

# A Crisis of Care: Addressing the Shortage of Child and Adolescent Psychiatrists in New York State

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# A Crisis of Care: Addressing the Shortage of Child and Adolescent Psychiatrists in New York State

## Introduction

According to the U.S. Surgeon General, there are nearly one million children in New York State with emotional, behavioral, or substance abuse disorders. These disorders are treatable, and recovery is possible. We will refer to the children discussed in this paper as “children in need of mental health services” or “children with mental health issues.”

Unfortunately, most children and youth who need services do not have access to high-quality treatment and support. Barriers to access are due to a number of factors, including inadequate service capacity, a shortage of child psychiatrists, lack of adequate insurance coverage, lack of cultural competence, and stigma surrounding mental illness and its treatment.

This policy paper will address just one of these access issues—the crisis-level shortage of child and adolescent psychiatrists (CAPs). In September 2007, the Schuyler Center for Analysis and Advocacy (SCAA) and the New York State Conference of Local Mental Hygiene Directors (NYSCLMHD) brought key policymakers and interested parties together for a roundtable on this issue. The roundtable was part of a larger STEPS (Solutions to End Psychiatric Shortages) Campaign made possible by a legislative member item. Attendees at the one-day meeting heard presentations on the CAP shortage from issue experts. This policy paper is a result of that meeting and further research. Both SCAA and NYSCLMHD plan to use this paper to spark continued conversation about the problem, and as the

foundation for convening a group dedicated to determining next steps for action. It should be viewed as a preliminary discussion of the issue.

## Executive Summary

This paper will examine the reasons behind the CAP shortage, discuss how New York is currently tackling the problem, and make recommendations for how the state can increase the supply of CAPs, as well as offer other alternatives for care to families in need.

The reasons for the shortage are many and varied. Barriers exist for those considering CAP training, and disincentives exist for those entering the field. The New York State Office of Mental Health (OMH) currently contracts with 25 programs to fund 135 residencies, some of them CAP positions. OMH will fund more positions in July 2008. In addition, Governor Spitzer’s new Docs Across New York proposal may make more positions possible in high-need areas.

Since the demand for CAPs may always exceed capacity, there are several steps the state can consider to expand the training of other medical professionals and to provide early interventions and assessments of children in normative settings.

There are also a number of things that the state can do to increase the supply of CAPs, including identifying and implementing ways to attract and retain them. However, increasing the number of CAP training programs may be the best solution.

## Proposal

SCAA and NYSCLMHD propose that the state pilot four new or expanded CAP training programs as part of an upstate economic development plan. Increasing the number of CAPs in the state, and in these regions in particular, will increase the quality of life for children and their families who are currently struggling to find services. Families want to live in communities that offer access to health care services, including mental health, and are more apt to settle in areas that meet their needs. Such a project will require a commitment and investment from the state, and will reflect the understanding that children's mental health needs must be addressed by qualified professionals.

The state could pilot a program in Albany, where one CAP training program closed but where there continues to be interest in reviving it, especially from the psychiatric community. The state could also expand the existing training programs in Buffalo, Rochester, and Syracuse. These cities are all in counties and regions with diverse populations, so the data collected on outcomes would be significant.

The first task at hand will be to build an infrastructure in Albany, including the hiring and training of three full-time CAPs (FTEs) or six part-time psychiatrists. Staffing this endeavor is a critical component, and one that may prove difficult. According to interviewees at SUNY Upstate Medical University, which has a CAP training program, the starting salary there for an assistant professor is \$35,000 and the maximum salary for a full professor is \$55,000. The university has had a problem expanding its faculty because of the low pay. Any new initiative should take into account that the staff salaries must be competitive in order to attract high-quality

people who will remain in those positions. Next, the state will need to recruit residents. SCAA and NYSCLMHD support the idea of funding 12-16 "positions" or a total of six-eight residents, two per program. (Four positions equals two residents per year for the length of a two-year program.) Often, CAP residents stay in the area where they train. Additional incentives, such as loan forgiveness and practice start-up grants, may assist trainees in staying in the Albany, Buffalo, and Rochester areas.

SCAA and NYSCLMHD plan to engage other interested parties in this proposal and to present it to the Legislature in the near future.

