

Meeting the Mental Health Needs of Ohio's Children



Creating an Action Plan to Increase Ohio's Child and Adolescent Psychiatry Services

A Report from the Ohio
Department of Mental
Health, Ohio Psychiatric
Association and the Ohio
Association of County
Behavioral Health
Authorities

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Executive Summary

“There is a dearth of child psychiatrists...”

- Mental Health: A Report of the Surgeon General (1999)

The 1999 report of the Surgeon General cited, “particularly keen shortages are found in the numbers of mental health professionals serving children and adolescents...”¹ The national average ratio of child and adolescent psychiatrists is proof. There are nearly seven child and adolescent psychiatrists for 100,000 youth nationally and the shortage has been documented repeatedly by the General Medical Education National Advisory Council since the first national effort to determine the need for medical specialists. Experts estimate that an average of 14 for 100,000 youth are needed.² Despite reports from the American Academy of Child and Adolescent Psychiatry and many governmental agencies, there have been no significant initiatives or improvements in the child and adolescent psychiatry workforce. Ohio had a ratio of four child and adolescent psychiatrists per 100,000 children and youth in 1990 and 5.71 in 2001.³ Ohio’s mental health boards estimate that they only have about half the number of child and adolescent psychiatrists needed in their systems.

The shortage of child and adolescent psychiatrists has been studied nationally by the American Academy of Child and Adolescent Psychiatry (AACAP). The 2001 report of the AACAP Task Force on Work Force Needs cited a number of factors that limit the workforce serving children and adolescents. Among these findings were:

- Medical students do not have sufficient knowledge of child and adolescent psychiatry;
- Roles, functions and opportunities for child and adolescent psychiatrists are not understood;
- Medical students and psychiatry residents are not sufficiently mentored;
- Training to become a child and adolescent psychiatrist takes more time, and therefore, leads to a greater indebtedness, than general medicine or other subspecialties;
- Child and adolescent psychiatry is one of the lower paying subspecialties; and
- Funding of residency training and limitations on reimbursement for clinical services.

The Ohio Psychiatric Association began studying the problem of recruitment and retention of child and adolescent psychiatrists in Ohio in 2000. The Ohio Department of Mental Health and the Ohio Association of County Behavioral Health Authorities also recognized the problem and joined with the Ohio Psychiatric Association in their study. The contents of Ohio’s study closely mirror the findings of AACAP’s national study on workforce needs.

What is a Child and Adolescent Psychiatrist?

Child and adolescent psychiatry has been an official subspecialty of psychiatry since 1959. To become a child and adolescent psychiatrist, an individual first earns a bachelor’s degree and then attends medical school to receive a medical degree. The individual then attends a residency-training program with three years in general psychiatry and an additional two-year fellowship in child and adolescent psychiatry for a total of nine years beyond college.

As a resident and fellow, the physician works in a hospital, clinic, or community setting under supervision on direct patient care. There are classroom lectures, much reading, and some research opportunities. At the end of training, the resident is board eligible in general psychiatry and child and adolescent psychiatry. The trainee must first pass the general psychiatry boards to become board certified in general psychiatry and then may take the subspecialty boards in child and adolescent psychiatry.

As a result, the Ohio Department of Mental Health will convene a broad-based workgroup of major stakeholders including representatives from the Ohio Department of Mental Health, the Ohio Association of County Behavioral Health Authorities, the Ohio Psychiatric Association, the regional councils of the American Academy of Child and Adolescent Psychiatry, family and consumer groups, and the Departments of Psychiatry at all Ohio medical schools. The group will be expected to provide a specific report to the ODMH Director and Medical Director within a specified period of time. They will address the contents of this report and provide recommendations on improving training and mentoring initiatives, access to services, financial incentives, recruitment and retention, job satisfaction, and practice enhancement initiatives.

This report and its recommendations are intended to raise awareness and initiate actions that will help improve children and youth's access to quality psychiatric care. This problem cannot be solved through the actions of any one person or organization. Successful solutions will involve partnerships between universities, government, advocacy agencies, mental health boards, mental health providers, physician groups, and consumers and families.

