New York City Mental Health Workforce I: Proceedings

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Summary of the Summit on the New York City Mental Health Workforce Held May 25, 2016

Co-sponsored by

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I. Introduction

New York City's mental health system faces deep challenges. Approximately one in five city residents will experience a mental illness in a given year, but many do not seek the help they need.[1] Mental illness imposes pain and suffering on individuals and families, diminishes personal and population health, and burdens our economy and health care and social services systems. Growing evidence links mental health problems to other major health problems. For example, depression and anxiety are associated with chronic diseases such as diabetes and heart disease.[2,3]

Yet too many New Yorkers report not getting access to the care that they need.[1] In addition, the kinds of approaches that should be part of a public health response appropriately matched to meet these daunting needs require new skills and roles for the workforce. That public health response and a commitment to implement it led the City of New York to launch ThriveNYC: A Mental Health Roadmap for All in November 2015, headed by the First Lady of New York City Chirlane McCray with the implementation overseen by the Deputy Mayor for Strategic Policy Initiatives Richard Buery.[1] This ambitious and comprehensive plan and its initiatives represented a "new commitment about thinking big and thinking differently" about mental health.

Taking on a public health approach and scaling up more accessible approaches to mental health care will need an adequately sized, trained and supported workforce. **Feedback groups across the city and across a wide range of constituencies, including providers, identified a gap between needs, vision and the current state of the mental health workforce.** City government alone cannot overcome these challenges. Consequently, ThriveNYC convened a Mental Health Workforce Summit to bring together the many interests and institutions that drive workforce policy and innovation as a first step to accelerating these changes.

ThriveNYC Workforce Summit

On May 25, 2016, in order to develop specific plans to create the mental health workforce that would be needed to implement ThriveNYC's vision, the City University of New York (CUNY) Graduate School of Public Health and Health Policy, the New York City Department of Health and Mental Hygiene (DOHMH) and the First Lady of New York City, Chirlane McCray, convened the **New York City Mental Health Workforce Summit**. The event brought together a diverse, multi-sectoral group of policy makers, mental health professionals, academics, unions, advocates and others to identify issues and make recommendations designed to advance needed change to New York City's mental health workforce.

> *"I still remember when people were afraid to say "breast" and "cancer" out loud…when that disease was only discussed between sisters and girlfriends in stolen whispers. Thankfully, that has changed. It's time to do the same when it comes to treating mental illness and promoting mental health. The work won't be easy or fast. But if we follow the guideposts laid out in the Roadmap, we can create a city where it's as easy to get help for anxiety as it is to get a flu shot—a city where every New Yorker can live with dignity."*
>
> *— First Lady Chirlane McCray, Speaker at the Summit*

The Workforce Summit Planning Committee created four work groups designed to address workforce related needs identified in the *ThriveNYC: A Roadmap for Mental Health for All* report. The Planning Committee identified four broad goals and designated one work group per goal. This report summarizes the work group recommendations. The four work group areas were:

1. Diversify and expand the mental health workforce in New York City
2. Enhance professional training programs to advance skills needed for a public health approach to mental health
3. Create better pipelines and career ladders for peers and community health workers

4. Develop metrics and data for monitoring and improving the mental health workforce in New York City

Dean Ayman El-Mohandes of the City University of New York Graduate School of Public Health and Health Policy and Executive Deputy Commissioner Gary Belkin from the New York City Department of Health and Mental Hygiene framed the agenda for the day, and Chirlane McCray, First Lady of New York City, and Richard Buery, Deputy Mayor for Strategic Policy Initiatives, provided the Summit Introduction.

