrs living in poverty[2]	903
Children and youth 0 to 17 yrs living below poverty[53]	1,986
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	9.3
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	1,697.44
Population Density per sq mile	31.3
Housing Density per sq mile of land area	14.7
Economics[1]:	
Median Family Income	38,472
Number unemployed	2,383

[51] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[52] U.S. Census Bureau; Census 2000
[53] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	3	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	No need at all
Preschool children (0-5 yrs)	Most significant need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Great need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	No need at all
Children and adolescents in the child welfare system	Most significant need	Other:	
Other, please describe			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-2 hr	Inpatient psychiatric services	Yes	10
Long term state psychiatric hospitalization	22	3-8 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	15
Placement in a residential treatment facility		1-12 hr	Residential treatment programs	Yes	8
Outpatient psychiatric services		1-3 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, International graduate medical residents with J-1 Visas or waivers, and Other: We applied for and received a federal HERSA outreach grant in hopes of attracting a full time CAP to the area. After 3 yrs and many resumes and interviews we were not able to get a CAP so we requested an approval to use the funding to purchase additional equipment for tele psychiatry.

County Name: Fulton

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	1	Census population under 18 yrs[54]	13,688
Practice full time	1	CAPs per 100,000 youth	7
Practice part time	0		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	0
Employed by contract by county	0	Outpatient service organizations	30
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	0	**Number of CAPs (AMA data):**	
Female	0	In 2005	0
White	0	In 2006	0
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	1		
Other	0		
Speakers of ESL	1		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	55,073	Families w/related children <18[55] yrs	6,673
Total Number of Females	27,943	Families w/children <18 yrs living in poverty[2]	1,042
Total Number of Males	27,130	Children and youth 0 to 17 yrs living below poverty[56]	2,406
Median Age	39	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	52,863	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	992	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	105	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	293	**Density[2]**	
Native Hawaiian and Pacific Islander	9	Total Area per sq mile	532.90
Other	308	Population Density per sq mile	111.0
Disabilities[1]		Housing Density per sq mile of land area	56.0
Total population 5 to 15 yrs w/disability	8,543	**Economics[1]:**	
With a mental disability	610	Median Family Income	39,801
		Number unemployed	1,627

[54] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[55] U.S. Census Bureau; Census 2000
[56] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	3	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Most significant need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Most significant need	Medication management	Great need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Great need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Great need
Children and adolescents in the child welfare system	Great need	Other: Anger Management. Child or the family of the child. System is set up around the kid and many times the problems are family centered.	
Other: Demand from families with severely autistic children for MH services. Depending on if high functioning autism. Adolescent sexual perpetrators and the MH system does not have the capacity to serve this population.			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		30 min	Inpatient psychiatric services		
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility		
Placement in a residential treatment facility		1 hr	Residential treatment programs		
Outpatient psychiatric services	42		Additional child and adolescent crisis psychiatric services		N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

County Name: Genesee

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	4
Practice full time	0
Practice part time	4
Reside outside of the county	1
Employed by private organizations or in private practice	2
Employed by contract by county	2
Employed by contract by state	0
Within 10 years of retirement	4
Female	2
White	2
Black	1
Hispanic	0
Asian	1
Other	0
Speakers of ESL	1

CAPS per Youth:	
Census population under 18 yrs[57]	15,730
CAPs per 100,000 youth	25
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	10
Office based only	20
Number of CAPs (AMA data):	
In 2005	0
In 2006	0
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	60,370
Total Number of Females	30,653
Total Number of Males	29,717
Median Age	37
Race[1]:	
White	57,167
Black	1,284
American Indian and Alaskan Native	470
Asian	292
Native Hawaiian and Pacific Islander	14
Other	430
Disabilities[1]	
Total population 5 to 15 yrs w/disability	10,099
With a mental disability	610

Families:	
Families w/related children <18[58] yrs	7,572
Families w/children <18 yrs living in poverty[2]	726
Children and youth 0 to 17 yrs living below poverty[59]	1,824
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	7.4
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	7.7
Density[2]	
Total Area per sq mile	495.33
Population Density per sq mile	122.2
Housing Density per sq mile of land area	49.0
Economics[1]:	
Median Family Income	47,771
Number unemployed	1,337

[57] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[58] U.S. Census Bureau; Census 2000
[59] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	1	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Most significant need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Some need
Children and adolescents in the child welfare system	Great need	Other:	
Other, please describe			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1 hr	Inpatient psychiatric services	Yes	6
Long term state psychiatric hospitalization	28	1.5 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Placement in a residential treatment facility		About 1 hr	Residential treatment programs	Yes	6
Outpatient psychiatric services	42	1-1.5 hr drive	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	98	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry

County Name: Greene

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[60]	11,092
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	0
In 2006	0
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	48,195
Total Number of Females	23,337
Total Number of Males	24,858
Median Age	39
Race[1]:	
White	43,740
Black	2,664
American Indian and Alaskan Native	135
Asian	260
Native Hawaiian and Pacific Islander	8
Other	734
Disabilities[1]	
Total population 5 to 15 yrs w/disability	7,230
With a mental disability	396

Families:	
Families w/related children <18[61] yrs	5,332
Families w/children <18 yrs living in poverty[2]	761
Children and youth 0 to 17 yrs living below poverty[62]	1,717
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	4.8
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	4.7
Density[2]	
Total Area per sq mile	658.13
Population Density per sq mile	74.4
Housing Density per sq mile of land area	41.0
Economics[1]:	
Median Family Income	43,854
Number unemployed	1,330

[60] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[61] U.S. Census Bureau; Census 2000
[62] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of CAPs needed	3	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Little need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other, please describe			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1 hr-2 hr and 15 min	Inpatient psychiatric services		
Long term state psychiatric hospitalization	180		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility		
Placement in a residential treatment facility		1 hr-2 hr	Residential treatment programs		
Outpatient psychiatric services	0	1 hr away.	Additional child and adolescent crisis psychiatric services		N/A
Day treatment services	30	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, Psychiatry residents, and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Limited permit CAPs, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, Collaborating with CAP training program, International graduate medical residents with J-1 Visas or waivers, and Special training in Child and Adolescent psychiatry for: Pediatricians Primary Care Physicians and Adult Psychiatrist

County Name: Hamilton

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	0	Census population under 18 yrs[63]	1,059
Practice full time	N/A	CAPs per 100,000 youth	0
Practice part time	N/A		
Reside outside of the county	N/A	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	N/A	Inpatient facilities	
Employed by contract by county	N/A	Outpatient service organizations	N/A
Employed by contract by state	N/A	Office based only	N/A
Within 10 years of retirement	N/A	**Number of CAPs (AMA data):**	N/A
Female	N/A	In 2005	0
White	N/A	In 2006	0
Black	N/A	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	N/A		
Asian	N/A		
Other	N/A		
Speakers of ESL	N/A		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	5,379	Families w/related children <18[64] yrs	558
Total Number of Females	2,690	Families w/children <18 yrs living in poverty[2]	64
Total Number of Males	2,689	Children and youth 0 to 17 yrs living below poverty[65]	121
Median Age	45	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	5,257	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	24	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	14	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	8	**Density[2]**	
Native Hawaiian and Pacific Islander	3	Total Area per sq mile	1,807.81
Other	36	Population Density per sq mile	3.1
Disabilities[1]		Housing Density per sq mile of land area	4.6
Total population 5 to 15 yrs w/disability	680	**Economics[1]:**	
With a mental disability	44	Median Family Income	39,676
		Number unemployed	251

[63] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[64] U.S. Census Bureau; Census 2000
[65] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of CAPs needed	0.12	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Some need
School age (6-12 yrs)	Some need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Some need
Children and adolescents in the child welfare system	Great need	Other:	
Other, please describe			

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		2-2.5 hr
Long term state psychiatric hospitalization	210	1.5 hr
Placement in a residential treatment facility		2-2.5 hr
Outpatient psychiatric services		1-2 hr
Day treatment services		N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	1
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, and Other: A child psychologist in the clinic who will consult with pediatricians to do monitoring.

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry and Other: Have been trying to find some contractual arrangement. Haven't found any takers yet.

County Name: Herkimer

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	1
Practice full time	0
Practice part time	1
Reside outside of the county	1
Employed by private organizations or in private practice	0
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	1
Female	0
White	1
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[66]	15,692
CAPs per 100,000 youth	6
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	8
Office based only	0
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Organized through family support services - Parent support groups, not advocacy groups.

Additional Secondary County Data

Population[1]:	
Total	64,427
Total Number of Females	33,179
Total Number of Males	31,248
Median Age	39
Race[1]:	
White	63,031
Black	329
American Indian and Alaskan Native	139
Asian	263
Native Hawaiian and Pacific Islander	11
Other	113
Disabilities[1]	
Total population 5 to 15 yrs w/disability	10,133
With a mental disability	550

Families:	
Families w/related children <18[67] yrs	7,866
Families w/children <18 yrs living in poverty[2]	1,197
Children and youth 0 to 17 yrs living below poverty[68]	2,550
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	7.4
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	1,458.35
Population Density per sq mile	45.7
Housing Density per sq mile of land area	22.7
Economics[1]:	
Median Family Income	40,570
Number unemployed	2,105

[66] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[67] U.S. Census Bureau; Census 2000
[68] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	2	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Little need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Some need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Little need
Children and adolescents in the child welfare system	Most significant need	Other:	
Other: Adolescents in jail.			

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		30 min
Long term state psychiatric hospitalization	3	2.5 hr
Placement in a residential treatment facility		2 hr
Outpatient psychiatric services	0	30 min
Day treatment services	45	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	16
Residential treatment programs	Yes	8
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Other: Collocated or integrated with another Mental Health Clinic program, a program with a children's satellite collocated with this department. Consolidation and multiple efforts to substitute CAP workforce.