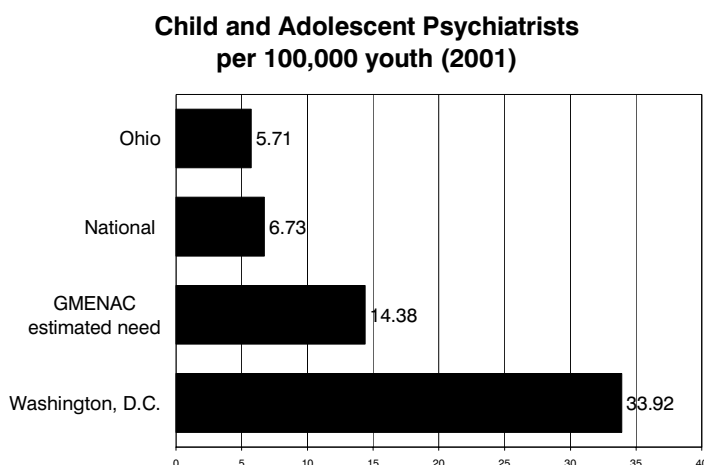
National Trends

Scope of Problem

A severe shortage of child and adolescent psychiatrists exists nationwide. This shortage is most severe in rural areas and for youth who live in poverty.

Currently, 6,300 children and adolescent psychiatrists are practicing in the United States. The Graduate Medical Education National Advisory Committee (GMENAC) estimates a need for 14.38 child psychiatrists per 100,000 youth. The rate of child and adolescent psychiatrists nationally is currently 7.5.⁴ Many child and adolescent psychiatrists also are involved in activities other than clinical care and many in clinical practice see adult patients as well, so the number actually available to see children is less than the 7.5 national rate.

Ohio's rate is 6.5 child and adolescent psychiatrists per 100,000 youth, according to data from the 2001 American Medical Association Physician Characteristics and Distribution in the United States. Ohio ranks 29th among the 50 states. Washington, D.C. has the highest rate of 33.92 child and adolescent psychiatrists per 100,000 youth. In addition to the District of Columbia, only five other states meet the Graduate Medical Education National Advisory Committee's estimate of 14.38 child psychiatrists needed per 100,000 youth; Connecticut, Hawaii, Maryland, Massachusetts and New York.⁵



Metropolitan counties mean rate of child and adolescent psychiatrists is 18 times the rate of child and adolescent psychiatrists in rural areas. A 2001 American Medical Association report shows that children living in poverty anywhere have similar access problems to child and adolescent psychiatrists as children in rural areas.⁶

Because child and adolescent psychiatrists are not readily available in many areas of the United States, many families turn to their family practitioner for diagnosis and treatment. A 2000 study on treatment services for attention-deficit hyperactivity disorder (ADHD) showed that family practitioners are more likely than either pediatricians or psychiatrists to prescribe stimulants and less likely to use diagnostic services, provide mental health counseling, or recommend follow-up care for ADHD.⁷

Recruiting Physicians into Child and Adolescent Psychiatry

Despite many reports and governmental agency findings exploring the shortage, there has been no significant improvement in the child and adolescent psychiatry workforce. To address the shortage of child and adolescent psychiatrists, recruitment efforts must be applied more vigorously.

Since 1990, the number of child and adolescent psychiatry residency training programs, decreased from 120 to 115. Twenty percent of U.S. medical schools do not have a child and adolescent psychiatry-training program. Thirty percent of U.S. medical students have minimal or no clinical clerkship experiences in child and adolescent psychiatry. These factors have had a significant impact on the recruitment and education of

future doctors. The number of child and adolescent psychiatry residents has decreased from 712 to 669.⁸

While the number of residents has decreased overall, the proportion of international medical graduates in child and adolescent psychiatry has increased from 20 percent in 1990 to 39.3 percent in 2000⁹. However, the recommendation by various governmental agencies that international medical graduates return to their home country after training will further reduce the child and adolescent psychiatry workforce. Additionally, anecdotal reports indicate that more frequent visa delays and denials have resulted in the loss of residency spots and problems for underserved areas that rely on international medical graduates.¹⁰

Further hindering recruitment efforts, child and adolescent psychiatry is one of the lower paying subspecialties, yet requires more training than general medicine or other subspecialties. The median income of recent child and adolescent psychiatrist graduates was between \$121,000 and \$150,000 for full-time workers. The mean income for all physicians in 1997 was \$164,000.¹¹ Child and adolescent psychiatry requires five years post-medical school training, while pediatrics and family medi-

“Recruitment is influenced strongly by perceived career opportunities, income potential, perceived job satisfaction and professional status. Having a respected mentor in the field also has been identified as key to career choice. Child and adolescent psychiatry is a relatively low-paying specialty, especially considering the time required for training. Additionally, psychiatry and child and adolescent psychiatry remain plagued by the stigma of mental illness and the perception of the work as ‘soft science.’ Enthusiastic, highly involved mentors in academic departments make a positive difference for recruitment.”