At the Summit's outset, expert panels provided an overview of national, state and local mental health workforce issues. The panelists recommended that the work groups apply the following framework when developing their recommendations:

- Use a "systems" approach that considers the interactions among educational institutions, service providers, third-party payers and government.
- Connect the education of mental health and substance use professionals with the task of rebuilding a behavioral health system that meets the needs of New York City's population.
- Recruit mental health and substance use professionals from the communities that are under-served by our system, including, but not limited to, Black, Latino, recent immigrant and LGBT communities.
- Enhance providers' ability to serve people from different cultures and backgrounds.
- Better integrate community-based organizations, non-professionals, community members and family members as mental health and substance use providers and workforce educators.
- Recognize the contributions that each type of mental health worker—from peers and community health workers to nurses, social workers, counselors, psychologists and psychiatrists—can make in training and residency programs and supervision models that prepare staff to effectively work together in interdisciplinary teams.

With this framework in mind, Summit participants developed recommendations for each of the four work group areas. Before these are described, let us first look at the current state of New York City's mental health workforce.

II. Overview of New York City's Mental Health Workforce

In New York State, the licensed mental health workforce includes mental health counselors, marriage and family therapists, creative arts therapists, psychologists, licensed clinical social workers, licensed master social workers, nurse practitioners, psychiatrists, psychoanalysts and physician assistants.[4,5]

New York City is home to 44% of the state population and to about 44% of all licensed mental health professionals in the state. However, this seemingly equitable distribution of mental health professionals masks two realities. First, the distribution of some licensed mental health professionals, as shown in Table 1, differs between the state and the city.

While the percent of the state's social workers and psychologists practicing in New York City are approximately the same as the percent working throughout the state, psychiatrists, marriage and family therapists and psychoanalysts are over-represented in New York City. On the other hand, psychiatric nurse practitioners and mental health counselors are underrepresented in the city compared to the state as a whole: they are professionals who can help drive the expansion of needed approaches to integrated care and improved access, yet they are less likely to accept health insurance for their services than those practicing in other places, reducing access for those unable to pay out of pocket.[6]

Table 1 compares the number of licensed mental health professionals in specified job categories in New York State in column 1 and New York City in column 3. Column 2 shows the percent of the total New York State mental health workforce in this profession, and column 4 shows the percent of professionals located in New York City. These comparisons do not take into account possible differences in need for mental health services between residents of New York City and other residents of New York State.

Table 1. New York State (NYS) and New York City (NYC) Licensed Mental Health (MH) Workforce by Profession in 2014[a]

Profession	Numbers by Profession, NYS	% of Total NYS MH Workforce	Numbers by Profession, NYC	% of NYC MH Workforce
Licensed Master Social Workers	25,086	32.8%	11,180	33.3%
Licensed Clinical Social Workers	24,727	32.4%	10,269	30.7%
Psychologists	10,732	14.0%	4,979	14.9%
Psychiatrists	6,578	8.6%	3,691	11.0%
Mental Health Counseling	5,081	6.7%	1,608	4.8%
Nurse Practitioners–Psychiatry[b]	1,292	1.7%	288	<1.0%
Other[c]	2,889	3.8%	1,488	4.4%
Total	76,385	100%	33,503	100%

a Sources: Table adapted from New York State Office of Mental Health5 data from New York Education Department, Office of the Professions (2014); Data for psychiatrists is from the American Board of Psychiatry and Neurology, Inc. (ABPN), and reflects board certification.[7] All other data were provided by the Office of the Professions at the New York State Education Department. Licensure address may be practice or home address. Not all who are licensed may be practicing.

b Note: Excludes all mental health nurses except nurse practitioners.

c Note: Because of their smaller numbers, marriage and family therapists, psychoanalysts and creative arts therapists are combined in the "Other" category.

The city's licensed mental health workforce consists of 33,503 professionals, yielding a ratio of 40 professionals per 10,000 population, about the same as the state ratio of 39 per 10,000. An examination of the distribution of mental health professionals by borough, however, shows significant variation. New York County (Manhattan) has the highest ratio, with 98 professionals per 10,000 population, while the Bronx has the lowest ratio, with 20 professionals per 10,000 population. Although the state reports that provide these data do not distinguish between a professional's borough of residence and place of work, making interpretation of this skewed distribution more difficult, it seems reasonable to conclude that more mental health professionals are available in Manhattan than in the other four boroughs, where the ratios range from 20 to 30 professionals per 10,000 population.