County Name: Jefferson

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	2
Practice full time	1
Practice part time	1
Reside outside of the county	2
Employed by private organizations or in private practice	0
Employed by contract by county	1
Employed by contract by state	1
Within 10 years of retirement	2
Female	0
White	2
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[69]	27,961
CAPs per 100,000 youth	7
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	48
Office based only	0
Number of CAPs (AMA data):	
In 2005	1
In 2006	2

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Northern Regional Center for Independent Living Center has an active family support program

Additional Secondary County Data

Population[1]:	
Total	114,264
Total Number of Females	56,702
Total Number of Males	57,562
Median Age	33
Race[1]:	
White	102,387
Black	5,531
American Indian and Alaskan Native	540
Asian	1,312
Native Hawaiian and Pacific Islander	431
Other	1,226
Disabilities[1]	
Total population 5 to 15 yrs w/disability	18,121
With a mental disability	1,024

Families:	
Families w/related children <18[70] yrs	14,894
Families w/children <18 yrs living in poverty[2]	2,342
Children and youth 0 to 17 yrs living below poverty[71]	5,738
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	8.6
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	4.2
Density[2]	
Total Area per sq mile	1,857.08
Population Density per sq mile	87.8
Housing Density per sq mile of land area	42.5
Economics[1]:	
Median Family Income	44,168
Number unemployed	4,447

[69] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[70] U.S. Census Bureau; Census 2000
[71] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	2
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Little need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Little need
Adolescents w/special needs (developmental or physical)	Little need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Little need
Crisis care	Some need
Residential treatment facilities	No need at all
Child day treatment program	Some need
Psychiatric assessment	Most significant need
Medication consultation	Great need
Medication management	Great need
Individual mental health counseling	No need at all
Family therapy	Little need
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		1 hr
Long term state psychiatric hospitalization	2	3-4 hr
Placement in a residential treatment facility		1 hr
Outpatient psychiatric services	0	20 min-1 hr
Day treatment services	14	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	8
Residential treatment programs	Yes	3
Additional child and adolescent crisis psychiatric services	No	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Nurse practitioners, and Other: Physician's assistants

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, and Other: Some interaction between the hospital and the former upstate medical center in Syracuse Department of Psychiatry for recruitment and consultation and training. Occasionally over the years we've had a child and adolescent psychiatrist assigned to Fort Drum by Department of Defense

County Name: Lewis

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	1
Practice full time	0
Practice part time	1
Reside outside of the county	0
Employed by private organizations or in private practice	0
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	0
Female	1
White	0
Black	0
Hispanic	0
Asian	1
Other	0
Speakers of ESL	1

CAPS per Youth:	
Census population under 18 yrs[72]	7,494
CAPs per 100,000 youth	13
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	20
Office based only	0
Number of CAPs (AMA data):	
In 2005	0
In 2006	1
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	26,944
Total Number of Females	13,565
Total Number of Males	13,379
Median Age	37
Race[1]:	
White	26,451
Black	106
American Indian and Alaskan Native	76
Asian	63
Native Hawaiian and Pacific Islander	14
Other	76
Disabilities[1]	
Total population 5 to 15 yrs w/disability	4,858
With a mental disability	223

Families:	
Families w/related children <18[73] yrs	3,548
Families w/children <18 yrs living in poverty[2]	539
Children and youth 0 to 17 yrs living below poverty[74]	1,176
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	7.7
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	8.1
Density[2]	
Total Area per sq mile	1,289.89
Population Density per sq mile	21.1
Housing Density per sq mile of land area	11.9
Economics[1]:	
Median Family Income	39,287
Number unemployed	987

[72] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[73] U.S. Census Bureau; Census 2000
[74] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	2	Inpatient psychiatry program	No need at all
Does this need significantly impact your county?	Yes	Crisis care	No need at all
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	Little need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Great need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Most significant need
Children and adolescents in the child welfare system	Great need	Other:	
Other: Children with parents with MH issues have a great need for services.	Great need		

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		2 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	200	As far as 3.5 hr-5 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Placement in a residential treatment facility		3 hr	Residential treatment programs	Yes	4
Outpatient psychiatric services	63	Unknown where they go.	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Collaborating with CAP training program, and International graduate medical residents with J-1 Visas or waivers

County Name: Livingston

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	3	Census population under 18 yrs[75]	15,063
Practice full time	0	CAPs per 100,000 youth	20
Practice part time	3		
Reside outside of the county	3	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	0
Employed by contract by county	2	Outpatient service organizations	19
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	2	In 2005	0
White	2	In 2006	0
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Parent Support Groups	
Hispanic	0		
Asian	1		
Other	0		
Speakers of ESL	1		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	64,328	Families w/related children <18[76] yrs	7,530
Total Number of Females	32,059	Families w/children <18 yrs living in poverty[2]	719
Total Number of Males	32,269	Children and youth 0 to 17 yrs living below poverty[77]	1,741
Median Age	35	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	60,494	Suicide Mortality Rate 10-19 in 2001-03	6.3
Black	1,938	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	172	Suicide Mortality Rate 10-19 in 2003-05	3.2
Asian	492	**Density[2]**	
Native Hawaiian and Pacific Islander	20	Total Area per sq mile	640.44
Other	545	Population Density per sq mile	101.8
Disabilities[1]		Housing Density per sq mile of land area	38.0
Total population 5 to 15 yrs w/disability	9,549	**Economics[1]:**	
With a mental disability	851	Median Family Income	50,513
		Number unemployed	1,991

[75] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[76] U.S. Census Bureau; Census 2000
[77] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	No

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Most significant need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Little need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Little need
Crisis care	Some need
Residential treatment facilities	Little need
Child day treatment program	Little need
Psychiatric assessment	Some need
Medication consultation	Some need
Medication management	Some need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		30 and 50 min
Long term state psychiatric hospitalization	0	Don't know
Placement in a residential treatment facility		Don't know
Outpatient psychiatric services	7	
Day treatment services	0	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, Nurse Practitioner, and Psychiatry Residents

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Special training in Child and Adolescent psychiatry for Pediatricians and Primary Care Physicians

County Name: Madison

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	3	Census population under 18 yrs[78]	14,921
Practice full time	0	CAPs per 100,000 youth	20
Practice part time	3		
Reside outside of the county	3	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	0
Employed by contract by county	2	Outpatient service organizations	14
Employed by contract by state	1	Office based only	20
Within 10 years of retirement	3	**Number of CAPs (AMA data):**	
Female	1	In 2005	1
White	3	In 2006	1
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Grandparents support group - For grandparents who may be primary caretakers	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	70,197	Families w/related children <18[79] yrs	8,517
Total Number of Females	35,645	Families w/children <18 yrs living in poverty[2]	877
Total Number of Males	34,552	Children and youth 0 to 17 yrs living below poverty[80]	2,128
Median Age	36	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	67,006	Suicide Mortality Rate 10-19 in 2001-03	8.4
Black	916	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	358	Suicide Mortality Rate 10-19 in 2003-05	2.8
Asian	387	**Density[2]**	
Native Hawaiian and Pacific Islander	10	Total Area per sq mile	661.54
Other	184	Population Density per sq mile	105.9
Disabilities[1]		Housing Density per sq mile of land area	43.7
Total population 5 to 15 yrs w/disability	11,012	**Economics[1]:**	
With a mental disability	607	Median Family Income	58,756
		Number unemployed	2,132

[78] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[79] U.S. Census Bureau; Census 2000
[80] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Great need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Some need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Some need
Crisis care	Great need
Residential treatment facilities	Some need
Child day treatment program	Some need
Psychiatric assessment	Great need
Medication consultation	Some need
Medication management	Some need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		30 min-1 hr.
Long term state psychiatric hospitalization	75	3 hr-6 hr
Placement in a residential treatment facility		1.5-2 hr
Outpatient psychiatric services	42	30 min-1 hr
Day treatment services	60	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	Yes	5
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	5
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, Nurse practitioners, and Psychiatry residents

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry and Other: Get certified by National Health Service Core as HPSA (Health Professional Shortage Area) to get clinicians to come out, to get recruitment and retention techniques as in loan repayment for providers.

Top 7- County Name: Monroe

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	8	Census population under 18 yrs[81]	174,009
Practice full time	3	CAPs per 100,000 youth	5
Practice part time	5		
Reside outside of the county	2	**Number of CAPs (AMA data):**	
Within 10 years of retirement	4	In 2005	33
Female	7	In 2006	42
White	0		
Black	1	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	0		
Other	2		
Speakers of ESL	8		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	704,993	Families w/related children <18[82] yrs	91,173
Total Number of Females	340,661	Families w/children <18 yrs living in poverty[2]	12,949
Total Number of Males	364,332	Children and youth 0 to 17 yrs living below poverty[83]	32,303
Median Age	38.2	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	2
White	579,045	Suicide Mortality Rate 10-19 in 2001-03	1.5
Black	103,398	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	1,770	Suicide Mortality Rate 10-19 in 2003-05	1.2
Asian	21,349	**Density[2]**	
Native Hawaiian and Pacific Islander	122	Total Area per sq mile	1,365.61
Other	12,584	Population Density per sq mile	1,115.3
Disabilities[1]		Housing Density per sq mile of land area	461.7
Total population 5 to 15 yrs w/disability	120,819	**Economics[1]:**	
With a mental disability	8,137	Median Family Income	60,383
		Number unemployed	24,021

[81] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[82] U.S. Census Bureau; Census 2000
[83] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:		Need for services by Outpatient Public CAPS for:	
Number of additional CAPs needed	6	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Most significant need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other:	
Other, please describe			

Access to services

Need for the following services

Service	Wait time in Days	Drive time (if going outside the county)	Service	Needed Yes/no	# of Beds
Inpatient psychiatric hospitalization	1	1-1.5 hr	Additional Inpatient psychiatric services	Yes	3
Long term state psychiatric hospitalization	60	2 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Placement in a residential treatment facility	45	1.5 hr	Additional Residential treatment programs	Yes	4
Outpatient psychiatric services	60		Additional child and adolescent crisis psychiatric services	No	N/A
Day treatment services	0	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, and Other: County works with school of nursing on NP with cert in child psychiatry, trying to increase that workforce.

County Name: Montgomery

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	1	Census population under 18 yrs[84]	12,164
Practice full time	1	CAPs per 100,000 youth	8
Practice part time	0		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	1	Inpatient facilities	0
Employed by contract by county	0	Outpatient service organizations	0
Employed by contract by state	0	Office based only	60
Within 10 years of retirement	0	**Number of CAPs (AMA data):**	
Female	0	In 2005	2
White	0	In 2006	1
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	1		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	49,708	Families w/related children <18[85] yrs	5,893
Total Number of Females	25,972	Families w/children <18 yrs living in poverty[2]	862
Total Number of Males	23,736	Children and youth 0 to 17 yrs living below poverty[86]	2,262
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	47,160	Suicide Mortality Rate 10-19 in 2001-03	4.9
Black	572	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	124	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	263	**Density[2]**	
Native Hawaiian and Pacific Islander	6	Total Area per sq mile	410.32
Other	952	Population Density per sq mile	122.8
Disabilities[1]		Housing Density per sq mile of land area	55.6
Total population 5 to 15 yrs w/disability	7,751	**Economics[1]:**	
With a mental disability	508	Median Family Income	40,688
		Number unemployed	1,340

[84] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[85] U.S. Census Bureau; Census 2000
[86] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	0.5
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Little need
School age (6-12 yrs)	Little need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Little need
Adolescents w/special needs (developmental or physical)	Great need
Children and adolescents in the child welfare system	Little need
Other: Adolescents who abuse drugs and alcohol.	

Need for services by CAPS for:	
Inpatient psychiatry program	No need at all
Crisis care	Some need
Residential treatment facilities	Little need
Child day treatment program	No need at all
Psychiatric assessment	Most significant need
Medication consultation	Great need
Medication management	Great need
Individual mental health counseling	Some need
Family therapy	Some need
Other: CAPS who go into the school and the home. County noted that psychiatrists are not needed for crisis care, but rather other professionals are needed to fill the gap in services.	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		1 hr
Long term state psychiatric hospitalization	2	Varies. From 3-5 hr going to LI or Buffalo.
Placement in a residential treatment facility		1-5 hr
Outpatient psychiatric services	30	45 min
Day treatment services		N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	10
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Developmental behavioral pediatricians

Top 7- County Name: Nassau

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	14	Census population under 18 yrs[87]	313,861
Practice full time	0	CAPs per 100,000 youth	4
Practice part time	14		
Reside outside of the county	0	**Number of CAPs (AMA data):**	
Within 10 years of retirement	9	In 2005	100
Female	8	In 2006	108
White	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Children's advocacy committee, mainly parents and agency and county representation. Family support coalition-parents and others on committees.	
Black	1		
Hispanic	0		
Asian	5		
Other	3		
Speakers of ESL	14		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	1,325,662	Families w/related children <18[88] yrs	157,804
Total Number of Females	642,856	Families w/children <18 yrs living in poverty[2]	8,550
Total Number of Males	682,806	Children and youth 0 to 17 yrs living below poverty[89]	25,285
Median Age	40.7	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	3
White	984,965	Suicide Mortality Rate 10-19 in 2001-03	1.8
Black	143,755	Suicide Mortality 10-19 in 2003-05	2
American Indian and Alaskan Native	1,767	Suicide Mortality Rate 10-19 in 2003-05	1.1
Asian	91,602	**Density[2]**	
Native Hawaiian and Pacific Islander	47	Total Area per sq mile	453.08
Other	87,759	Population Density per sq mile	4,655.0
Disabilities[1]		Housing Density per sq mile of land area	1,598.1
Total population 5 to 15 yrs w/disability	207,005	**Economics[1]:**	
With a mental disability	6,519	Median Family Income	99,212
		Number unemployed	29,934

[87] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[88] U.S. Census Bureau; Census 2000
[89] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:		Need for services by Outpatient Public CAPS for:	
Number of additional CAPs needed	21	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Some need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other:	
Other: Transitional adolescents 18-25 years.			