The organizations will request \$1.5 million for the development of a CAP training program in Albany. This would cover the cost of six residency positions, three FTEs with benefits, and administrative costs. The organizations will request an additional \$2 million for the expansion of the programs in Buffalo, Rochester, and Syracuse. The total request, for the first year, is \$3.5 million.

In order to ensure that the programs are funded while they start-up and become established (at which point the cost to the state will be less because faculty will be generating some of their own income), SCAA and NYSCLMHD will advocate that a five-year allocation be included in the 2009-10 Budget.

## Background

The American Academy of Child and Adolescent Psychiatry (AACAP), defines a CAP as "a Doctor of Medicine or Doctor of Osteopathy who specializes in the diagnosis and, if indicated, the treatment of disorders of thinking, feeling and/or

behavior affecting children, adolescents, and their families. A CAP offers families the advantages of a medical education, the medical traditions of professional ethics, and medical responsibility for providing comprehensive care.”

There are currently about 7,000 CAPs in this country. The federal government has designated more than 1,600 communities as Mental Health Professional Shortage Areas. To heighten the concern, the U.S. Bureau of Health projects that there will be approximately 8,300 CAPs in 2020—only two-thirds of the 12,600 necessary to cope with demand.<sup>1</sup> There is a critical shortage of CAPs in New York State that mirrors the shortage across the United States and abroad. As in the rest of the nation, New York’s shortage is much worse in the rural areas of the state—there are 24 counties with no CAPs at all and seven counties with only one CAP.<sup>2</sup> Of the 62 counties in the state, 44 have less than four CAPs.

The average age of a CAP has shifted, with fewer under age 35.<sup>3</sup> This means that most CAPs are older professionals with an eye toward retirement. In addition, the number of residents training to be CAPs has not changed much in more than a decade.<sup>4</sup> In 1990, that number was 712; in 2000, it dropped to 669; in 2005, it stood at 720.<sup>5</sup> According to the American Board of Medical Specialties (ABMS), there are 4,649 physicians certified in psychiatry in New York State. With a population of approximately 20 million, if every resident required psychiatric services, each psychiatrist would have about 4,300 patients.<sup>6</sup> Using 2004 data, New York’s 898 CAPs are currently responsible for treating the one million children in the state with known mental health issues. That amounts to approximately 1,113 children per CAP.

Those who pursue certification in the specialty might not pursue that certification in New York. Although the Accreditation Council for Graduate Medical Education lists 17 accredited CAP programs in the state, this number may not hold steady. In fact, as mentioned previously, the CAP program in the capital city closed a number of years ago.

Finally, the CAPs these programs do produce may not stay in the state, or in the state’s high-need areas, to practice. Although New York trains twice as many CAPs as other states, half practice elsewhere. Many do not want to practice in rural areas, and so find jobs in cities. Others, from states with few (Wisconsin) or no (Delaware, Wyoming) accredited programs, return to those states after school to find jobs.

The inadequate supply of CAPs is influenced by many factors including an increased need for these specialists, inadequate reimbursement for services, additional years of required training, funding and salary disparities, and uncertainty regarding Medicaid reimbursement.

### ► Increased Need

There is some dispute over whether there are more children in need of mental health services now than ever before, or whether there is an increase in need due to expanding awareness of mental health and better identification of social, emotional or behavioral issues in children. There has also been an increase in the use of psychotropic drugs to treat children. In turn, this use of medication has served to identify these children (to schools, etc.) as being in need of other services. In New York State, passage of Timothy’s Law, which mandates parity in insurance coverage for mental health issues, and implementation of Child and Family

Clinic Plus, which provides school-based early identification of mental health issues, are responses to both the growing need and to the increased awareness of the prevalence of children's mental health issues.

Whatever the reason for the increased need, it is real and staggering. Paradoxically, with more children in need of treatment comes a shortage of CAPs. According to the speakers at the September meeting, the need for CAPs surpasses both the number of CAPs and the outreach to potential CAPs. Often students are simply not educated about the opportunities, or encouraged to pursue them. Unfortunately, even within the medical profession there are still those who think that medical issues and mental health issues are two separate entities. Therefore, the people who choose to study and practice child psychiatry are often interested prior to entering medical school. Those who come to it later may have been introduced to the field as part of their medical school education or during a medical school or residency rotation.