This overview raises more questions than it answers about the impact of the workforce composition to provide the right foundation for setting goals, closing gaps and innovating design of treatment and access. As such, it underscores the need for better data in order to improve access and align our workforce to meet needs, and reach across our city equitably.

Data on selected mental health professions within New York State also indicate that the aggregate racial and ethnic background of these professionals may not be similar to the overall racial and ethnic composition of New York City. Table 2 shows select mental health professions in the state by race and ethnicity compared to the total population of New York City. Compared to the New York City population, Latino and Asian individuals are under-represented in three major categories of licensed mental health professionals in the state as a whole; Black/African American individuals are under-represented in the field of psychology, but not among social workers and counselors; and white individuals are over-represented in all three disciplines. Because evidence suggests that mental health professionals who match the race/ethnicity of their patients are more likely to practice in under-served communities,[8] these data point to the need to diversify the city and state mental health workforce. Data are not available for other relevant professional characteristics, such as immigration, disability, sexual orientation or gender identity.

New York City is fortunate to have a large, skilled mental health workforce. However, in all of our feedback groups, participants voiced concerns that the city's workforce does not fully reflect the population it serves.[9] Lack of optimal diversity in the workforce may contribute to health disparities through provider biases, and it may exacerbate barriers to care for various racial and ethnic groups.[10] Health professionals from these groups are more likely than other health professionals to serve people of color, which may improve patient-provider relationships. Diversity programs have improved inclusion of underrepresented racial and ethnic groups within the healthcare workforce in recent years, but the workforce still does not reflect the population of the United States (U.S.) or the city. A critical component of advancing health equity is to have a mental health workforce that mirrors the population it serves.[11]

Table 2. Select Licensed Mental Health Professions in New York by Race and Ethnicity[a]

Occupation	Hispanic	Non-Hispanic				
		White	African American	Alaska Native & American Indian	Asian	Other
Counselors	13.8%	53.6%	27.2%	0.5%	2.8%	2.1%
Social Workers	14.0%	53.7%	28.0%	0.2%	2.7%	1.5%
Psychologists	6.1%	84.2%	5.3%	0.0%	3.4%	0.9%
Total NYC Population12	28.9%	33.5%	23.2%		14.1%	

[a] *Sources: Center for Health Workforce Studies, School of Public Health, SUNY Albany and American Community Survey, 2010-2014*

Finally, Table 3 shows the age distribution of New York City's mental health professionals as derived from the 2014 New York State Office of Mental Health report.[5] For three categories of professions — licensed clinical social workers, psychologists and "other" — about two in five licensed professionals are of retirement age, defined as 62 or older. For licensed master social workers, mental health counselors and the combined category of psychiatric nurse practitioners and psychiatrists, the proportion nearing retirement age is smaller. These data point to the importance of recruiting mental health professionals in New York City in order to replace retiring workers.

The New York City mental health workforce also includes unlicensed workers such as community health workers, peer specialists, advocates and other emerging job titles. Analysts agree that these staff also play critical roles in modernizing the workforce. The limited data on this portion of the workforce creates challenges in using them well.

Table 3. Select Licensed Mental Health Professions in New York City by Age[a]

Age Group	LCSW N=10221	LMSW N=11134	Mental Health Counseling N=1604	Nurse Practitioners/ Psychiatry N=288	Psychologists N=4927	Other N=1462
<40	16.0%	49.9%	28.8%	24.0%	19.4%	23.9%
>50	66.7%	31.3%	53.1%	55.9%	61.5%	59.8%
Retirement Age (62+)	40.4%	13.5%	28.1%	27.4%	38.8%	40.6%

a Source: Table from New York State Office of Mental Health 2014 Mental Health Workforce Overview

Note: LCSW (licensed as Clinical Social Worker) and LMSW (Licensed Master Social Worker)

As we will also see in later sections, how mental health training programs recruit, graduate and support licensure of their students influences both the size and diversity of the mental health workforce. For example, from 2005-06 through 2012-13, only 65% of the graduates from Hunter College's social work programs and only 56% of the graduates from Lehman's Master of Social Work (MSW) program were ever licensed as MSWs in New York State.[13] Far fewer were licensed as Clinical Social Workers (LCSWs). Further, there are significant ethnic disparities in licensure rates among CUNY MSW graduates.