Access to services			Need for the following services		
Service	**Wait time in Days**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0	About 20 min	Inpatient psychiatric services	Yes	20
Long term state psychiatric hospitalization	21		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	7
Placement in a residential treatment facility	14	20 min-1 hr	Residential treatment programs	No	
Outpatient psychiatric services	42	About 20 min	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	0	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Collaborating with CAP training program

County Name: Niagara

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	5	Census population under 18 yrs[90]	47,264
Practice full time	1	CAPs per 100,000 youth	11
Practice part time	4		
Reside outside of the county	2	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	5	Inpatient facilities	40
Employed by contract by county	0	Outpatient service organizations	.
Employed by contract by state	0	Office based only	.
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	1	In 2005	3
White	3	In 2006	4
Black	1	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** MHA Niagara, Lockport Family Support Center	
Hispanic	.		
Asian	1		
Other	.		
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	216,130	Families w/related children <18[91] yrs	27,121
Total Number of Females	112,454	Families w/children <18 yrs living in poverty[2]	3,916
Total Number of Males	103,676	Children and youth 0 to 17 yrs living below poverty[92]	8,232
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	194,892	Suicide Mortality Rate 10-19 in 2001-03	3.2
Black	13,167	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	1,781	Suicide Mortality Rate 10-19 in 2003-05	1.1
Asian	1,910	**Density[2]**	
Native Hawaiian and Pacific Islander	28	Total Area per sq mile	1,139.83
Other	328	Population Density per sq mile	420.4
Disabilities[1]		Housing Density per sq mile of land area	183.0
Total population 5 to 15 yrs w/disability	34,919	**Economics[1]:**	
With a mental disability	2,013	Median Family Income	55,148
		Number unemployed	7,418

[90] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[91] U.S. Census Bureau; Census 2000
[92] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	2	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Great need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Great need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Great need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Great need
Children and adolescents in the child welfare system	Most significant need	Other: Inpatient reports- evidence based treatment modalities, CBT, Dialectical Behavior Therapy, Behavior Modification and family therapy.	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0	1 hr	Additional Inpatient psychiatric services	Yes	3
Long term state psychiatric hospitalization	120		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	10
Placement in a residential treatment facility		1 hr	Residential treatment programs	Yes	10
Outpatient psychiatric services		1 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Nurse practitioners w/advanced cert. in child psychiatry

County Name: Oneida

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[93]	50,397
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	2
In 2006	6
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	233,954
Total Number of Females	116,622
Total Number of Males	117,332
Median Age	40
Race[1]:	
White	209,879
Black	13,276
American Indian and Alaskan Native	605
Asian	3,820
Native Hawaiian and Pacific Islander	107
Other	2,731
Disabilities[1]	
Total population 5 to 15 yrs w/disability	35,821
With a mental disability	1,826

Families:	
Families w/related children <18[94] yrs	27,555
Families w/children <18 yrs living in poverty[2]	4,858
Children and youth 0 to 17 yrs living below poverty[95]	10,270
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	2
Suicide Mortality Rate 10-19 in 2001-03	6.0
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	4.0
Density[2]	
Total Area per sq mile	1,257.11
Population Density per sq mile	194.2
Housing Density per sq mile of land area	84.8
Economics[1]:	
Median Family Income	49,799
Number unemployed	7,355

[93] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[94] U.S. Census Bureau; Census 2000
[95] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of CAPs needed	6	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Great need
School age (6-12 yrs)	Most significant need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Some need
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	3	between 1.5 and 2 hr	Additional inpatient psychiatric services	Yes	9
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Don't Know	
Placement in a residential treatment facility	70	About 2 hr	Additional Residential treatment programs		
Outpatient psychiatric services	11	1.5-2 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, and Other: Community MH nurse, RN

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry and International graduate medical residents with J-1 Visas or waivers

Top 7- County Name: Onondaga

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	11	Census population under 18 yrs[96]	108,205
Practice full time	11	CAPs per 100,000 youth	10
Practice part time	0		
Reside outside of the county	4	**Number of CAPs (AMA data):**	
Within 10 years of retirement	8	In 2005	18
Female		In 2006	22
White		**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Family Tapestry, NAMI, The MH Association	
Black			
Hispanic			
Asian			
Other	5		
Speakers of ESL	11		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	456,777	Families w/related children <18[97] yrs	57,796
Total Number of Females	218,219	Families w/children <18 yrs living in poverty[2]	8,259
Total Number of Males	238,558	Children and youth 0 to 17 yrs living below poverty[98]	18,234
Median Age	37.8	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	3
White	382,057	Suicide Mortality Rate 10-19 in 2001-03	4.3
Black	46,353	Suicide Mortality 10-19 in 2003-05	3
American Indian and Alaskan Native	2,376	Suicide Mortality Rate 10-19 in 2003-05	4.8
Asian	12,077	**Density[2]**	
Native Hawaiian and Pacific Islander	326	Total Area per sq mile	805.69
Other	2,633	Population Density per sq mile	587.4
Disabilities[1]		Housing Density per sq mile of land area	252.0
Total population 5 to 15 yrs w/disability	75,364	**Economics[1]:**	
With a mental disability	4,536	Median Family Income	60,029
		Number unemployed	13,705

[96] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[97] U.S. Census Bureau; Census 2000
[98] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:	
Number of additional CAPs needed	5
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes
Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Great need
Adolescents w/special needs (developmental or physical)	Great need
Children and adolescents in the child welfare system	Great need
Other, please describe	

Need for services by Outpatient Public CAPS for:	
Inpatient psychiatry program	Some need
Crisis care	Great need
Residential treatment facilities	Some need
Child day treatment program	
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Some need
Individual mental health counseling	Little need
Family therapy	Little need
Other:	

Access to services

Service	Wait time in Days	Drive time (if going outside the county)
Inpatient psychiatric hospitalization	5	Anywhere from 1-3 hr
Long term state psychiatric hospitalization	5	1-3 hr
Placement in a residential treatment facility	60	About 1 hr Could be 5-6 hr if NYC.
Outpatient psychiatric services	90	30 min
Day treatment services	0	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	Yes	16
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, Psychiatry residents, and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Limited permit CAPs, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, Collaborating with CAP training program, International graduate medical residents with J-1 Visas or waivers, and Special training in Child and Adolescent psychiatry for: Pediatricians and Primary Care Physicians, and Other: Setup satellite clinics in neighborhoods where transportation issues exist.

County Name: Ontario

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	2
Practice full time	1
Practice part time	1
Reside outside of the county	2
Employed by private organizations or in private practice	2
Employed by contract by county	2
Employed by contract by state	1
Within 10 years of retirement	1
Female	1
White	1
Black	1
Hispanic	1
Asian	1
Other	2
Speakers of ESL	1

CAPS per Youth:	
Census population under 18 yrs[99]	23,011
CAPs per 100,000 youth	9
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	24
Office based only	0
Number of CAPs (AMA data):	
In 2005	5
In 2006	4

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Parent driven program called Finger Lakes Parent Network also have NAMI in the county traditionally more for adult advocacy.

Additional Secondary County Data

Population[1]:	
Total	104,353
Total Number of Females	52,845
Total Number of Males	51,508
Median Age	40
Race[1]:	
White	97,924
Black	2,423
American Indian and Alaskan Native	189
Asian	1,092
Native Hawaiian and Pacific Islander	0
Other	1,479
Disabilities[1]	
Total population 5 to 15 yrs w/disability	16,314
With a mental disability	1,074

Families:	
Families w/related children <18[100] yrs	12,579
Families w/children <18 yrs living in poverty[2]	1,047
Children and youth 0 to 17 yrs living below poverty[101]	2,817
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	2.2
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	2.2
Density[2]	
Total Area per sq mile	662.43
Population Density per sq mile	155.5
Housing Density per sq mile of land area	66.2
Economics[1]:	
Median Family Income	63,907
Number unemployed	2,846

[99] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[100] U.S. Census Bureau; Census 2000
[101] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for services by CAPS for:	
Inpatient psychiatry program	Great need
Crisis care	Great need
Residential treatment facilities	Little need
Child day treatment program	Little need

Need for CAP services by population group:	
Preschool children (0-5 yrs)	No need at all
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Some need
Adolescents w/special needs (developmental or physical)	Some need
Children and adolescents in the child welfare system	Some need
Other:	

Psychiatric assessment	Most significant need
Medication consultation	Great need
Medication management	Most significant need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		Ranging between 40 min and 3 hr
Long term state psychiatric hospitalization	14	Rochester 40 min and Buffalo is about 1.5-2hr
Placement in a residential treatment facility		Ranging from 40 min to 2 hr
Outpatient psychiatric services	35	40 min
Day treatment services	120	N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	Yes	8
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Developmental behavioral pediatricians and Special training in Child and Adolescent psychiatry for: Pediatricians and Primary Care Physicians

County Name: Orange

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	8	Census population under 18 yrs[102]	100,225
Practice full time	6	CAPs per 100,000 youth	8
Practice part time	2		
Reside outside of the county	2	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	5	Inpatient facilities	0
Employed by contract by county	2	Outpatient service organizations	168
Employed by contract by state	4	Office based only	120
Within 10 years of retirement	2	**Number of CAPs (AMA data):**	
Female	2	In 2005	5
White	4	In 2006	5
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Family Empowerment Council-funded by reinvestment dollars to provide family support for SPOA kids. MHA information referrals, community education, specialized groups.	
Hispanic	1		
Asian	3		
Other			
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	376,392	Families w/related children <18[103] yrs	45,426
Total Number of Females	187,694	Families w/children <18 yrs living in poverty[2]	5,438
Total Number of Males	188,698	Children and youth 0 to 17 yrs living below poverty[104]	13,806
Median Age	35	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	290,036	Suicide Mortality Rate 10-19 in 2001-03	2.3
Black	33,469	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	1,101	Suicide Mortality Rate 10-19 in 2003-05	2.3
Asian	10,061	**Density[2]**	
Native Hawaiian and Pacific Islander	109	Total Area per sq mile	838.55
Other	32,737	Population Density per sq mile	418.2
Disabilities[1]		Housing Density per sq mile of land area	150.4
Total population 5 to 15 yrs w/disability	62,640	**Economics[1]:**	
With a mental disability	3,272	Median Family Income	73,997
		Number unemployed	11,583

[102] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[103] U.S. Census Bureau; Census 2000
[104] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Great need
Other: Bilingual Services	Great need

Need for services by CAPS for:	
Inpatient psychiatry program	Most significant need
Crisis care	Most significant need
Residential treatment facilities	Some need
Child day treatment program	Little need
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Great need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other: Dual diagnostic services for the children MH/SA and MH/DD	Some need

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		Over an hour
Long term state psychiatric hospitalization	0	
Placement in a residential treatment facility		Over an hour, 2 hr, to Dutchess 1 hr
Outpatient psychiatric services	56	
Day treatment services	30	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	Yes	7
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	Yes	5
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Other: Advertising, trying to share, we're all struggling with the same barrier which is lack of access.