- AACAP Subcommittee
Report on Recruitment

Community Mental Health Training Experiences of Child and Adolescent Psychiatry Graduates

Lack of revenue from training programs or community placements has led many academic departments not to place trainees in community settings. Of child and adolescent psychiatry graduates surveyed, 58.5 percent had experience in this setting.

Residents felt the quality of their training was insufficient for their current real world practice.

Training was lacking in:

- administrative and leadership skills,
- medical economics,
- psychopharmacology,
- cognitive-behavioral therapy,
- family therapy,
- working with children with developmental disabilities,
- outpatient supervision,
- and working in community settings.

Source:
*Preparation for Practice: Child and Adolescent Psychiatry Graduates’
Assessment of Training Experiences
(between 1996-1998)
Stubbe, D.E. (2002)*

ine require three years. The greater indebtedness for child and adolescent psychiatry trainees, the national emphasis on primary care, and the relatively low earning potential for child and adolescent psychiatrists are factors that may influence medical students to not choose child and adolescent psychiatry as a specialty.

Funding for Child and Adolescent Psychiatry Training

Child and adolescent psychiatry training programs produce little revenue and it is becoming more and more difficult for medical schools to sustain them. Once trainees are recruited, funding their education is a daunting task.

In the 1990s, governmental agencies and the medical community projected a physician oversupply and recommended a decrease in the overall physician workforce by reducing the specialty workforce and decreasing the number of international medical graduates. The recommendations advocated increasing the primary care workforce.¹²

The Balanced Budget Act (BBA) of 1997 reduced funding for graduate medical education (GME). Graduate medical education is the specialty training that occurs after medical school to be a family practice doctor, a surgeon, a pediatrician, a psychiatrist, or other specialty. Much funding for graduate medical education came from Medicare, but the Balanced Budget Act drastically reduced the level of that funding. The Balanced Budget Act reduced direct funding by 50 percent for child and adolescent psychiatry training beyond the general psychiatry training. To offset the loss of these funds, medical schools rely more and more on clinical services generating revenue (50 percent today as opposed to 10 percent in 1970) to help pay for graduate medical education.¹³ Child and adolescent psychiatry training programs produce little revenue, making their viability more tenuous. For this reason, the Balanced Budget Act has affected child and adolescent psychiatry programs more than almost any other specialty area.

Ohio Trends

Scope of Problem

The number of practicing child and adolescent psychiatrists must increase more than two-fold to meet the needs of Ohio's youth.

Ohio had 4.37 children and adolescent psychiatrists per 100,000 youth for a total of 121 in 1990.¹⁴ Some improvement was seen in 2000, when the number of child and adolescent psychiatrists rose to 5.71 per 100,000 youth.¹⁵ However, this is still far from the Graduate Medical Education National Advisory Committee's estimate that 14.38 children and adolescent psychiatrists per 100,000 youth are needed. Counties in Ohio with greater poverty also have significantly fewer child psychiatrists per 100,000 youth than more affluent counties.

Ohio Mental Health Board Needs

ADAMH/CMH Boards report a need for more child and adolescent psychiatrists. They suggest more than doubling the number of child and adolescent psychiatrists, echoing the estimates suggested by GMENAC. The need is most evident in direct care service.

In a statewide survey, Boards identified the need for 97.9 additional FTEs in the state. The estimate of 97.9 additional FTEs would bring Ohio's number of child and adolescent psychiatrists to the number suggested by the Graduate Medical Education National Advisory Committee. An additional .88 FTEs are needed for psychiatric services to children birth to six.¹⁶

Boards suggested the rate of pay, the availability of psychiatrists trained in working with children, the location of the service delivery area, the availability of psychiatrists willing to work with children in the public sector and the availability of local child and adolescent inpatient units hinder the recruitment of child and adolescent psychiatrists by agencies.