As reported previously, there are 24 counties in New York without any CAPs. A 2003 report by the Bazelon Center for Mental Health Law described the findings when focus groups of Medicaid families were convened in three areas of the state—Manhattan, Schoharie County, and Onondaga County—and asked about the impact this

shortage had on their children. The focus groups noted that the “dearth of psychiatrists, psychologists and other mental health providers” was a problem. Although greater in rural regions, it also had a negative impact in more urban areas. In addition, transportation for families in rural regions “posed a significant barrier.” According to the report, some parents who seek treatment are forced to find it outside the county, or even the state.<sup>7</sup> Waiting lists for treatment out-of-state are often shorter than those in-state. As with other medical issues, time is of the essence when dealing with mental health issues.

During the 2005-06 school year, the State Education Department (SED) placed 567 emotionally disturbed children out-of-state. In 2006-07, that number dramatically declined—to 385. The decline occurred because the state intensified its residential and academic capacities. SED is currently involved in a five-year plan in state development with several other state agencies, including the Office of Mental Retardation and Developmental Disabilities (OMRDD), the Office of Children and Family Services (OCFS), and OMH. The plan includes ensuring collaboration between congregate care and the campus schools that serve these children.<sup>8</sup>

Children and adolescents with either physical or mental health issues who are unable to find consistent care frequently present in emergency rooms, where treatment comes later than needed. For those in need of mental health services, treatment may be compromised because it is administered by medical professionals not specifically equipped to deal with mental illnesses. Emergency rooms are also fast-paced places that are not ideally suited to the thoughtful diagnosis of mental health issues. Further-

“*We've had to go out of county for all of our school and day treatment services. There are absolutely no services available in our county for my son...*”

*“My nephew is in [another state] for services because no services for him were available—neither in the county or in the state.*”

” Family input for Bazelon study, 2003

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*According to Dr. Robert Maher, the superintendent of schools for the Greenburgh-North Castle school district in Dobbs Ferry, out-of-state facilities have been widely utilized in part because they “ramped up their clinical services,” which parents and school districts responded to. New York State, with its shortage of CAPs, had a very difficult time competing. But that appears to be changing. St. Christopher’s, Inc., in Dobbs Ferry, provides “a safe and supportive structure for youngsters who currently cannot be maintained and educated successfully in their home community.” According to Dr. Maher, at least 100 of the 155 children in residential placement there were in out-of-state placement or about to go into out-of-state placement before coming to St. Christopher’s. Of the 170 day-student population, he notes that half may have gone into residential treatment (many out-of-state), had it not been for the program.*

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more, treatment in emergency room settings is not optimum because costs are exceedingly high, as opposed to the cost of appropriate psychiatric treatment.

➤ **Inadequate Reimbursement for Services**

Reimbursement rates provide little or no incentive to provide services to children and adolescents. While the salary for a CAP is generally the same as that of an adult psychiatrist, treating a child generally takes more time than treating an adult and dealing with multiple child-serving agencies generates a large amount of extra work. Therefore, reimbursement of CAP services is frequently inadequate for the provision of those services.

Another result of inadequate reimbursement rates is that many CAPs simply do not accept insurance. Psychiatric services are expensive, and out-of-pocket payments are not possible for many families, causing the child to go without treatment. Even those who can pay the full cost of treatment often do so at a hardship to the family.

➤ **Additional Years of Training Required**

Those who initially pursue a specialty in CAP sometimes abandon training for a specialty in adult psychiatry because the

educational requirements for CAP are so rigorous and time-intensive. Training in the field requires a real commitment—four years of medical school; at least three years of approved residency training in medicine, neurology, and general psychiatry with adults; and an additional two years of training in psychiatric work with children, adolescents, and their families in an accredited residency in CAP. The additional two years of training following Board certification in psychiatry may be a significant disincentive.