County Name: Orleans

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[105]	11,559
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	0
In 2006	0
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	44,171
Total Number of Females	22,280
Total Number of Males	21,891
Median Age	36
Race[1]:	
White	39,367
Black	3,230
American Indian and Alaskan Native	203
Asian	142
Native Hawaiian and Pacific Islander	12
Other	682
Disabilities[1]	
Total population 5 to 15 yrs w/disability	7,299
With a mental disability	546

Families:	
Families w/related children <18[106] yrs	5,371
Families w/children <18 yrs living in poverty[2]	725
Children and youth 0 to 17 yrs living below poverty[107]	1,815
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	5.0
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	817.47
Population Density per sq mile	112.9
Housing Density per sq mile of land area	44.3
Economics[1]:	
Median Family Income	42,830
Number unemployed	1,384

[105] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[106] U.S. Census Bureau; Census 2000
[107] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of CAPs needed	1
Does this need significantly impact your county?	No
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Great need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Some need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Most significant need
Crisis care	Most significant need
Residential treatment facilities	No need at all
Child day treatment program	No need at all
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Most significant need
Family therapy	Most significant need
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		1 hr-1.5 hr
Long term state psychiatric hospitalization	30	
Placement in a residential treatment facility		75 min
Outpatient psychiatric services		
Day treatment services		N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	Yes	2
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry and Other: Tried to attract CAPs through personal connections and outreach. Networking.

County Name: Oswego

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	2	Census population under 18 yrs[108]	28,605
Practice full time	2	CAPs per 100,000 youth	7
Practice part time	0		
Reside outside of the county	2	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	2	Inpatient facilities	0
Employed by contract by county	0	Outpatient service organizations	80
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	0	**Number of CAPs (AMA data):**	
Female	1	In 2005	0
White	1	In 2006	1
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	1		
Other	0		
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	123,077	Families w/related children <18[109] yrs	15,914
Total Number of Females	62,252	Families w/children <18 yrs living in poverty[2]	2,471
Total Number of Males	60,825	Children and youth 0 to 17 yrs living below poverty[110]	5,618
Median Age	36	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	2
White	118,728	Suicide Mortality Rate 10-19 in 2001-03	10.0
Black	1,348	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	597	Suicide Mortality Rate 10-19 in 2003-05	6.6
Asian	735	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	1,312.18
Other	337	Population Density per sq mile	128.4
Disabilities[1]		Housing Density per sq mile of land area	55.4
Total population 5 to 15 yrs w/disability	21,437	**Economics[1]:**	
With a mental disability	1,359	Median Family Income	49,730
		Number unemployed	6,242

[108] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[109] U.S. Census Bureau; Census 2000
[110] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed		Inpatient psychiatry program	Some need
Does this need significantly impact your county?		Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?		Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	No need at all	Psychiatric assessment	Great need
School age (6-12 yrs)	Most significant need	Medication consultation	Some need
Adolescents (13-17 yrs)	Great need	Medication management	Little need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other: Respite services - overnight respite services as a means of hospital admission diversion.	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		40 min	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	14	2.5 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	8
Placement in a residential treatment facility		Varies depending on where.	Residential treatment programs	No	
Outpatient psychiatric services	90	40 min	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

International graduate medical residents with J-1 Visas or waivers and Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians, and Adult Psychiatrists

County Name: Otsego

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	4
Practice full time	3
Practice part time	1
Reside outside of the county	1
Employed by private organizations or in private practice	3
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	2
Female	0
White	4
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[111]	13,975
CAPs per 100,000 youth	29
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	56
Office based only	55
Number of CAPs (AMA data):	
In 2005	3
In 2006	4

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Family Resource Network, NAMI, MHA

Additional Secondary County Data

Population[1]:	
Total	61,676
Total Number of Females	31,939
Total Number of Males	29,737
Median Age	37
Race[1]:	
White	59,083
Black	1,079
American Indian and Alaskan Native	141
Asian	390
Native Hawaiian and Pacific Islander	31
Other	306
Disabilities[1]	
Total population 5 to 15 yrs w/disability	9,080
With a mental disability	580

Families:	
Families w/related children <18[112] yrs	6,883
Families w/children <18 yrs living in poverty[2]	1,029
Children and youth 0 to 17 yrs living below poverty[113]	1,968
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	0.0
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	3.2
Density[2]	
Total Area per sq mile	1,015.10
Population Density per sq mile	61.5
Housing Density per sq mile of land area	28.4
Economics[1]:	
Median Family Income	41,110
Number unemployed	4,061

[111] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[112] U.S. Census Bureau; Census 2000
[113] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	2
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Most significant need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Little need
Children and adolescents in the child welfare system	Little need
Other: Dual diagnosis, MH with MRDD, and with Kids who are Autistic Aspergers kids	Some need

Need for services by CAPS for:	
Inpatient psychiatry program	Great need
Crisis care	Some need
Residential treatment facilities	No need at all
Child day treatment program	Great need
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Some need
Individual mental health counseling	Some need
Family therapy	Little need
Other: Need a crisis bed and another community MH residence	Great need

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		1.5 hr
Long term state psychiatric hospitalization	35	75 mi
Placement in a residential treatment facility		2 hr
Outpatient psychiatric services	30	
Day treatment services		N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	Yes	12
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Nurse practitioners w/advanced cert. in child psychiatry, and Other: Active recruitment efforts for the private facilities

County Name: Putnam

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	8	Census population under 18 yrs[114]	24,337
Practice full time	0	CAPs per 100,000 youth	33
Practice part time	8		
Reside outside of the county		**Hours of CAP services per week:**	
Employed by private organizations or in private practice	8	Inpatient facilities	0
Employed by contract by county	0	Outpatient service organizations	8
Employed by contract by state	0	Office based only	5
Within 10 years of retirement	.	**Number of CAPs (AMA data):**	
Female	3	In 2005	0
White	7	In 2006	0
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Putnam Family Support and Advocacy	
Hispanic	0		
Asian	0		
Other	1		
Speakers of ESL	1		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	100,603	Families w/related children <18[115] yrs	12,737
Total Number of Females	50,551	Families w/children <18 yrs living in poverty[2]	487
Total Number of Males	50,052	Children and youth 0 to 17 yrs living below poverty[116]	1,253
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	89,429	Suicide Mortality Rate 10-19 in 2001-03	2.4
Black	2,460	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	0	Suicide Mortality Rate 10-19 in 2003-05	4.7
Asian	2,197	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	246.25
Other	5,428	Population Density per sq mile	414.0
Disabilities[1]		Housing Density per sq mile of land area	151.5
Total population 5 to 15 yrs w/disability	15,752	**Economics[1]:**	
With a mental disability	723	Median Family Income	95,105
		Number unemployed	2,685

[114] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[115] U.S. Census Bureau; Census 2000
[116] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	2	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	No need at all
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Most significant need
Need for CAP services by population group:		Child day treatment program	Most significant need
Preschool children (0-5 yrs)	Most significant need	Psychiatric assessment	Great need
School age (6-12 yrs)	Some need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Great need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Most significant need
Children and adolescents in the child welfare system	Great need	Other:	
Other: Growing Autistic population in the county.			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		30-60 plus min	Inpatient psychiatric services	Yes	12
Long term state psychiatric hospitalization	90		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility	42	30 min-5 hrs	Additional residential treatment programs		10
Outpatient psychiatric services	14	30 min to 3 hrs	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry

County Name: Rensselaer

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	1	Census population under 18 yrs[117]	34,096
Practice full time	0	CAPs per 100,000 youth	3
Practice part time	1		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	0	Inpatient facilities	0
Employed by contract by county	1	Outpatient service organizations	18
Employed by contract by state	0	Office based only	18
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	0	In 2005	1
White	1	In 2006	1
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** 1.5 parent advocate employed by the county, and a Support Group of parents named Wits End which is lead by the parent advocate.	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	155,292	Families w/related children <18[118] yrs	18,753
Total Number of Females	78,861	Families w/children <18 yrs living in poverty[2]	2,090
Total Number of Males	76,431	Children and youth 0 to 17 yrs living below poverty[119]	4,855
Median Age	38	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	139,278	Suicide Mortality Rate 10-19 in 2001-03	6.0
Black	6,907	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	235	Suicide Mortality Rate 10-19 in 2003-05	1.5
Asian	3,569	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	665.39
Other	455	Population Density per sq mile	233.3
Disabilities[1]		Housing Density per sq mile of land area	101.1
Total population 5 to 15 yrs w/disability	34,096	**Economics[1]:**	
With a mental disability	3	Median Family Income	65,247
		Number unemployed	6,355

[117] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[118] U.S. Census Bureau; Census 2000
[119] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	3
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Most significant need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Most significant need
Crisis care	Most significant need
Residential treatment facilities	Some need
Child day treatment program	Great need
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Great need
Family therapy	Some need
Other: School based consultation/community consultation by CAP	Some need

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization	2	Varies
Long term state psychiatric hospitalization		
Placement in a residential treatment facility		2.5 hr at the longest.
Outpatient psychiatric services	60	Varies, closer for families in rural areas than coming into Troy.
Day treatment services		N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Additional Inpatient psychiatric services	Yes	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Don't Know	
Residential treatment programs	Yes	8
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry, Collaborating with CAP training program, and Special training in Child and Adolescent psychiatry for Adult Psychiatrists

County Name: Rockland

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	14	Census population under 18 yrs[120]	80,235
Practice full time	9	CAPs per 100,000 youth	17
Practice part time	5		
Reside outside of the county	0	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	14	Inpatient facilities	80
Employed by contract by county	2	Outpatient service organizations	25
Employed by contract by state	3	Office based only	150
Within 10 years of retirement	5	**Number of CAPs (AMA data):**	
Female	5	In 2005	26
White	9	In 2006	29
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** MHA	
Hispanic	1		
Asian	0		
Other	4		
Speakers of ESL	3		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	294,965	Families w/related children <18[121] yrs	34,878
Total Number of Females	149,554	Families w/children <18 yrs living in poverty[2]	3,614
Total Number of Males	145,411	Children and youth 0 to 17 yrs living below poverty[122]	11,475
Median Age	37	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	228,998	Suicide Mortality Rate 10-19 in 2001-03	1.5
Black	33,256	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	798	Suicide Mortality Rate 10-19 in 2003-05	0.8
Asian	18,236	**Density[2]**	
Native Hawaiian and Pacific Islander	87	Total Area per sq mile	199.34
Other	9,522	Population Density per sq mile	1,645.9
Disabilities[1]		Housing Density per sq mile of land area	545.1
Total population 5 to 15 yrs w/disability	50,061	**Economics[1]:**	
With a mental disability	1,620	Median Family Income	91,169
		Number unemployed	5,752