Together, these data suggest (a) variability in the distribution of licensed mental health professionals across New York City boroughs, and lack of robust data or agreement about what roles, skills and geographic distribution are needed, (b) an under-representation of ethnic minority professionals relative to New York City's population, (c) an aging workforce that may not be keeping up with increasing need, (d) challenges in retaining professionals from enrollment through graduation to licensure and (e) a need for better data to analyze these issues.

These data also highlight some of the gaps in NYC's mental health workforce that must be addressed in order to achieve a truly integrated, diverse and accessible mental health care system for all New Yorkers. The following section describes the Summit's four priority areas, the identified problems that work group participants therefore focused on and their recommendations for action steps moving forward.

III. Summit Work Groups — Goals and Recommendations

The Workforce Summit Planning Committee assigned participants to one of four work groups based on their individual expertise. Each work group also had assigned co-chairs who facilitated the discussion and documented the collective ideas and recommendations of the group. The priority areas and their associated key problems are described below, along with the final recommendations of each group.

Work Group 1. Diversify and Expand the Mental Health Workforce in New York City

Co-Chairs: Margaret Reilly and Nicholas Freudenberg

The Problem: Meeting mental health care needs of New Yorkers requires a workforce that matches the diversity, languages and life experience of all New Yorkers. This challenges how we attract, train, graduate and license all professional disciplines that contribute to this work.

Recommendations: Focusing on social workers and psychologists, Work Group 1 considered the following strategies to expand and retain a diverse workforce: more consistent mentoring, financial support, career coaching, positive work environment, better pay scales and advancement opportunities.

Work group participants identified a variety of approaches to move towards this goal:

Educational institutions:

1. Promote competency development and reward excellence in acquiring the skills needed to be effective mental health professionals.
2. Engage and support the concerns of students and their future clients, including the mental health effects of poverty and racism.
3. Hire faculty that reflect the diversity we wish to see in students.
4. Create and grow field placements that reflect the diversity of our communities and that address unmet needs to better serve New York City.
5. Make nursing, social work and psychology preparation courses for licensure examination free and easily accessible to facilitate career advancement.

Policy makers and professional organizations:

1. Develop flexible scope of practice rules so that service providers can collaborate more effectively to meet patient needs.
2. Expand educational loan forgiveness programs for those who practice in under-served settings.
3. Create scholarship programs that provide an annual stipend for students in mental health professions who pledge to work for under-served communities.

Service providers:

1. Reward professionals who have under-represented skills (e.g., bilingual skills, expertise in child mental health or geriatric mental health) with pay incentives.
2. Create work environments that encourage entry-level staff to share concerns with organizational leaders and support quality improvement and change management efforts.

All

1. Create in-person and virtual networking opportunities that support recent graduates and working professionals making key transitions (e.g., from academic training to employment to career advancement).

Work Group 2: Enhance Existing Mental Health Professional Training Programs

Co-Chairs: Melissa Arbuckle and Eileen Sullivan-Marx

The Problem: Training programs for specialized mental health clinicians are not adequately preparing professionals to adapt to the evolving roles and settings that support accessible, cost-effective and/or population-based approaches to mental health treatment and promotion. Such approaches include integrated models of behavioral health in primary care. Physicians, nurses, nurse practitioners, social workers and physician assistants need specific training to work in flexible, team-based and integrated and community-based settings.

For example, a specific evidence-based integrated model of care called the Collaborative Care Model has enormous potential for improving access to mental health care for New Yorkers.[14] The model places health care workers in primary care settings, with the supervision and guidance of psychiatrists or psychiatric nurse practitioners; yet, nurses and psychiatrists are not commonly being trained in this model. These professionals also tend to get little training in using prevention and promotion methods or in leading interdisciplinary teams.