➤ **Funding and Salary Disparities**

Graduate medical education (GME) funding limits CAP training support to hospitals to a portion of the full residency, whereas a specialty such as geriatric psychiatry is fully funded.<sup>9</sup> This policy can be interpreted as reflecting a lack of respect for the specialty, and hospitals may be unable or unwilling to offer a program because of the funding disparity. The salary disparity to practicing CAPs in the field is also problematic. Of 28 medical specialties, CAP ranks 20th in terms of median income.<sup>10</sup>

➤ **Uncertainty Regarding Medicaid Reimbursement**

Medicaid reimbursement is the second largest source of funding for GME that, in turn, provides training for CAPs.<sup>11</sup> In 2005, 47 states used Medicaid money to pay

for GME—a total of \$3.2 billion. Some states subsidize medical residency programs by making direct payments to teaching hospitals using Medicaid funds. Others make payments to medical schools. Sixteen states carve-out Medicaid payments to managed care plans and re-channel them into teaching programs. President Bush’s FY08 budget would eliminate Medicaid as a source of GME funding over the next 10 years. Such a policy change would have a decidedly negative impact on GME and on the courses that teaching hospitals offer—including training for CAPs.<sup>12</sup>

## Addressing the Problem

The integration of mental health care into primary care is essential. Training primary care physicians, particularly pediatricians, to identify, refer, and even treat mental health issues is a step in the right direction. However, this practice should not take the place of recruiting and training child psychiatrists.

AACAP has formed a steering committee on workforce issues that concentrates its efforts on increasing recruitment of CAPs by 10% each year over the next 10 years (the project began in 2004). The committee focuses on three areas: attraction, expansion, and support. To begin, AACAP is collecting data regarding existing programs and recruitment statistics to serve as a baseline. Next, the organization is addressing attraction and stigma through a variety of

public relations efforts. In terms of expansion, AACAP is concentrating on multiple portals of entry and developing alternative paths to CAP, including integrated child and adolescent and adult psychiatry training tracks. Finally, AACAP is supporting and advocating for federal legislation, the Child Health Care Crisis Relief Act (H.R. 2073/S. 1572), that would provide loan forgiveness to CAP trainees and restore federal support for training.

In New York, demand for CAPs will continue to increase as Timothy’s Law and Child and Family Clinic Plus are implemented. Governor Spitzer’s creation of a Children’s Cabinet acknowledges that children’s issues must be a top priority in this state and for the state’s agencies. How can the policymakers and the people of New York work together to address the problem most effectively? SCAA and NYSCLMHD present the following short- and long-term strategies based on presentations at the September meeting, follow-up conversations, and additional research.

## Recommendations

The approach to addressing the CAPs shortage must be two-fold. In addition to piloting four new or expanded training programs, thereby increasing the number of CAPs, the state should utilize other means and methods of treatment for children and adolescents.

**In the short-term, New York State should:**

- ***Better understand current training programs and workforce***
- ***Address the limitations of Article 28 clinics***
- ***Utilize technology***
- ***Identify children earlier***
- ***Involve and empower families***

“...because there are never going to be enough child psychiatrists, eventually, we’re going to train thousands of pediatricians a year in identifying and treating depression, anxiety, ADHD and autism as a routine part of their practice.”

” Dr. Harold S. Koplewicz,  
director of the Child Studies Center at  
New York University;  
The *New York Times*, February 2006

### ***Better understand current training programs and workforce***

Starting with baseline data, New York should collect data on the current number of CAPs and on the areas in which they work. (It is safe to say that these areas will also be experiencing other physician shortages.) Data collection should include the number of medical students in the state who: plan to study to be CAPs, are studying to be CAPs, and are planning to stay in the state. Those who are undecided about their specialty or who are studying CAP but planning to leave the state to practice can be targeted for recruitment as part of a marketing campaign.

Since this shortage may be reflective of the scarcity and maldistribution of physicians across the state, any data collection that takes place should include information about all areas of practice. In order to ensure a solution that benefits all members of a community (especially those that are rural), all medical professions must work together to recruit and maintain a qualified workforce—data collection is only the first step.

### ***Address the limitations of Article 28 clinics***

Article 28 refers to the statute that governs general hospitals. General hospitals can provide OMH Licensed Clinic Treatment and/or incidental mental health care at health clinics or school health clinics. OMH and DOH are currently working to improve access and Medicaid reimbursement for incidental mental health services provided by school health clinics that are operated by Article 28 providers.

In addition, Article 28 providers cannot currently bill for social work services, only for medical visits. The 2008-09 *Executive Budget* included a provision that would allow for billing in these programs for services provided by social workers.