[120] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[121] U.S. Census Bureau; Census 2000
[122] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	3
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Great need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Most significant need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Most significant need
Crisis care	Most significant need
Residential treatment facilities	Little need
Child day treatment program	Some need
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Some need
Family therapy	Some need
Other:	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		30-60 min
Long term state psychiatric hospitalization		
Placement in a residential treatment facility		30-60 plus minutes
Outpatient psychiatric services	49	30 min-1.5 hr
Day treatment services	28	N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	Yes	15
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Don't Know	
Additional Residential treatment programs		4
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Nurse practitioners w/advanced cert. in child psychiatry

County Name: St. Lawrence

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	5	Census population under 18 yrs[123]	22,993
Practice full time	5	CAPs per 100,000 youth	22
Practice part time	0		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	0	Inpatient facilities	80
Employed by contract by county	0	Outpatient service organizations	0
Employed by contract by state	5	Office based only	120
Within 10 years of retirement	0	**Number of CAPs (AMA data):**	
Female	4	In 2005	2
White	1	In 2006	2
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	0		
Other	4		
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	111,284	Families w/related children <18[124] yrs	12,875
Total Number of Females	55,087	Families w/children <18 yrs living in poverty[2]	2,597
Total Number of Males	56,197	Children and youth 0 to 17 yrs living below poverty[125]	4,692
Median Age	36	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	104,644	Suicide Mortality Rate 10-19 in 2001-03	3.7
Black	2,208	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	1,206	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	1,231	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	2,821.48
Other	702	Population Density per sq mile	41.7
Disabilities[1]		Housing Density per sq mile of land area	18.5
Total population 5 to 15 yrs w/disability	16,971	**Economics[1]:**	
With a mental disability	1,187	Median Family Income	44,571
		Number unemployed	2,581

[123] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[124] U.S. Census Bureau; Census 2000
[125] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	8	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Most significant need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Great need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Most significant need	Medication management	Little need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Some need
Children and adolescents in the child welfare system	Most significant need	Other:	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization	0	2 hr	Additional Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	0	2 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility			Residential treatment programs	Yes	12
Outpatient psychiatric services			Additional child and adolescent crisis psychiatric services	Don't Know	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, and Other: Physician Assistants

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, and Limited permit CAPs

County Name: Saratoga

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	9	Census population under 18 yrs[126]	47,826
Practice full time	7	CAPs per 100,000 youth	19
Practice part time	2		
Reside outside of the county	0	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	8	Inpatient facilities	120
Employed by contract by county	1	Outpatient service organizations	133
Employed by contract by state	0	Office based only	50
Within 10 years of retirement	4	**Number of CAPs (AMA data):**	
Female	4	In 2005	11
White	9	In 2006	12
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	215,473	Families w/related children <18[127] yrs	26,294
Total Number of Females	109,707	Families w/children <18 yrs living in poverty[2]	1,674
Total Number of Males	105,766	Children and youth 0 to 17 yrs living below poverty[128]	3,962
Median Age	38	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	203,528	Suicide Mortality Rate 10-19 in 2001-03	2.3
Black	4,027	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	206	Suicide Mortality Rate 10-19 in 2003-05	1.2
Asian	3,931	**Density[2]**	
Native Hawaiian and Pacific Islander	91	Total Area per sq mile	843.71
Other	1,282	Population Density per sq mile	247.1
Disabilities[1]		Housing Density per sq mile of land area	106.8
Total population 5 to 15 yrs w/disability	31,441	**Economics[1]:**	
With a mental disability	1,703	Median Family Income	70,414
		Number unemployed	4,861

[126] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[127] U.S. Census Bureau; Census 2000
[128] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	9
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for services by CAPS for:	
Inpatient psychiatry program	Great need
Crisis care	Great need
Residential treatment facilities	Some need
Child day treatment program	No need at all

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Great need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Great need
Adolescents w/special needs (developmental or physical)	Great need
Children and adolescents in the child welfare system	Some need

Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Most significant need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other: Four winds has an intensive output program with CAP but Medicaid clients can't access	Some need

Other: Dually Diagnosed = Cross between child who are mentally retarded or have pervasive developmental disorders and mental health concerns. At the clinic we do not tx these kids, they are referred to center for the disabled, a lot of them are declined services and then are bounced back and forth.

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization	2	Btwn 20 min-4 hr
Long term state psychiatric hospitalization	30	3 hr- 12 hr
Placement in a residential treatment facility		Btwn 45 min-8 hr
Outpatient psychiatric services	180	1-2 hr
Day treatment services	90	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	Yes	30
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	20
Residential treatment programs	Yes	90
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, Collaborating with CAP training program, Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians, and Adult Psychiatrists, and Other: Clinic CAP does consult with pediatricians when pt is discharged from tx. When Pediatrician chooses to pick up pt, also four winds has grand rounds monthly- half are on child and adolescent psych issues.

County Name: Schenectady

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	7	Census population under 18 yrs[129]	34,362
Practice full time	4	CAPs per 100,000 youth	20
Practice part time	3		
Reside outside of the county	7	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	7	Inpatient facilities	42
Employed by contract by county	0	Outpatient service organizations	128
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	3	**Number of CAPs (AMA data):**	
Female	3	In 2005	2
White	5	In 2006	2
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	0		
Other	2		
Speakers of ESL	2		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	150,440	Families w/related children <18[130] yrs	17,898
Total Number of Females	78,187	Families w/children <18 yrs living in poverty[2]	2,428
Total Number of Males	72,253	Children and youth 0 to 17 yrs living below poverty[131]	5,963
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	123,457	Suicide Mortality Rate 10-19 in 2001-03	6.5
Black	13,617	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	641	Suicide Mortality Rate 10-19 in 2003-05	6.4
Asian	5,966	**Density[2]**	
Native Hawaiian and Pacific Islander	44	Total Area per sq mile	209.62
Other	5,334	Population Density per sq mile	711.1
Disabilities[1]		Housing Density per sq mile of land area	315.5
Total population 5 to 15 yrs w/disability	22,848	**Economics[1]:**	
With a mental disability	1,426	Median Family Income	65,207
		Number unemployed	4,040

[129] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[130] U.S. Census Bureau; Census 2000
[131] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	4
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Great need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Great need
Adolescents w/special needs (developmental or physical)	Great need
Children and adolescents in the child welfare system	Some need
Other:	

Need for services by CAPS for:	
Inpatient psychiatry program	Some need
Crisis care	Some need
Residential treatment facilities	Little need
Child day treatment program	No need at all
Psychiatric assessment	Some need
Medication consultation	Great need
Medication management	Some need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization	0	45 min
Long term state psychiatric hospitalization	45	
Placement in a residential treatment facility		1-2 hr or if Parsons, 30 min
Outpatient psychiatric services	21	30 min
Day treatment services	90	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	Yes	8
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	9
Residential treatment programs	Yes	12
Additional child and adolescent crisis psychiatric services	No	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, and Special training in Child and Adolescent psychiatry for: Pediatricians, Primary Care Physicians, and Adult Psychiatrists

County Name: Schoharie

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	1	Census population under 18 yrs[132]	7,569
Practice full time	0	CAPs per 100,000 youth	13
Practice part time	1		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	0	Inpatient facilities	0
Employed by contract by county	1	Outpatient service organizations	2
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	0	In 2005	0
White	1	In 2006	0
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:**	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	31,582	Families w/related children <18[133] yrs	3,736
Total Number of Females	15,869	Families w/children <18 yrs living in poverty[2]	490
Total Number of Males	15,713	Children and youth 0 to 17 yrs living below poverty[134]	1,038
Median Age	38	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	30,514	Suicide Mortality Rate 10-19 in 2001-03	6.3
Black	403	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	96	Suicide Mortality Rate 10-19 in 2003-05	0.0
Asian	120	**Density[2]**	
Native Hawaiian and Pacific Islander	7	Total Area per sq mile	626.36
Other	149	Population Density per sq mile	50.8
Disabilities[1]		Housing Density per sq mile of land area	25.6
Total population 5 to 15 yrs w/disability	4,775	**Economics[1]:**	
With a mental disability	364	Median Family Income	43,118
		Number unemployed	1,090

[132] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[133] U.S. Census Bureau; Census 2000
[134] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	1	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Some need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Great need
School age (6-12 yrs)	Some need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Little need
Children and adolescents in the child welfare system	Great need	Other:	
Other: Special Ed - co-occurring disorders and developmental disabilities	Some need		

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		EH 30-90 min, FW 1 hr, other facilities even longer	Inpatient psychiatric services	Yes	2
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		40-60 min	Residential treatment programs	No	
Outpatient psychiatric services	42		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	30	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Nurse practitioners w/advanced cert. in child psychiatry, Collaborating with CAP training program, International graduate medical residents with J-1 Visas or waivers, Special training in Child and Adolescent psychiatry for: Pediatricians and Adult Psychiatrists, and Other: Have made attempts to purchase from hospitals, but the attempts were not successful because the problem of availability is pervasive.

County Name: Schuyler

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	2	Census population under 18 yrs[135]	4,873
Practice full time	0	CAPs per 100,000 youth	41
Practice part time	2		
Reside outside of the county	1	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	0	Inpatient facilities	0
Employed by contract by county	2	Outpatient service organizations	20
Employed by contract by state	0	Office based only	0
Within 10 years of retirement	1	**Number of CAPs (AMA data):**	
Female	1	In 2005	0
White	2	In 2006	0
Black	0	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Finger Lakes Parent Network has a family support program	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	0		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	19,224	Families w/related children <18[136] yrs	2,380
Total Number of Females	9,590	Families w/children <18 yrs living in poverty[2]	372
Total Number of Males	9,634	Children and youth 0 to 17 yrs living below poverty[137]	756
Median Age	39	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	0
White	18,548	Suicide Mortality Rate 10-19 in 2001-03	0.0
Black	279	Suicide Mortality 10-19 in 2003-05	0
American Indian and Alaskan Native	77	Suicide Mortality Rate 10-19 in 2003-05	11.6
Asian	56	**Density[2]**	
Native Hawaiian and Pacific Islander	5	Total Area per sq mile	342.22
Other	69	Population Density per sq mile	58.5
Disabilities[1]		Housing Density per sq mile of land area	27.9
Total population 5 to 15 yrs w/disability	3,079	**Economics[1]:**	
With a mental disability	297	Median Family Income	41,441
		Number unemployed	684

[135] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[136] U.S. Census Bureau; Census 2000
[137] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	1
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for services by CAPS for:	
Inpatient psychiatry program	Some need
Crisis care	Great need
Residential treatment facilities	Some need
Child day treatment program	Some need

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Most significant need
Adolescents (13-17 yrs)	Great need
Children w/special needs (developmental or physical)	Some need
Adolescents w/special needs (developmental or physical)	Some need
Children and adolescents in the child welfare system	Some need
Other:	

Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	Some need
Family therapy	Little need
Other:	

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		About 40 min to Cayuga and 1.5 - 2 hr to St James
Long term state psychiatric hospitalization	1	
Placement in a residential treatment facility		45 min-1 hr
Outpatient psychiatric services	3	
Day treatment services	0	N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	3
Residential treatment programs	Yes	10
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

County Name: Seneca

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	5
Practice full time	0
Practice part time	5
Reside outside of the county	5
Employed by private organizations or in private practice	4
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	0
Female	2
White	3
Black	1
Hispanic	0
Asian	1
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[138]	8,273
CAPs per 100,000 youth	60
Hours of CAP services per week:	
Inpatient facilities	72
Outpatient service organizations	16
Office based only	0
Number of CAPs (AMA data):	
In 2005	1
In 2006	0
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	33,342
Total Number of Females	16,663
Total Number of Males	16,679
Median Age	38
Race[1]:	
White	31,682
Black	758
American Indian and Alaskan Native	83
Asian	227
Native Hawaiian and Pacific Islander	5
Other	222
Disabilities[1]	
Total population 5 to 15 yrs w/disability	5,542
With a mental disability	368