Recommendations: Work Group 2 convened leaders of psychiatry and medical residency training programs, physician assistant programs and nursing programs, as well as health care providers, insurance payers and national professional and accreditation organizations with interest in medical and nursing education. The work group focused on enhancing training programs so that the future workforce is better able to meet the needs of all New Yorkers

Participants first identified key skills and competencies necessary for advancing a community-focused mental health system. These include:

- Ability to practice in the Collaborative Care model
- Use of structured tools and pathways for screening, assessment and ongoing management and outcome measures for mental illness, including substance use disorders
- Reliance on evidence-based treatments for common conditions
- Specific knowledge of engagement and motivational interviewing methods
- Ability to assume cross-disciplinary and collaborative leadership, participation and facilitation roles
- Supervision and coaching of non-clinical professionals to support task-shifting
- Knowledge and use of trauma-informed principles and methods of care
- Ability to assess how social determinants of health may affect patient adherence to treatment
- Experience in health promotion and prevention in non-health care settings such as community based organizations and schools

Work Group 2 considered several mechanisms for change such as revised nursing and advanced practice nursing curriculum, medical and psychiatry residency training tracks or rotations and physician assistant specialization tracks across New York City programs. They also reviewed examples of efforts to develop standardized approaches and expectations across the city's psychiatry, nursing and other medical trainees. There was also interest in a shared nursing, psychiatry and medicine residency training experience. This cross-disciplinary training could assist with team-based practice changes.

Another recommended approach involved supporting community-facing roles by developing a geographic cluster in which nurse, psychiatry and medicine trainees work and learn as a team and be mentored in "community systems support" roles. Such roles would involve coaching and collaborating with other "lay" or non-specialized workers or community members in the skills they can use to lead projects that strengthen social ties and promote mental health in their communities.

The work group therefore proposed the following action items:

1. Create *Community Systems Support Training* in which students, medical residents and other trainees (e.g., interns) from multiple disciplines receive mentoring to enhance their understanding and practice.
2. Establish an *Inter-professional Mental Health Training Coalition* in which mental health training directors and school leaders develop training opportunities for shared learning experiences, new curricula, etc., that meet across different disciplines.

3. Convene a *Physician Training Learning Group* to establish standard new training experiences for medicine and psychiatry. A steering committee of New York City training directors would meet regularly to form this group and guide this effort.

4. Adopt standardized measures of provider burnout for systems leadership (e.g., through periodic surveys, and include self-care and burnout prevention as part of school curricula.

Work Group 3: Create Better Pipelines and Career Ladders for Peer and Community Health Workers

Co-Chairs: Wendy Brennan, Daliah Heller and Jody Silver

The Problem: The increased need for task-shifting and non-specialized licensed worker roles highlights more opportunities for peer workers and community health workers. Interest in these roles has also been spurred by the Delivery System Reform Incentive Payment (DSRIP) program, which promotes community-level collaborations and system reform.

However, there is no consistent set of competencies, trainings or career development opportunities for individuals in these roles. Policy makers, practitioners and insurers disagree about how these roles and their basic competencies differ or overlap, how to pay for and value their work and what is needed for these positions to be scalable and reimbursable. These uncertainties could impede the use of these roles in behavioral health care. There is also concern about how to preserve the social model upon which these roles are based as they are integrated into the health care structure and how to provide career ladders for those who serve in these positions.

Work Group 3 focused on challenges facing the following roles:

1. *Community Mental Health Workers* are community members who can provide a range of assistance and counseling methods tailored to meet the needs of their communities. This approach has been shown to be efficacious for treating depression in under-resourced settings.[15]

2. *Peer Bridgers* are trained staff who help people with severe mental illness and co-occurring mental health and substance use issues to transition into community-based care. This model promotes wellness and self-management skills.[16]

3. *Peer Wellness Coaches* help improve the wellness of people with serious mental disorders. Working peers receive intensive training to work with patients experiencing chronic physical health conditions, to help patients identify specific physical wellness goals and to coach and support them through the steps needed to achieve their goals.[17]

4. The *Family-to-Family* course provides peer-led psycho-education to family members with an adult loved one who has a serious mental illness. The course has been shown to improve knowledge of mental illness and enhance coping and empowerment and it has been included in the national registry of evidence-based practices.[18]

5. *Youth Peer Advocates, Family Peer Advocates* and *Recovery Coaches*,[19,20,21] which have demonstrated efficacy in increasing access and service utilization in various behavioral health settings, such as rehabilitation programs, clubhouses, outpatient services and ambulatory care settings.