### ***Utilize technology***

Tele-medicine is a useful tool—especially in rural areas where access to services is a barrier to receiving those services. The 2006-07 state Budget included funding for the creation of a Child and Adolescent Telepsychiatry Initiative. In 2007, OMH contracted with Columbia University to hire one full-time CAP to work on this project. To better meet the need for services, three CAPs now split the workload. They provide consultations to the clinical team (general psychiatrist, clinician(s), primary care provider, case manager) for youth who are enrolled in an OMH Licensed Outpatient Clinic. At the end of 2007, 10 counties had received new video conferencing equipment, bringing the total number of counties participating in the project to 14.<sup>13</sup>

The 2008-09 *Executive Budget* includes funding to expand the Children's Rural Telepsychiatry Initiative by adding 10 more counties. Counties should utilize this valuable technology if doing so would increase access to services.

### ***Identify children earlier***

Intervening early can not only save money (since later, more intensive interventions are costlier); it can prevent the suffering that undiagnosed children and their families experience. It is also often the key to recovery, since treatment that is started early may yield the best results. Pediatricians must be trained to identify and either treat or refer children with mental health issues. Parents, teachers, and others in close contact with children and adolescents need to feel comfortable assessing certain behaviors and seeking the proper treatment when warranted.

The Child and Family Clinic Plus initiative to identify children with mental health issues in normative settings offers a ground-breaking opportunity to build awareness about

the importance of mental health and its connection with a child's overall health and well-being. To date, there are 211 licensed sites statewide. Child and Family Clinic Plus is the first policy initiative that addresses the mental health needs of children when they are young by offering identification and assessment to families at their child's child care center, preschool, school, after-school program and countless other settings. The providers in charge of identification report their results to OMH. The state is expected to release data on the number of children whose parents consented to identification, the number of children who were identified, the number of completed assessments, the number of children treated, and the number of in-home visits that occurred.

### ***Involve and empower families***

Children are not autonomous creatures. They have families that directly impact and are directly affected by their mental health needs. The state strategy for addressing children's mental health issues should include a high level of family involvement.

New York State should provide training for direct care staff and service providers (such as CAPs and pediatricians) in family and youth involvement and in strengths-based, culturally-competent best practices.

**In the long-term, New York State should:**

- ***Attract and retain CAPs***
- ***Increase international medical graduate (IMG) recruitment***
- ***Increase graduate medical education (GME) funding from state and federal sources***
- ***Enhance the relationship between mental health and primary care***

### ***Attract and retain CAPs***

In his 2008 State of the State address, Governor Spitzer proposed a program entitled Docs Across New York. One-quarter of the state's population live in areas designated "underserved" by appropriate health care providers. The 2008-09 *Executive Budget* proposes programs to "provide physicians and clinics grants and enhanced reimbursement rates designed to encourage new primary care and specialist physicians to establish or join existing practices in rural and inner-city underserved communities." The Spitzer Administration plans to work with medical schools and teaching hospitals to support educational loan repayment programs for residents who agree to serve in underserved regions.

Loan forgiveness is a good recruitment tool for those who have chosen to practice, but in order to recruit more CAPs the state must make the profession more attractive overall. The stigmatized view of CAP as a "soft science" is reinforced by practices such as lower salaries. Paying CAPs less than other physicians is not only a disincentive to practicing—it simply makes for bad economic policy. While it appears to save money in the short-term, it actually does not, since the higher-paid physicians end up treating these children anyway. In addition, as outlined earlier, the CAPs shortage results in children being sent out-of-state and children going without treatment—both situations that result in costly long-term consequences.

According to presenters at the September event, a number of adult psychiatrists would practice CAP if it were not for the longer training time required. The drop-off that occurs among potential CAPs during the adult-only part of training can be decreased by integrating adult and child training.

Integrated training sets the requirement that psychiatrists must complete training in both adult psychiatry and in CAP in order to be Board certified in either specialty.<sup>14</sup> Combining these specialty programs would reduce the time and requirements necessary to complete training. Currently, students in the post-graduate psychiatric training (PGY-4) program may use the final year of that training as the first year of CAP training.

In addition, a number of pediatricians might become involved in the delivery of mental health services if they had the necessary training. Programs such as the Child/Adolescent Psychiatric Mental Health Nurse Practitioner course of study (discussed below) could be adapted for pediatricians, who are often the first line observers of and responders to children's health issues.

Finally, New York State could launch a marketing campaign aimed at attracting more people to the field. This campaign could be targeted to medical students who have not yet chosen a specialty. In addition, offering summer electives and mentorship programs would increase awareness and early exposure.