Families:	
Families w/related children <18[139] yrs	4,023
Families w/children <18 yrs living in poverty[2]	523
Children and youth 0 to 17 yrs living below poverty[140]	1,171
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	0.0
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	390.51
Population Density per sq mile	102.6
Housing Density per sq mile of land area	45.5
Economics[1]:	
Median Family Income	45,445
Number unemployed	936

[138] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[139] U.S. Census Bureau; Census 2000
[140] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	2	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Some need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Little need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Little need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Little need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		20 min-1.5hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		1 hr	Additional Residential treatment programs		
Outpatient psychiatric services	42		Additional child and adolescent crisis psychiatric services	No	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Limited permit CAPs

County Name: Steuben

Current Status

Number of CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	0	Census population under 18 yrs[141]	22,756
Practice full time	N/A	CAPs per 100,000 youth	0
Practice part time	N/A		
Reside outside of the county	N/A	**Hours of CAP services per week:**	
Employed by private organizations or in private practice	N/A	Inpatient facilities	N/A
Employed by contract by county	N/A	Outpatient service organizations	N/A
Employed by contract by state	N/A	Office based only	N/A
Within 10 years of retirement	N/A	**Number of CAPs (AMA data):**	
Female	N/A	In 2005	0
White	N/A	In 2006	1
Black	N/A	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Finger Lakes Parent Network	
Hispanic	N/A		
Asian	N/A		
Other	N/A		
Speakers of ESL	N/A		

Additional Secondary County Data

Population[1]:		**Families:**	
Total	98,236	Families w/related children <18[142] yrs	12,430
Total Number of Females	50,084	Families w/children <18 yrs living in poverty[2]	2,091
Total Number of Males	48,152	Children and youth 0 to 17 yrs living below poverty[143]	4,542
Median Age	40	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	1
White	94,142	Suicide Mortality Rate 10-19 in 2001-03	6.8
Black	1,558	Suicide Mortality 10-19 in 2003-05	1
American Indian and Alaskan Native	387	Suicide Mortality Rate 10-19 in 2003-05	4.6
Asian	1,317	**Density[2]**	
Native Hawaiian and Pacific Islander	0	Total Area per sq mile	1,404.10
Other	75	Population Density per sq mile	70.9
Disabilities[1]		Housing Density per sq mile of land area	33.1
Total population 5 to 15 yrs w/disability	16,528	**Economics[1]:**	
With a mental disability	1,102	Median Family Income	50,442
		Number unemployed	2,991

[141] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[142] U.S. Census Bureau; Census 2000
[143] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of CAPs needed	2
Does this need significantly impact your county?	No
Has there been a strain on other professions as a result of this shortage?	Yes

Need for services by CAPS for:	
Inpatient psychiatry program	Some need
Crisis care	Some need
Residential treatment facilities	Some need
Child day treatment program	Some need

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Some need
Children w/special needs (developmental or physical)	Some need
Adolescents w/special needs (developmental or physical)	Some need
Children and adolescents in the child welfare system	Some need
Other:	

Psychiatric assessment	Some need
Medication consultation	Some need
Medication management	Some need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization	1	Btwn 1.5-2 hr
Long term state psychiatric hospitalization	0	
Placement in a residential treatment facility		A couple of hours
Outpatient psychiatric services	49	About 2 hr
Day treatment services	0	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	Yes	5
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	No	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Locum tenens CAPs, Limited permit CAPs, and Special training in Child and Adolescent psychiatry for Adult Psychiatrists

Top 7- County Name: Suffolk

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	31	Census population under 18 yrs[144]	367,874
Practice full time	18	CAPs per 100,000 youth	8
Practice part time	13		
Reside outside of the county	0	**Number of CAPs (AMA data):**	
Within 10 years of retirement	12	In 2005	58
Female	8	In 2006	63
White	2		
Black	.	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** LIFT, Long Island Families Together. Parent to parent program.	
Hispanic	3		
Asian	.		
Other	15		
Speakers of ESL	31		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	1,469,715	Families w/related children <18[145] yrs	173,671
Total Number of Females	724,410	Families w/children <18 yrs living in poverty[2]	10,928
Total Number of Males	745,305	Children and youth 0 to 17 yrs living below poverty[146]	33,174
Median Age	38.3	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	6
White	1,228,372	Suicide Mortality Rate 10-19 in 2001-03	3.0
Black	109,174	Suicide Mortality 10-19 in 2003-05	6
American Indian and Alaskan Native	2,281	Suicide Mortality Rate 10-19 in 2003-05	2.7
Asian	50,603	**Density[2]**	
Native Hawaiian and Pacific Islander	40	Total Area per sq mile	2,373.07
Other	57,424	Population Density per sq mile	1,556.0
Disabilities[1]		Housing Density per sq mile of land area	572.6
Total population 5 to 15 yrs w/disability	232,241	**Economics[1]:**	
With a mental disability	9,672	Median Family Income	86,993
		Number unemployed	33,348

[144] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[145] U.S. Census Bureau; Census 2000
[146] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:	
Number of additional CAPs needed	147
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes
Need for CAP services by population group:	
Preschool children (0-5 yrs)	Great need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Little need
Children w/special needs (developmental or physical)	Little need
Adolescents w/special needs (developmental or physical)	Little need
Children and adolescents in the child welfare system	Little need
Other: JJ and they have the most significant need. Far too many kids have come to attention of police and they are emotionally disturbed and no one has seen them, some are as young as 10 yrs.	Most significant need

Need for services by Outpatient Public CAPS for:	
Inpatient psychiatry program	Little need
Crisis care	Little need
Residential treatment facilities	Little need
Child day treatment program	Little need
Psychiatric assessment	Most significant need
Medication consultation	Most significant need
Medication management	Most significant need
Individual mental health counseling	No need at all
Family therapy	No need at all
Other:	

Access to services

Service	Wait time in Days	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		30 min-3 hr
Long term state psychiatric hospitalization		30 min-3 hr
Placement in a residential treatment facility	0	30 min-3 hr
Outpatient psychiatric services		30-3 hr
Day treatment services	90	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Inpatient psychiatric services	Yes	10
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	10
Residential treatment programs	Yes	10
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, Psychiatry residents, and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, Collaborating with CAP training program, and Special training in Child and Adolescent psychiatry for Adult Psychiatrists.

County Name: Sullivan

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	2
Practice full time	1
Practice part time	1
Reside outside of the county	2
Employed by private organizations or in private practice	0
Employed by contract by county	1
Employed by contract by state	1
Within 10 years of retirement	1
Female	1
White	2
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[147]	17,222
CAPs per 100,000 youth	12
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	60
Office based only	0
Number of CAPs (AMA data):	
In 2005	2
In 2006	1
Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:	

Additional Secondary County Data

Population[1]:	
Total	76,588
Total Number of Females	37,682
Total Number of Males	38,906
Median Age	40
Race[1]:	
White	63,103
Black	6,292
American Indian and Alaskan Native	197
Asian	825
Native Hawaiian and Pacific Islander	29
Other	2,139
Disabilities[1]	
Total population 5 to 15 yrs w/disability	11,763
With a mental disability	737

Families:	
Families w/related children <18[148] yrs	8,653
Families w/children <18 yrs living in poverty[2]	1,739
Children and youth 0 to 17 yrs living below poverty[149]	3,291
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	12.3
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	6.1
Density[2]	
Total Area per sq mile	996.85
Population Density per sq mile	76.3
Housing Density per sq mile of land area	46.1
Economics[1]:	
Median Family Income	56,264
Number unemployed	2,254

[147] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[148] U.S. Census Bureau; Census 2000
[149] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	1.5	Inpatient psychiatry program	Great need
Does this need significantly impact your county?	Yes	Crisis care	Most significant need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Little need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Some need
School age (6-12 yrs)	Little need	Medication consultation	Some need
Adolescents (13-17 yrs)	Most significant need	Medication management	Some need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Some need
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		2 hr	Inpatient psychiatric services	Yes	8
Long term state psychiatric hospitalization	2		Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		2.5 hr	Residential treatment programs	No	
Outpatient psychiatric services	10		Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	60	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

County Name: Tioga

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[150]	14,007
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Finger Lakes Parent Network

Additional Secondary County Data

Population[1]:	
Total	51,784
Total Number of Females	26,208
Total Number of Males	25,576
Median Age	38
Race[1]:	
White	50,501
Black	282
American Indian and Alaskan Native	112
Asian	296
Native Hawaiian and Pacific Islander	7
Other	108
Disabilities[1]	
Total population 5 to 15 yrs w/disability	9,238
With a mental disability	580

Families:	
Families w/related children <18[151] yrs	6,847
Families w/children <18 yrs living in poverty[2]	655
Children and youth 0 to 17 yrs living below poverty[152]	1,717
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	4.1
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	4.3
Density[2]	
Total Area per sq mile	522.91
Population Density per sq mile	99.8
Housing Density per sq mile of land area	41.3
Economics[1]:	
Median Family Income	46,509
Number unemployed	26,018

[150] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[151] U.S. Census Bureau; Census 2000
[152] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of CAPs needed	2	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Great need
Preschool children (0-5 yrs)	Little need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Most significant need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Great need
Children and adolescents in the child welfare system	Most significant need	Other:	
Other: Kids in Juvenile Justice System	Some need		

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		30 min-50 min	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	1	2 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		2.5-5 hr	Residential treatment programs	No	
Outpatient psychiatric services	60	1-1.5 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	90	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Other: Spoken with neighboring counties who experience shortages, Local MH directors are meeting. Discussions of starting up Tele Psychiatry.

County Name: Tompkins

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	3
Practice full time	2
Practice part time	1
Reside outside of the county	0
Employed by private organizations or in private practice	2
Employed by contract by county	1
Employed by contract by state	0
Within 10 years of retirement	0
Female	1
White	0
Black	2
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[153]	15,907
CAPs per 100,000 youth	19
Hours of CAP services per week:	
Inpatient facilities	28
Outpatient service organizations	14
Office based only	40
Number of CAPs (AMA data):	
In 2005	1
In 2006	2

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: NAMI and a parent support group, mental health board has family representatives.

Additional Secondary County Data

Population[1]:	
Total	100,407
Total Number of Females	49,909
Total Number of Males	50,498
Median Age	28
Race[1]:	
White	82,445
Black	3,856
American Indian and Alaskan Native	219
Asian	10,657
Native Hawaiian and Pacific Islander	0
Other	1,507
Disabilities[1]	
Total population 5 to 15 yrs w/disability	11,552
With a mental disability	603

Families:	
Families w/related children <18[154] yrs	9,393
Families w/children <18 yrs living in poverty[2]	1,057
Children and youth 0 to 17 yrs living below poverty[155]	2,189
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	7.6
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	3.9
Density[2]	
Total Area per sq mile	491.63
Population Density per sq mile	202.7
Housing Density per sq mile of land area	81.1
Economics[1]:	
Median Family Income	72,957
Number unemployed	2,433

[153] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[154] U.S. Census Bureau; Census 2000
[155] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:	
Number of additional CAPs needed	3
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes

Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Some need
Children w/special needs (developmental or physical)	Great need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Great need
Other: Kids with severe behavioral problems or conduct disorders	Great need

Need for services by CAPS for:	
Inpatient psychiatry program	Little need
Crisis care	Some need
Residential treatment facilities	Some need
Child day treatment program	Some need
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Some need
Individual mental health counseling	Some need
Family therapy	Little need
Other:	

Access to services

Service	Wait time in Days (Average)	Drive time (if going outside the county)
Inpatient psychiatric hospitalization		1 hr
Long term state psychiatric hospitalization	20	1-3 hr
Placement in a residential treatment facility		1.5 hr
Outpatient psychiatric services	14	1-6 hr
Day treatment services	60	N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	Yes	4
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	5
Residential treatment programs	Yes	6
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Developmental behavioral pediatricians, Special training in Child and Adolescent psychiatry for: Pediatricians Primary Care Physicians, Adult Psychiatrists, and Other: To bring one CAP (for the public system) here it took a collaborative effort of a hospital, the county legislature, a not for profit health provider and county MH system and private funds.