Recommendations: Work Group 3 recommends that DOHMH establish a consortium of stakeholders to advance strategies for sustainability and growth of these roles. Recommended outcomes for the consortium are:

1. Engage stakeholders from Work Group 3 to serve on a consortium steering committee, which will provide a mechanism for ongoing feedback and support of future consortium initiatives.

2. Develop a matrix comparing training programs and position criteria for the various peer positions, including state-certified positions and positions incorporated into health care systems. Use this analysis to establish shared standards for roles, compensation, training, supervision, responsibility and career advancement opportunities.

3. Support individuals interested in peer roles by linking peer training programs to academic credentials or academic credits, providing models for career advancement as peers and by providing ongoing professional development such as self-assessment.

4. Work with key stakeholders with expertise in peer integration or peer provider training to develop an organizational readiness tool for integrating peers into various settings.

5. Find opportunities to market and share the tool readiness instrument with organizations considering peer integration.

Work Group 4: Develop Metrics for Improving the Mental Health Workforce in New York City

Co-Chairs: Jean Moore and Bill Ebenstein

The Problem: Comprehensive data on the supply of and demand for behavioral health providers is lacking, thereby limiting our ability to identify gaps and effect solutions. We must develop new methods and networks of data gathering to plan for the workforce we want.

Recommendations: Work Group 4 proposes establishing an entity that can systematically aggregate, analyze and share multiple existing and proposed new data sources to create a more detailed profile of the city's behavioral health workforce and the programs and policies needed to strengthen it.

The following were identified as potential starting points for such a mental health workforce database:

- Hospital Association of New York State and Community Health Care Association Network of New York State member surveys
- City University of New York data on graduates, including graduation rates, demographics, post-graduate licensing, employment and wages for CUNY professionals
- New York State Education Department data on state-licensed providers (e.g., social workers, psychologists).
- Performing Provider Systems health care workforce data
- Health Association of New York State and the Community Health Care Association of New York State (CHCANYS) survey data on recruitment, retention, salaries and burnout

Other possible data sources that have not yet been explored include Medicaid reimbursement data and Statewide Planning and Research Cooperative System (SPARCS) data on hospital admissions.

Despite these resources, we need more data and we must also develop new sources and methods of data gathering. Current data sources have several weaknesses: they are not comprehensive and include only subsets of the city's behavioral health workforce (e.g., only CUNY graduates or employees in a specific health system); they are often delayed and not highly actionable; they are not comparable to each other, since organizations ask questions differently; and they are not integrated with citywide trends on future workforce needs.

In addition to quantitative data, Work Group 4 also considered ways to gather qualitative information about progress in needed areas of workforce change, such as adopting integration of behavioral health in primary care settings and of primary care in behavioral health settings. One approach might be to conduct comparative case studies with key informant interviews across various integration sites, or to adapt and advance functional checklists and tools that can be shared and scaled, such as formal readiness checklists for integrated care roles like the one being used to scale in the ThriveNYC Mental Health Service Corps.[22] Similarly, Work Group 4 suggests developing case studies that document the specific types of health care workers used in various settings, as well as the frequency and cost. Team-based-care case studies provide an example of this type of monitoring and evaluation.[23] We also need more information about the types of services the behavioral health workforce offers across organizational characteristics, workforce responses and best practices.

IV. Overall Priority Areas and Recommendations for Action

Although each work group put forth several recommendations, Summit participants established five priorities for immediate action:

1. Develop strategies to recruit, retain, graduate, license and employ a mental health workforce that includes more representatives of under-served populations and has the skills needed to serve these populations effectively.