Exposure to Child and Adolescent Psychiatry in Ohio Training

The amount of exposure to community psychiatry and child and adolescent psychiatry mentors varies with each program. Many medical students have little exposure to child and adolescent psychiatry.

In Ohio, five of the six medical schools have a child and adolescent psychiatry training program. The matrix on the next page is a summary of what medical students in Ohio learn about child and adolescent psychiatry as noted in a survey done by Patricia L. Goetz, M.D.¹⁷

Meeting the Mental Health Needs of Ohio's Children

School	First Year	Second Year	Third Year	Fourth Year
Medical College of Ohio	22 hours of lecture on child and adolescent psychiatry		All have four hours of lectures - 60 percent have three-week clerkship	Elective available through Public Psychiatry
Wright State University	Series of lectures on child development and two-week elective clerkship	Series of lectures on child development and two-week elective clerkship	One hour of lecture - 50 percent have three-week clerkship	One-month elective - is the most popular elective in psychiatry
University of Cincinnati	Series of lectures	Lectures on child and adolescent psychiatry	Series of lectures - three-week rotation in a variety of academic and community placements	Offers a number of electives
Ohio State University	No exposure		25 percent have a clerkship at a site working with children and adolescents	One-month elective
Case Western Reserve University/University Hospitals	Elective time offered during the academic year or opportunity to complete elective during the summer between the first and second year	10 hours of lectures on child development and on psychiatric problems in children and adolescents	Five-day sampler while on psychiatry rotation, in an inpatient setting, day treatment setting and in community outpatient setting	One-month elective that is a clinical placement
NEOUCOM	Three hours of lectures and three hour introduction to psychiatry taught by a child and adolescent psychiatrist		Two-week rotation on a child psychiatry inpatient unit for 25 percent of the third-year medical students	Lecture elective on Human Values with four hours devoted to children's issues and electives are available in community child mental health clinics and child inpatient psychiatry units

Note: a clerkship is a placement in a clinical setting with supervision and teaching by child and adolescent psychiatrists and other mental health professionals who specialize in working with children.

Training Child and Adolescent Psychiatrists in Ohio

Six sites in the state of Ohio offer child and adolescent training: University of Cincinnati, Wright State University, The Ohio State University, Medical College of Ohio (Toledo), the Cleveland Clinic, and Case Western Reserve University (University Hospitals). The Ohio Psychiatric Association Child and Adolescent Committee designed a survey of the programs, which produced the following results in 2001¹⁸:

Recruiting Child and Adolescent Psychiatry Fellows

- Of the programs polled, 85 percent of the positions offered over the past five years were filled.
- Sixty percent of these positions were filled with the current fellow from within their general residency program.
- One of the six programs had cut fellowship positions, four indicated no change in the number of positions, and one program had expanded its program over the past five years.

Funding of Training

- The source of funding most often identified for the six programs was the teaching hospital affiliated with the university. Two of the programs indicated that the university hospital was the sole source of funding. The four other programs indicated mixed sources of funding. Examples of diverse sources of funding for faculty positions were the U.S. Air Force, a special endowment fund, affiliated teaching hospitals, and drug studies.
- Five of the six programs reported no increase in service requirement of the fellows despite funding problems.
- Several programs reported changes due to financial pressure.
- One program cited less contact with core faculty members because of their involvement with service requirements at multiple sites and increased productivity requirements.
- Three of the six child and adolescent psychiatry programs had increased the number of faculty over the past five years while the other three lost faculty, including psychiatrists and other mental health professionals who taught.

Community Psychiatry Training

The training directors or division chairpersons of each of the six child and adolescent psychiatry training programs were questioned about training available in community settings for the year 1999-2000. In spite of funding limitations, supervision by a child and adolescent psychiatrist who knows the setting is available at most sites. Different programs have worked out varied methods of funding the fellow and the supervisor, but this remains a great limitation.

- All of the six programs train child and adolescent psychiatry residents in the community. Some have brief rotations through various settings. Two programs out of the six have ongoing training in one community setting, and four have training in more than one such setting.

Success in building Ohio's workforce

In June 2001, 47 percent of child and adolescent psychiatry graduates went to work in a community setting. Seventeen fellows graduated from the six fellowship programs, of which more than half stayed in Ohio. Five graduated fellows took part-time positions working in community child and psychiatry positions. Two began work in rural areas of Ohio. Seven fellows went out of state, with only three of those individuals obtaining a position in community psychiatry.