### ***Increase IMG recruitment***

J-1 visas allow states to recruit up to 30 international medical graduates (IMGs) who complete their residency in the state and then serve for at least three years in underserved areas. This agreement waives the requirement that IMGs must return to their home country for two years upon completion of their residency in the U.S. New York State should recruit more IMGs through international marketing efforts, and by targeting IMGs who are undecided about their specialty. The state should also look into setting aside a certain number of IMG slots for CAP residents.

In addition, waiver requirements are such that IMGs must start work within 90 days of their change in status approval, regardless of whether they have completed their CAP training. The state should examine these requirements to ensure that CAPs have adequate training prior to practice.

### ***Increase GME funding from state and federal sources***

There is currently \$3.5 million available in New York State for graduate medical education (GME). This money is used to support training for residents and to reimburse hospitals. As discussed earlier, the President's FY08 budget would eliminate Medicaid as a source of GME funding over the next 10 years. DOH is examining and identifying specialty areas where there are oversupplies of physicians and where there are shortages. Upon identification of needy areas, DOH will reinvest existing resources. Obviously, the distribution of funds to increase the number of CAPs is one area that needs to be addressed.

However, as noted previously, there is a statewide shortage of physicians—not just CAPs. As with data collection, any funding strategy should take into account the overall scarcity of providers. All human service departments should work together on developing a strategy to address this issue and should create a plan that encourages the sharing of resources and the development of creative ways to respond to children's health and mental health needs.

### ***Enhance the relationship between mental health and primary care***

Systemic mental health reform in New York should embrace a public health approach and utilize a wellness model. This model would look at the overall wellness of the

individual by using an inclusive approach that includes physical factors, life experiences, mental health, etc. Such an approach would de-stigmatize mental illness by including it as part of a whole—a critical component of positive public health. It would also provide incentives for prevention, further encouraging people to seek treatment and providers to address health concerns before they become health problems.

The CAPs shortage is another reason why mental health issues should be treated as chronic diseases. As noted earlier, pediatricians and primary care physicians should be trained in diagnosing and treating mental health issues, not simply in prescribing medications. In rural areas, where shortages are especially severe, OMH and DOH should work together to locate rural networks that are willing to serve as liaisons between primary care and mental health care.

The American Academy of Pediatrics recommends developmental screening at the 9-, 18-, and 30-month visits, and developmental surveillance at every well-child visit. Positive screens should be followed by referrals for evaluation and possible intervention.<sup>15</sup> The state can take small but important steps regarding screening, by doing so in physicians' waiting rooms. Primary care physicians and pediatricians have a limited amount of time to diagnose

and treat patients. A brief, evidence-based questionnaire such as Ages and Stages that a parent can fill out while waiting for their child's appointment saves time and serves as a useful tool.

In addition to physicians, the state should utilize qualified nurse practitioners as providers of mental health care. An example of the opportunities available is demonstrated by the University of Rochester's School of Nursing, which implemented two nurse practitioner programs in 2006—the Child/Adolescent Psychiatric Mental Health Nurse Practitioner (C/A NPP) program and an expanded Pediatric Nurse Practitioner program. In July 2007, the School received a grant from the federal office of Health Resources and Services Administration to train C/A NPPs who will practice in rural and underserved areas of the state. The grant was submitted to address the shortage concerns. The intent of the program is to prepare students to practice in their home communities and, to facilitate that, students will complete clinic hours in those communities.<sup>16</sup>

## Conclusion

The shortage of CAPs in New York State is reaching crisis proportions and is no doubt already of critical importance to many children and families. As outlined in this policy paper, the state may employ a number of short-term strategies to immediately address the problem, including funding pilot programs in CAP training. While longer-term solutions will take more time to design and implement, they are necessary to consider. Only an overhaul of funding strategies and infrastructure, in combination with a change in the culture, will produce the result that New York desperately needs—increased access to high-quality mental health care for our most vulnerable citizens, our children.

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*The Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) can be used for children ages 6 to 60 months, is written at a fifth grade level, is available in both English and Spanish, and takes 10 to 15 minutes to complete. Parents complete the questionnaire, which covers five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social. Professionals score the answers and are able to identify children at-risk for social-emotional difficulties, behaviors of concern, and the need for further assessment. The ASQ:SE has a 94% reliability rate.*

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## Endnotes

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