   » Establish a Thrive Scholars Program that will provide tuition reimbursement and/or a stipend for full- and part-time students who enroll in mental health professional graduate programs and commit to working in under-served areas after graduation.

   » Create faculty collaboratives that can work together to develop interdisciplinary anti-racism and anti-oppression training modules for faculty, staff and students in mental health professional training programs.

   » Summit participants who serve as faculty members for CUNY's programs in nursing, social work, public health, psychology, mental health counseling and other mental health professions should create a CUNY Task Force on the Mental Health Workforce to expand inter-professional activities for students in CUNY's many mental health training programs and identify new ways to prepare its graduates to transition to full-time professional employment and licensure.

2. Create or strengthen mental health professional training approaches that teach evidence-based behavioral health skills and prepare graduates to work in interdisciplinary integrated care and community-based models.[24,25,26]

   » Convene a *Physician Training Learning Group* with directors from New York City residency training programs in psychiatry and internal medicine. This group would explore how to establish standard new training experiences for medicine and psychiatry.

   » Create *Community Systems Support Training* demonstrations in which students, residents and trainees from multiple disciplines are mentored in a defined geographic community-based learning experience to understand and practice community system support roles and an *Inter-professional Mental Health Training Coalition* in which training directors and school leaders from multiple disciplines involved in providing mental health care will consider training opportunities that blend these trainees in shared learning experiences in integrated care.

3. Strengthen support for mental health professionals transitioning from training programs to employment to improve retention, prevent burnout and increase professional development.

   » Advance the creation of a mental health professionals network that connects new mental health professionals (i.e., recent graduates of licensed programs) to peers, employers, professional organizations, unions and academic institutions with the goal of providing more consistent and diverse professional support for new professionals.

   » Pursue regular and ongoing use of validated self-reporting measures of mental health professional burnout by Article 28, 31 and 32 facilities.

4. Establish a New York City Peer Workforce Consortium to describe the scope of practice, core competencies, expected impact/benefit and training and career development paths for peers and community health workers, and propose reimbursement mechanisms and other policies that grow and sustain the distinct contributions of these mental health providers. DOHMH will support and staff a consortium that can help meet these goals by December 2018.

5. Create capacity to identify, collect, analyze and monitor metrics for the mental health workforce in New York City and share data and analytics that enable policy makers, mental health providers, third-party payers, universities and others to track progress towards achieving workforce goals.

   » Establish the New York City Behavioral Health Workforce Research Initiative to systematically collect, develop, analyze and disseminate data and reports on the characteristics, gaps and performance of the mental health workforce, including analyses of:

   - New York City's composition of the behavioral health workforce
   - New needs
   - The quality of currently available data that could be used to better understand the professional and paraprofessional behavioral health workforce in New York City
   - Potential research strategies to illuminate gaps, impact and use of behavioral health workers in New York City in the context of population needs

> ***"If we are going to truly change the way we approach mental health and well-being in this city, we need to start by investing in the men and women who are responsible for providing care."***
>
> ***— Richard Buery, Deputy Mayor for Strategic Policy Initiatives at the Mental Health Workforce Summit***

V. Sustainability Framework

The goal for each work group was to identify specific actions that the Summit participants could take in the next year or two.

Implementation and sustainability of these recommendations will also require core principles for achieving change. In this section, we propose a framework to help advance the approaches and goals of the work groups and their further evaluation. The changes we recommend will need a broader circle of engagement and commitment over the next several years in order to translate this vision into reality.

Several themes emerged that may guide the Summit's work moving forward:

1. Think and act across levels, stages, systems and disciplines.

"Siloed," "fragmented" "uncoordinated" are common adjectives used to describe the city's and the nation's mental health care systems. Moving beyond the current system's inefficiencies and inequities will require a new capacity to think and act outside of traditional boundaries.

To work across the stages of the development of the mental health workforce, we must track the pathways from recruitment to training, graduation, licensure, employment and retention. Successes at one stage define the options for later stages. Developing metrics and data collection systems that track these outcomes across stages of workforce development will help us identify opportunities for improvement.