- Fellows are located at a single community setting between half days every other week up to four half days per week in some programs.
- The supervision varies with the community placement. In some locations it is by onsite child psychiatry faculty, well-trained social workers and psychologists who work at the site or child and adolescent psychiatry faculty who go out to the site with the fellow or by faculty at the university who do not go out to the site with the fellow. The supervision at the maximum is one hour out of every four hours of clinical work and at a minimum on an “as needed basis.”
- In two programs, the funding of the fellows in the community site is by the university or hospital where the child and adolescent psychiatry program is based. In five programs, it is by the community setting (this may include ADAMH Board funds).
- Supervisors are paid by the university or hospital where the fellowship is based in three of the programs, by the community setting in six of the programs, or by the ODMH Public Psychiatry Professorship in one program.
- The programs must preserve the time needed for the fellow to serve the needs at the university setting first.
- To sustain the child and adolescent psychiatry-training program, the university requires the community setting to pay for the resident and the supervisor. Since Medicaid funding for non-licensed residents at mental health centers is not allowed, the community setting, which is predominantly Medicaid, would have no way to generate revenue for the residents work.
- Some community settings require large caseloads that prevent adequate supervision, and prevent adequate models for learning.

Factors Impacting Recruitment and Retention in the Community Setting

Salary

Salary varies from region to region. A May 2002 survey showed total compensation by specialty for psychiatry to range from a low of \$125,000 to a high of \$250,000, with average total compensation at \$160,000.¹⁹ A survey of graduating residents and fellows in New York and California shows a median starting income for child and adolescent psychiatrists of \$140,000 in 2002.²⁰ A survey by Stubbe and Thomas correlated the current pay level with educational debt. The average educational debt was \$69,000 and the median income of those surveyed was between \$91,000 and \$150,000. Respondents with the most cumbersome debt level sought higher paying positions.²¹ Compensation of Ohio child and adolescent psychiatrists has yet to be studied.

Job Description

Child and adolescent psychiatrists are highly trained in the biopsychosocial model with many different treatment approaches. However, the critical need for assessments and medication management has many child and adolescent psychiatrists doing only this. Child and adolescent psychiatrists, once out in the world, treated 61 percent of patients with medications only, treated 30 percent of patients with medications and therapy, and treated nine percent of patients with therapy alone.²²

Job Satisfaction and Retention

In a national survey of early career child psychiatrists (finishing training in 1996, 1997 and 1998), most were very happy overall with their careers. The positives most cited were the clinical work with children and families, the ability to provide a full range of therapeutic services (psychotherapy and psychopharmacology), variety, autonomy, flexibility, and a lifestyle that accommodated career and family. The frustrating aspects were dealing with insurance companies, too much paperwork, and the lack of resources to provide the full range of services for children and their families. Twenty-one percent of the total workforce hours reported were spent in public mental health, while 44 percent of the sample reported doing some work in public mental health.²³ These children are generally the most disturbed or difficult diagnostically in the system. The productivity demands are high and collaborating with others on the treatment team is seen as non-revenue producing and is discouraged.

Job Satisfaction and Retention in Ohio

One Ohio child and adolescent psychiatrist reported leaving the public mental health setting because the child and adolescent psychiatrist is not involved in team meetings and psychotherapy, but is delegated to prescribe medications only and having huge case loads. Some child and adolescent psychiatrists feel they cannot provide the high quality of services patients deserve because of the large volume of patients to be seen. They cite barriers in collaborating with Advanced Practice Nurses, pediatricians and other professionals, and lack of telemedicine and proper case management to alleviate access problems.

Collaboration with Child and Adolescent Training Programs

Successful collaborative efforts between state and local partners would encourage more child and adolescent psychiatrists to choose to practice in community settings. Involvement from all levels of the system, including mental health boards, agencies, educational institutions, advocacy groups and others, is needed to increase the number of child and adolescent psychiatrists working in the public mental health system.

ODMH has a long-standing, legislature-funded incentive for universities to influence the training of students in mental health professional training programs, including psychiatric residents, psychology students, graduate-level nurses and social workers to serve adults and children who seek services through Ohio's public mental health system. This approach measures success of a program by how many graduates take employment in Ohio's public/community mental health system. The successful recruitment and retention of professionals to work in public mental health is closely linked to training experiences in community mental health settings. Currently, two Ohio schools are interested in developing new community child and adolescent psychiatry training initiatives in fellowship programs.