County Name: Ulster

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	10
Practice full time	5
Practice part time	5
Reside outside of the county	5
Employed by private organizations or in private practice	2
Employed by contract by county	5
Employed by contract by state	3
Within 10 years of retirement	4
Female	4
White	6
Black	1
Hispanic	1
Asian	1
Other	1
Speakers of ESL	2

CAPS per Youth:	
Census population under 18 yrs[156]	38,392
CAPs per 100,000 youth	26
Hours of CAP services per week:	
Inpatient facilities	6
Outpatient service organizations	162
Office based only	12
Number of CAPs (AMA data):	
In 2005	3
In 2006	3

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Loosely affiliated groups, MH Association has some family support, grassroots started by parents in the county and eating disorder coalition started by parents.

Additional Secondary County Data

Population[1]:	
Total	182,742
Total Number of Females	92,210
Total Number of Males	90,532
Median Age	40
Race[1]:	
White	160,379
Black	11,339
American Indian and Alaskan Native	163
Asian	3,131
Native Hawaiian and Pacific Islander	292
Other	3,530
Disabilities[1]	
Total population 5 to 15 yrs w/disability	27,036
With a mental disability	1,516

Families:	
Families w/related children <18[157] yrs	20,746
Families w/children <18 yrs living in poverty[2]	2,532
Children and youth 0 to 17 yrs living below poverty[158]	5,441
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	2.6
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	1.3
Density[2]	
Total Area per sq mile	1,160.76
Population Density per sq mile	157.8
Housing Density per sq mile of land area	68.9
Economics[1]:	
Median Family Income	64,040
Number unemployed	4,418

[156] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[157] U.S. Census Bureau; Census 2000
[158] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	3	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	No need at all
Need for CAP services by population group:		Child day treatment program	Most significant need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Some need
School age (6-12 yrs)	Some need	Medication consultation	Some need
Adolescents (13-17 yrs)	Some need	Medication management	Some need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	Little need
Children and adolescents in the child welfare system	Little need	Other:	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-3.5 hr	Inpatient psychiatric services	Yes	10
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Placement in a residential treatment facility		1.5 hr	Residential treatment programs	Yes	7
Outpatient psychiatric services	60	.5-1 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services	7	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Locum tenens CAPs

County Name: Warren

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	3
Practice full time	3
Practice part time	0
Reside outside of the county	1
Employed by private organizations or in private practice	3
Employed by contract by county	0
Employed by contract by state	0
Within 10 years of retirement	2
Female	1
White	3
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[159]	13,303
CAPs per 100,000 youth	23
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	80
Office based only	40
Number of CAPs (AMA data):	
In 2005	3
In 2006	1

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Family Support Services

Additional Secondary County Data

Population[1]:	
Total	66,087
Total Number of Females	33,978
Total Number of Males	32,109
Median Age	41
Race[1]:	
White	61,705
Black	395
American Indian and Alaskan Native	130
Asian	347
Native Hawaiian and Pacific Islander	7
Other	145
Disabilities[1]	
Total population 5 to 15 yrs w/disability	9,855
With a mental disability	675

Families:	
Families w/related children <18[160] yrs	7,891
Families w/children <18 yrs living in poverty[2]	1,008
Children and youth 0 to 17 yrs living below poverty[161]	2,039
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	3.7
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	3.7
Density[2]	
Total Area per sq mile	931.66
Population Density per sq mile	72.8
Housing Density per sq mile of land area	40.1
Economics[1]:	
Median Family Income	58,756
Number unemployed	2,317

[159] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[160] U.S. Census Bureau; Census 2000
[161] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	1	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Great need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Great need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-5 hr	Inpatient psychiatric services	Yes	12
Long term state psychiatric hospitalization	3	3.5 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Placement in a residential treatment facility		2 hr	Residential treatment programs	No	
Outpatient psychiatric services	60	1- 2 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Nurse practitioners w/advanced cert. in child psychiatry, and Special training in Child and Adolescent psychiatry for Pediatricians and Primary Care Physicians

County Name: Washington

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	1
Practice full time	0
Practice part time	1
Reside outside of the county	1
Employed by private organizations or in private practice	1
Employed by contract by county	0
Employed by contract by state	1
Within 10 years of retirement	1
Female	0
White	1
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[162]	15,028
CAPs per 100,000 youth	7
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	10
Office based only	0
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Located in Warren but membership in both Warren and Washington Counties. Family Support Services. Glens Falls Hospital has a family support program and parenting groups.

Additional Secondary County Data

Population[1]:	
Total	61,042
Total Number of Females	29,741
Total Number of Males	31,301
Median Age	38
Race[1]:	
White	57,973
Black	1,785
American Indian and Alaskan Native	125
Asian	172
Native Hawaiian and Pacific Islander	9
Other	510
Disabilities[1]	
Total population 5 to 15 yrs w/disability	9,927
With a mental disability	721

Families:	
Families w/related children <18[163] yrs	7,461
Families w/children <18 yrs living in poverty[2]	819
Children and youth 0 to 17 yrs living below poverty[164]	2,082
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	0.0
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	0.0
Density[2]	
Total Area per sq mile	845.84
Population Density per sq mile	73.1
Housing Density per sq mile of land area	32.1
Economics[1]:	
Median Family Income	43,500
Number unemployed	1,410

[162] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[163] U.S. Census Bureau; Census 2000
[164] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		Need for services by CAPS for:	
Number of additional CAPs needed	1	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Some need
Need for CAP services by population group:		Child day treatment program	Some need
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Great need	Medication consultation	Most significant need
Adolescents (13-17 yrs)	Great need	Medication management	Most significant need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services			Need for the following services		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-5 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization		3.5 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	6
Placement in a residential treatment facility		2 hr	Residential treatment programs	No	
Outpatient psychiatric services	14	1-2 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Special training in Child and Adolescent psychiatry for: Pediatricians and Primary Care Physicians

County Name: Wayne

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	3
Practice full time	0
Practice part time	3
Reside outside of the county	3
Employed by private organizations or in private practice	3
Employed by contract by county	3
Employed by contract by state	0
Within 10 years of retirement	1
Female	1
White	2
Black	0
Hispanic	0
Asian	0
Other	1
Speakers of ESL	1

CAPS per Youth:	
Census population under 18 yrs[165]	22,556
CAPs per 100,000 youth	13
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	16
Office based only	0
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Finger Lakes Parent Network and NAMI

Additional Secondary County Data

Population[1]:	
Total	92,889
Total Number of Females	47,257
Total Number of Males	45,632
Median Age	39
Race[1]:	
White	86,426
Black	3,246
American Indian and Alaskan Native	436
Asian	604
Native Hawaiian and Pacific Islander	103
Other	1,348
Disabilities[1]	
Total population 5 to 15 yrs w/disability	16,813
With a mental disability	1,115

Families:	
Families w/related children <18[166] yrs	12,599
Families w/children <18 yrs living in poverty[2]	1,224
Children and youth 0 to 17 yrs living below poverty[167]	3,446
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	2.3
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	2.3
Density[2]	
Total Area per sq mile	1,384.14
Population Density per sq mile	155.2
Housing Density per sq mile of land area	64.2
Economics[1]:	
Median Family Income	56,624
Number unemployed	3,235

[165] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[166] U.S. Census Bureau; Census 2000
[167] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed	3	Inpatient psychiatry program	Most significant need
Does this need significantly impact your county?	Yes	Crisis care	Great need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	Great need
Need for CAP services by population group:		Child day treatment program	No need at all
Preschool children (0-5 yrs)	Most significant need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Great need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Great need
Children w/special needs (developmental or physical)	Great need	Individual mental health counseling	Some need
Adolescents w/special needs (developmental or physical)	Great need	Family therapy	Some need
Children and adolescents in the child welfare system	Great need	Other: Case consultation between CAP and therapist, limited hours of CAPs, not able to collaborate on cases as needed. Tele-psychiatry	Great need Some need
Other: Dually diagnosed children with Substance Abuse and MH problem	Great need		

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1 hr	Inpatient psychiatric services	Yes	6
Long term state psychiatric hospitalization	18	Over 2 hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	2
Placement in a residential treatment facility		1-1.5 hr	Residential treatment programs	Yes	6
Outpatient psychiatric services	90	1 hr	Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, and Nurse practitioners. Use adult psychiatrist and PCP only on a crisis and limited basis.

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Nurse practitioners w/advanced cert. in child psychiatry

Top 7- County Name: Westchester

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	8	Census population under 18 yrs[168]	234,666
Practice full time	3	CAPs per 100,000 youth	3
Practice part time	5		
Reside outside of the county	2	**Number of CAPs (AMA data):**	
Within 10 years of retirement	2	In 2005	130
Female	7	In 2006	149
White	0		
Black	1	**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** Westchester made a decision to support an independent family organization in the county. We had a 7 year system of care federal grant. Community investment funding was used for the family organization. This organization now has a budget of 2 million, named Family Ties of Westchester. 7 FRCs in Westchester county and do cross system work funded thru family support and representatives and include about 800 families.	
Hispanic	0		
Asian	0		
Other	0		
Speakers of ESL	8		

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	949,355	Families w/related children <18[169] yrs	114,677
Total Number of Females	457,780	Families w/children <18 yrs living in poverty[2]	11,716
Total Number of Males	491,575	Children and youth 0 to 17 yrs living below poverty[170]	27,106
Median Age	39.1	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	3
White	646,654	Suicide Mortality Rate 10-19 in 2001-03	2.1
Black	132,025	Suicide Mortality 10-19 in 2003-05	3
American Indian and Alaskan Native	1,484	Suicide Mortality Rate 10-19 in 2003-05	2.1
Asian	52,703	**Density[2]**	
Native Hawaiian and Pacific Islander	242	Total Area per sq mile	500.08
Other	101,076	Population Density per sq mile	2,133.6
Disabilities[1]		Housing Density per sq mile of land area	807.4
Total population 5 to 15 yrs w/disability	142,647	**Economics[1]:**	
With a mental disability	6,045	Median Family Income	96,926
		Number unemployed	24,973

[168] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[169] U.S. Census Bureau; Census 2000
[170] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:	
Number of additional CAPs needed	3
Does this need significantly impact your county?	Yes
Has there been a strain on other professions as a result of this shortage?	Yes
Need for CAP services by population group:	
Preschool children (0-5 yrs)	Some need
School age (6-12 yrs)	Some need
Adolescents (13-17 yrs)	Some need
Children w/special needs (developmental or physical)	Most significant need
Adolescents w/special needs (developmental or physical)	Most significant need
Children and adolescents in the child welfare system	Some need
Other: Just beginning to talk about the DD and Substance abusing populations. One provider in the county who serves DD/MH population and has a one year waiting list.	