To work across systems, we need to identify where our educational, health and mental health care and social service systems intersect to influence the preparation of mental health professionals. Reforms in one part of the workforce must consider the capacity of others. Systems science, an evolving methodology to understand how systems interact, may help map the systems that influence mental health workforce development.[27]

Finally, if we wish to integrate disciplines such as psychiatry, social work, nursing, psychology and the emerging non-licensed mental health workforce, we must require that professionals and the organizations that represent them communicate to each other and work together in clinical settings. The development of a consortium, as recommended by Work Group 3, can provide the practice-based evidence to guide such innovation. In addition, professional organizations will need to forge common policy agendas that define opportunities to increase policy support for interdisciplinary mental health services.

2. Integrate efforts to strengthen the city's mental health workforce with efforts to strengthen its mental health system.

How can we prepare a better, stronger mental health workforce without first creating systems of care that will enable these new professionals to practice differently? Both processes need to take place simultaneously. As training programs take on the challenges of urban public mental health, care systems will need to modify their organizations to meet new needs, such as the need to build capacity, integrate primary care and behavioral health services,[28] integrate substance use and mental health services[29] and deliver culturally appropriate services.[30]

In this way, mental health care providers will improve services to their patients and create the environments in which students and entry-level professionals can apply the skills they learned in the classroom. By bringing together the key players in mental health workforce development, the Summit set the stage for ongoing collaborations. Each work group suggested initial strategies for strengthening the links among universities, treatment providers and professional organizations as a means of improving training and the quality and effectiveness of care.

3. Break down transformative change efforts into short- and long-term actionable steps.

Another dilemma that surfaced frequently at the Summit was how to balance two correct but seemingly contradictory insights. On the one hand, the problems facing our mental health care system and its workforce are extraordinarily complex, multi-faceted and multi-disciplinary. How can a few dozen organizations and individuals in New York City do anything that has a realistic chance of transforming this system? On the other hand, many Summit participants are already engaged in daily efforts to reduce the problems we encounter and can drive innovation efforts upon which broader change can rest. By finding the right balance between acknowledging complexities and taking action to achieve near-term, scalable successes, mental health professionals and their allies can tip the scales towards transformative change.

> ***"The most characteristic response among policy makers, educators and providers to the workforce crisis is to feel overwhelmed by its magnitude and paralyzed by its complexity. To avoid that state you need a framework or a conceptual roadmap for tackling the problem, you need colleagues with whom to collaborate and you need a plan to guide your actions. You have the opportunity today to begin that collective planning and action."***
>
> ***— Michael Hoge, Professor of Psychiatry at Yale University, and a Summit Keynote speaker***

4. Link efforts to strengthen the mental health workforce with other initiatives to address inequality in New York City.[31]

Deeply rooted structural racism and inequality can hinder our efforts to improve access to mental health services and workforce diversity. We must connect our efforts with other reform efforts to achieve sustainable change.

These are connected to larger questions such as:

- Can college education be free or more affordable?
- Should insurance and public reimbursement policies incentivize or discourage private practice?
- Will parental leave benefits and living wages enable people to better cope with the stresses of poverty and parenting?
- Will undocumented Americans have access to health care and other public benefits?
- How can Medicaid pay for social interventions to improve health?
- How can we support our police officers so that they have the necessary resources to respond to mental illness?
- How can we undo patterns of racism in our social service systems?

Each of these questions further determines who becomes a mental health professional, who gets mental health services and what the content and quality of that care will be. We cannot accomplish our goals without taking into account the current policy and political context.

Summit participants agree on the recommendations set forth in this report to serve as the basis for interim and then continued work for when the Summit reconvenes in 2017.

A key goal for *ThriveNYC: A Mental Health Roadmap for All*, according to Mayor Bill de Blasio, is to "make sure every New Yorker in every community has access to a mental health professional." By taking action to expand, strengthen, diversify and retain New York City's mental health workforce, the participants in the Summit are helping to turn that vision into a reality.

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Appendix

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