One University's experience

University programs hinge on nurturing by the university during their infancy and a critical mass of skill and motivation in the public system. Wright State University (WSU), which is not a "university hospital" setting, has a successful community training program due to support from and collaboration with the U.S. Air Force and because all training sites are community sites. The Psychiatry Department has been heavily involved with the community in developing resources that the residents find desirable. Graduates of WSU's program tend to stay in the Dayton area after graduation.²⁴

Increasing Access to Mental Health Services

Access to mental health services could improve through utilizing practice enhancement initiatives. An increased child and adolescent psychiatry workforce could be achieved through collaboration with pediatricians, family practitioners, general psychiatrists and advance practice nurses.

Increasing pediatricians' and family practitioners' ability to recognize and appropriately treat mental health problems could also increase access to care for children and adolescents. The President's New Freedom Commission on Mental Health reported that, "While mental health and physical health are clearly connected, a chasm exists between the mental health care and general health care systems in financing and practice. Primary care providers may lack the necessary time, training, or resources to provide appropriate treatment for mental health problems."²⁵

General psychiatrists who have significant training in child and adolescent psychiatry may also be an under utilized resource to expand services for child and adolescent patients and their families.

In some areas, access to psychiatric services has increased through collaboration with Advance Practice Psychiatric Mental Health Nurses (APRN PMH nurses). An APRN PMH nurse is a registered nurse who has completed graduate education (Masters or Doctorate) in Psychiatric Mental Health nursing and has been certified as an APRN by a national body as an expert clinician in the specialty. Some may also have completed additional education regarding pharmacology as well as supervised experiences in pharmacologic prescribing practices and under Ohio law need to have a collaborative agreement with a psychiatrist in order to prescribe medications. The Ohio Southern Consortium for Children and the Akron Child Guidance Center are examples of organizations that have improved access to psychiatric services through the use of APRNs.

Action Steps for Meeting Mental Health Needs Through Increased Child and Adolescent Psychiatry Services

A dearth of child and adolescent psychiatrists is not unique to Ohio; the recruitment and retention of child and adolescent psychiatrists is problematic on a national level. This report recommends the following focus areas for Ohio:

- Addressing recruitment and retention of child and adolescent psychiatrists;
- Exploring funding initiatives to increase the number of mental health professionals serving children and adolescents;
- Improving training and mentoring initiatives; and
- Utilizing other professionals within the mental health and physical health systems.

Recommended Action Steps

Convene workgroups of key stakeholders

- The Ohio Department of Mental Health shall meet with the university professors of psychiatry and the training directors for child and adolescent psychiatry to discuss the needs of Ohio training programs and their role in increasing the number of child and adolescent psychiatrists.
- The Department will establish a broad-based workgroup of major stakeholders including representatives from the Ohio Department of Mental Health, the Ohio Association of County Behavioral Health Authorities, the Ohio Psychiatric Association, the regional councils of the American Academy of Child and Adolescent Psychiatry, family and consumer groups, and the Departments of Psychiatry at all Ohio medical schools. The workgroup should have assigned leadership and a long-term commitment to address the problem. The group will be expected to provide a specific report to the ODMH Director and Medical Director within a specified period of time.

Suggested workgroup focus areas

- Recruitment and Retention enhancements:
 - Recruitment activity enhancements at state and local levels;
 - Peer support and mentorship opportunities;
 - Consultation and liaison with primary care and other caregivers; and
 - Teleconferencing in rural and underserved areas.
- Funding enhancements:
 - Improved state, local and foundation support for community-focused child and adolescent psychiatry programs; and
 - Loan repayment opportunities.
- Practice enhancements:
 - Agency support for child and adolescent psychiatry participation in non-clinical areas (quality improvement, team participation, training); and
 - Coordination with other professionals within local mental health and physical health systems

Work initiatives that may be considered by the group for moving toward increasing Ohio's child and adolescent psychiatry workforce are included in Appendix A of this publication.

Appendix A: Work Initiatives Suggested by the Study Group

Provide Financial Investment and Incentives

Ohio Department of Mental Health

- Provide financial support directly to University Medical Schools to develop or enhance child and adolescent public psychiatry programs in a current or new fellowship program.
- Provide loan repayment programs for child and adolescent psychiatrists who work in underserved areas or who choose to be employed by ODMH working in community support network programs.
- Conduct a survey of Ohio child and adolescent psychiatrists to get an understanding of job satisfaction and to determine why they leave public sector psychiatry and what efforts could increase retention.