Need for services by Outpatient Public CAPS for:	
Inpatient psychiatry program	Great need
Crisis care	Some need
Residential treatment facilities	Some need
Child day treatment program	Some need
Psychiatric assessment	Great need
Medication consultation	Great need
Medication management	Some need
Individual mental health counseling	Some need
Family therapy	Great need
Other:	

Access to services

Service	Wait time in Days	Drive time (if going outside the county)
Inpatient psychiatric hospitalization	0	
Long term state psychiatric hospitalization		
Placement in a residential treatment facility		Varies
Outpatient psychiatric services	60	Varies
Day treatment services		N/A

Need for the following services

Service	Needed Yes/no	# of Beds
Additional Inpatient psychiatric services	No	
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Additional Residential treatment programs	Yes	121
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, Nurse practitioners, Psychiatry residents, and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs, Collaborating with CAP training programs, and International graduate medical residents with J-1 Visas or waivers

County Name: Wyoming

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	0
Practice full time	N/A
Practice part time	N/A
Reside outside of the county	N/A
Employed by private organizations or in private practice	N/A
Employed by contract by county	N/A
Employed by contract by state	N/A
Within 10 years of retirement	N/A
Female	N/A
White	N/A
Black	N/A
Hispanic	N/A
Asian	N/A
Other	N/A
Speakers of ESL	N/A

CAPS per Youth:	
Census population under 18 yrs[171]	10,444
CAPs per 100,000 youth	0
Hours of CAP services per week:	
Inpatient facilities	N/A
Outpatient service organizations	N/A
Office based only	N/A
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Glow family support group- 4 counties are involved.

Additional Secondary County Data

Population[1]:	
Total	43,424
Total Number of Females	19,889
Total Number of Males	23,535
Median Age	37
Race[1]:	
White	39,880
Black	2,395
American Indian and Alaskan Native	116
Asian	161
Native Hawaiian and Pacific Islander	10
Other	572
Disabilities[1]	
Total population 5 to 15 yrs w/disability	6,766
With a mental disability	465

Families:	
Families w/related children <18[172] yrs	5,094
Families w/children <18 yrs living in poverty[2]	514
Children and youth 0 to 17 yrs living below poverty[173]	1,230
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	1
Suicide Mortality Rate 10-19 in 2001-03	10.9
Suicide Mortality 10-19 in 2003-05	1
Suicide Mortality Rate 10-19 in 2003-05	11.2
Density[2]	
Total Area per sq mile	596.44
Population Density per sq mile	73.2
Housing Density per sq mile of land area	28.6
Economics[1]:	
Median Family Income	45,088
Number unemployed	1,221

[171] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[172] U.S. Census Bureau; Census 2000
[173] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of CAPs needed	2	Inpatient psychiatry program	Some need
Does this need significantly impact your county?	Yes	Crisis care	Little need
Has there been a strain on other professions as a result of this shortage?	Yes	Residential treatment facilities	
Need for CAP services by population group:		Child day treatment program	
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Most significant need
School age (6-12 yrs)	Most significant need	Medication consultation	Great need
Adolescents (13-17 yrs)	Great need	Medication management	Some need
Children w/special needs (developmental or physical)	Most significant need	Individual mental health counseling	No need at all
Adolescents w/special needs (developmental or physical)	Most significant need	Family therapy	No need at all
Children and adolescents in the child welfare system	Great need	Other:	
Other:			

Access to services

Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**
Inpatient psychiatric hospitalization		40-60 min
Long term state psychiatric hospitalization	0	1-3 hr
Placement in a residential treatment facility		1-2 hr
Outpatient psychiatric services	30	1-1.5 hr
Day treatment services		N/A

Need for the following services

Service	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric services	Yes	3
Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	No	
Residential treatment programs	No	
Additional child and adolescent crisis psychiatric services	Yes	N/A

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Adult psychiatrists, Primary care physicians, Pediatricians, and Nurse practitioners

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry and Special training in Child and Adolescent psychiatry for Pediatricians

County Name: Yates

Current Status

Number of CAPs (Telephone Survey):	
Practice in county	3
Practice full time	1
Practice part time	2
Reside outside of the county	3
Employed by private organizations or in private practice	3
Employed by contract by county	0
Employed by contract by state	0
Within 10 years of retirement	1
Female	2
White	3
Black	0
Hispanic	0
Asian	0
Other	0
Speakers of ESL	0

CAPS per Youth:	
Census population under 18 yrs[174]	6,568
CAPs per 100,000 youth	46
Hours of CAP services per week:	
Inpatient facilities	0
Outpatient service organizations	30
Office based only	0
Number of CAPs (AMA data):	
In 2005	0
In 2006	0

Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are: Finger Lakes Parent Network

Additional Secondary County Data

Population[1]:	
Total	24,621
Total Number of Females	12,605
Total Number of Males	12,016
Median Age	38
Race[1]:	
White	24,103
Black	139
American Indian and Alaskan Native	36
Asian	69
Native Hawaiian and Pacific Islander	4
Other	88
Disabilities[1]	
Total population 5 to 15 yrs w/disability	4,048
With a mental disability	263

Families:	
Families w/related children <18[175] yrs	2,846
Families w/children <18 yrs living in poverty[2]	479
Children and youth 0 to 17 yrs living below poverty[176]	1,141
Suicide Rates[3]:	
Suicide Morality 10-19 in 2001-03	0
Suicide Mortality Rate 10-19 in 2001-03	8.4
Suicide Mortality 10-19 in 2003-05	0
Suicide Mortality Rate 10-19 in 2003-05	8.4
Density[2]	
Total Area per sq mile	375.76
Population Density per sq mile	72.8
Housing Density per sq mile of land area	35.7
Economics[1]:	
Median Family Income	40,681
Number unemployed	768

[174] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[175] U.S. Census Bureau; Census 2000
[176] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for CAPs and Impacts:		**Need for services by CAPS for:**	
Number of additional CAPs needed		Inpatient psychiatry program	Some need
Does this need significantly impact your county?		Crisis care	Little need
Has there been a strain on other professions as a result of this shortage?		Residential treatment facilities	Little need
Need for CAP services by population group:		Child day treatment program	Little need
Preschool children (0-5 yrs)	Some need	Psychiatric assessment	Little need
School age (6-12 yrs)	Some need	Medication consultation	Little need
Adolescents (13-17 yrs)	Some need	Medication management	Little need
Children w/special needs (developmental or physical)	Some need	Individual mental health counseling	Little need
Adolescents w/special needs (developmental or physical)	Some need	Family therapy	Little need
Children and adolescents in the child welfare system	Some need	Other:	
Other:			

Access to services			**Need for the following services**		
Service	**Wait time in Days (Average)**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		1-2 hr	Inpatient psychiatric services	No	
Long term state psychiatric hospitalization	7	About 1hr	Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Yes	4
Placement in a residential treatment facility		1-2 hr	Residential treatment programs	No	
Outpatient psychiatric services	7	.5 hr	Additional child and adolescent crisis psychiatric services	No	N/A
Day treatment services	0	N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Primary care physicians and Pediatricians

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Locum tenens CAPs and Nurse practitioners w/advanced cert. in child psychiatry

Top 7- County Name: New York City

Current Status			
Number of Outpatient Public CAPs (Telephone Survey):		**CAPS per Youth:**	
Practice in county	380*	Census population under 18 yrs[177]	1,943,923
Practice full time		CAPs per 100,000 youth	20
Practice part time			
Reside outside of the county		**Number of CAPs (AMA data):**	
Within 10 years of retirement		In 2005	423
Female		In 2006	531
White			
Black		**Family groups or associations that influence the provision of child and adolescent psychiatric services in our county is/are:** 37 family support programs in NYC	
Hispanic			
Asian			
Other			
Speakers of ESL			

Additional Secondary County Data			
Population[1]:		**Families:**	
Total	8,214,426	Families w/related children <18[178] yrs	897,856
Total Number of Females	3,914,597	Families w/children <18 yrs living in poverty[2]	266,616
Total Number of Males	4,299,829	Children and youth 0 to 17 yrs living below poverty[179]	579,570
Median Age	35.9	**Suicide Rates[3]:**	
Race[1]:		Suicide Morality 10-19 in 2001-03	20
White	3,604,789	Suicide Mortality Rate 10-19 in 2001-03	1.9
Black	2,062,095	Suicide Mortality 10-19 in 2003-05	24
American Indian and Alaskan Native	23,196	Suicide Mortality Rate 10-19 in 2003-05	2.3
Asian	963,295	**Density[2]**	
Native Hawaiian and Pacific Islander	2,270	Total Area per sq mile	54,556.00
Other	1,397,702	Population Density per sq mile	401.9
Disabilities[1]		Housing Density per sq mile of land area	162.6
Total population 5 to 15 yrs w/disability	1,195,337	**Economics[1]:**	
With a mental disability	50,040	Median Family Income	51,830
		Number unemployed	314,004

*NYC reports on 2006 AACAP data including both public and private CAPS

[177] U.S. Census Bureau; Census 2000 if < 65,000 & American Communities Survey 2006 if > 65,000
[178] U.S. Census Bureau; Census 2000
[179] Kids' Well-being indicator Clearinghouse Indicator Profile: Self-Inflicted Injuries

Need

Need for Outpatient Public CAPs and Impacts:		Need for services by Outpatient Public CAPS for:	
Number of additional CAPs needed		Inpatient psychiatry program	
Does this need significantly impact your county?		Crisis care	
Has there been a strain on other professions as a result of this shortage?		Residential treatment facilities	
Need for CAP services by population group:		Child day treatment program	
Preschool children (0-5 yrs)	Great need	Psychiatric assessment	
School age (6-12 yrs)		Medication consultation	
Adolescents (13-17 yrs)		Medication management	
Children w/special needs (developmental or physical)		Individual mental health counseling	
Adolescents w/special needs (developmental or physical)		Family therapy	
Children and adolescents in the child welfare system		Other:	
Other: Transitional aged youth 16-25 yr old and MH services in general	Great need		

Access to services			Need for the following services		
Service	**Wait time in Days**	**Drive time (if going outside the county)**	**Service**	**Needed Yes/no**	**# of Beds**
Inpatient psychiatric hospitalization		30 min to 1.5 hr	Additional Inpatient psychiatric services	Yes	
Long term state psychiatric hospitalization			Additional beds at your county's regional long term inpatient child and adolescent psychiatric facility	Don't Know	
Placement in a residential treatment facility		30 min - 2 hr	Additional Residential treatment programs	Don't Know	
Outpatient psychiatric services			Additional child and adolescent crisis psychiatric services	Yes	N/A
Day treatment services		N/A			

Professional groups responsible for prescribing and/or monitoring psychotropic medications for children and adolescents.

Psychiatry residents and CAP psychiatry fellows

Strategies, practitioners or trainings employed to supplement the child psychiatry workforce.

Tele-psychiatry, Nurse practitioners w/advanced cert. in child psychiatry, Developmental behavioral pediatricians, and Other: Learning collaborative that Dr LaRoth is doing out of MT Sinai to get Primary Care Peds to screen for MH disorders in the Tristate area and the hope is that they will eventually be able to treat as well. Quality improvement took place over a year.