Ohio Department of Mental Health and other State Agencies

- ODMH shall explore, with other state agencies, opportunities to increase the supply of Child and Adolescent Psychiatrists in Ohio through an integrated, multi-department budget approach.

Mental Health Boards

- Provide loan repayment programs for child and adolescent psychiatrists who work in the board area.
- Provide stipends to do non-revenue generating projects (consultation to schools, consultation to early childhood teams, teaching pediatricians, working on a research project, participating in and monitoring a medication algorithm project, etc.).

Agencies

- Provide time to be involved in agency projects such as quality improvement, team meetings, training, and evidence-based psychotherapy projects.
- Provide incentives such as paying the hourly rate for travel time if the child and adolescent psychiatrist lives in a city that is a substantial distance from the agency.
- Provide the opportunity for the child and adolescent psychiatrist to be an employee who receives a paycheck they can count on and benefits such as vacation, malpractice insurance, etc.

Improve Training and Mentoring Initiatives

Ohio Department of Mental Health

- Provide child and adolescent psychiatrists with special training opportunities in System of Care activities and/or evidence-based practices through opportunities with Coordinating Centers of Excellence (CCOEs).
- Help recruit child and adolescent psychiatrists nationally through Web sites, newspaper ads and visits to national meetings.
- Create a Web site similar to the AACAP mentoring Web site, but tailor the communication to Ohio child and adolescent psychiatry residents and Ohio child and adolescent psychiatrists in public psychiatry serving as Web site mentors.

ODMH and Universities

- Support Public Professors of Child and Adolescent Psychiatry through the Public Academic Liaison (PAL) model. Requirements include a core curriculum in public child and adolescent psychiatry; establishing professorship in the department and community setting; providing core training in community child and adolescent psychiatry for all child and adolescent psychiatry fellows and for general psychiatry residents when possible; and measuring outcomes of efforts to increase the number of child and adolescent psy-

chiatry fellows working in the community setting.

ODMH, Ohio Psychiatric Association, and Ohio AACAP members

- Develop a peer support program for new child and adolescent psychiatrists working in the community on how to work effectively in the public system. This could be achieved through a Web site, special sections for this group at state meetings, and developing a video conference series.

Ohio Psychiatric Association, Ohio AACAP members and Universities

- Develop a structured mentorship/internship program with child and adolescent psychiatry residents coming to public sector settings. These groups would put together lists of their members working in the public sector, when they are there, and when residents could join them for a day or afternoon. This could range from a one-time visit to an elective.

Ohio Psychiatric Association, AACAP and Universities

- Provide medical students and psychiatry residents with more classroom training opportunities about community-based child and adolescent psychiatry. The lectures should be given by those actually working in the community. These groups would agree on the number of lectures and develop a list of topics and appropriate community-based child and adolescent psychiatrists to give the lectures.

Utilize Practice Enhancement Initiatives

ODMH, Ohio Psychiatric Association and Mental Health Boards

- Promote the development of consultation to primary care physicians by child and adolescent psychiatrists. Primary care physicians currently play a key role in the delivery of medication evaluation and management services to children and adolescents. The provision of this consultation will improve the practice of primary care physicians and increase the number of children and adolescents who are provided with needed services. ODMH and mental health boards could provide resources for projects such as ADHD medication algorithms, teleconferences, etc.

ODMH and Ohio Nurses Association

- Promote the development and employment of advance practice nurses working as extenders for child and adolescent psychiatrists. These groups would work together to develop education programs about this practice type at state meetings, recruit child and adolescent psychiatrists currently associated with an advanced practice nurse to tell about their experience on Web sites or at state and local meetings, and develop lists of areas where child and adolescent psychiatrists would be interested in an advanced practice nurse joining their agency.

ODMH and Universities

- Use Residency and Training program monies to increase educational access for nurses to complete their graduate degree in psychiatric mental health nursing for children and adolescents.
- Increase access to online educational opportunities to increase overall skill levels of nurses and move them toward the more formal educational approaches within academic settings.

ODMH

- Provide for the use of telemedicine among child and adolescent psychiatrists, especially in rural areas.

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