Improving Child & Community Health:

Addressing Workforce Challenges in Our Community Mental Health Centers

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Providing Clarity to an Often Unclear World

ENDOWMENT for Health

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Peter Antal, Ph.D., has over 10 years experience working with and reviewing NH's mental health system. Past works across a range of organizations (including the Children's Alliance of New Hampshire, NH Center for Public Policy Studies, NH Association for Infant Mental Health, Community Health Institute, the Institute on Disability Studies at UNH, and Antal Consulting, LLC) have focused on understanding the prevalence and costs of mental illness in NH, perceptions of consumers receiving services in New Hampshire's Community Mental Health Centers, improving staff competencies for delivering services, and supporting infrastructure improvements across the system.

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Executive Summary

Children's mental health affects how they socialize, how they learn, and how well they meet their potential. That is why it is in our best interest as a state to ensure children with mental health needs receive skilled and consistent care - both *when* they need it, and *where* they need it.

To serve the needs of children living with mental illness, New Hampshire relies on a number of providers from an array of different systems and disciplines, including the public children's mental health system, school providers, residential treatment providers, hospitals, private community-based providers, faith based groups, the child protection and juvenile justice systems, as well as primary care providers. Within this spectrum, the community mental health centers (CMHCs) fill a critical gap, providing targeted treatment services to children and their families who are often living with the most significant mental health concerns. Every year, nearly 12,000 New Hampshire children and their families rely on the mental health care provided via our State's CMHCs.

Today, CMHCs face serious challenges in providing reliable and effective care to children because of high staff[1] turnover in centers (as high as 1 in 5 child-serving staff turning over per year). Staff turnover is associated with a range of undesirable outcomes for patients, staff, and organizations. This results in multiple missed opportunities to improve the quality of care for those most in need and a mental health system that is struggling to maintain sustainability (the number of child-serving staff who leave in five years can be equivalent to the entirety of the direct services workforce in year one).

Compounding these challenges -

- The rate of children needing mental health services has been increasing since 2007 as has the proportion of children receiving services under Medicaid (indicating participation of children and families who may have greater and more complex unmet needs).
- CMHC budgets have been severely constrained during the past several years relative to the need that they know is out there. Average uncompensated care across New Hampshire's CMHCs ranged from 5% to 12% of total expenses[2], Medicaid reimbursement rates have not increased since 2006 and only limited state general funds are made available to supplement

Core Findings

✓ CMHCs face serious challenges in providing reliable and effective care to children because of significant staff turnover serving this population

✓ Respondents note that low wages and excessive paperwork burdens are primary drivers of low satisfaction among staff

✓ An array of potential solutions are available - financial and management based - that can help to improve staff retention and improve the care received by children living with mental illness

1 Although issues facing child serving staff and adult serving staff are often similar, the research conducted for this study specifically focused on understanding the barriers and challenges experienced by CMHC staff directly serving children and their families.

2 Based on Executive Director email feedback from 8 of 10 CMHCs in Feb. 2016

children's mental health services. Wait lists for new patients can range from 7-84 days across NH's CMHCs[3].

› Multiple policy and legislative barriers inefficiently shape what staff are able to do as part of their job responsibilities. This includes a lack of licensure reciprocity, which staff are allowed to sign off on a treatment plan, and the lack effective coordination of services and billing across the service environment supporting individuals with mental illness.

› Many of the staff who are able to move on to better paying and less restrictive jobs do so. The remaining staff must work with higher caseloads and more complex needs.

It is clear that this is a problem that has been building for several years, with significant and long-term negative effects on the children's mental health workforce, and ultimately, the people of New Hampshire.

In order to better understand the current state of the children's mental health workforce, the NH Children's Behavioral Health Collaborative, in conjunction with the Endowment for Health, the Institute on Disability at UNH, and Antal Consulting, LLC, has undertaken this study to examine the characteristics of the children's mental health workforce, the impact of staff turnover, and the perspectives of the workforce. Recommendations to improve retention of staff in the public children's community mental health system are provided. The research process involved multiple meetings with key stakeholders, an updated literature review, as well as surveys with CMHC directors (100% participation, N=10), HR staff (70%, N=10), and service staff (73%, N=335). Additionally, multiple follow up meetings were held with both members of the project's advisory board as well as directors of the mental health centers to review the findings and pursue answers to questions raised during the research process.

As a result of the research, five core findings were identified:

Finding # 1: Staff Turnover Disrupts Quality Care

Staff turnover may cause: a loss of critical professional experience among staff, lost opportunities to strengthen the care environment, declines in staff competency, experience and productivity, excessive financial burdens for the agency, negative impacts on workplace culture, failure to improve outcomes for children, youth, and their families, and lost opportunities to integrate and improve services.

Finding # 2: There is a Lack of Service Capacity in a Range of Areas

CMHC Directors noted that, although a few centers may have sufficient supports within a particular area (such as nursing), there is a general shortage of all service positions across the state, with particular shortfalls cited in the area of drug and alcohol counseling.

3 Based on 8 of 10 CMHCs responding. Of note, CMHCs maintain a triage system in order to identify and serve critical cases, typically within 1 day

Finding # 3: Voluntary Turnover Rates Vary Substantively By Position Type

The five year average voluntary turnover rate for psychologists, FFS/Case Managers, unlicensed masters level family support and licensed clinic based therapists is near 20%, whereas the rate for MD psychiatrists (14%), licensed masters level family support and community based therapists (11%), and supervisory staff (8%) is much lower.

Finding #4: There Are Very Specific Reasons Why Staff Leave

Directors and service providers agree that the top two factors driving low staff satisfaction are the low wages received for the work provided as well as the impact of excessive state documentation requirements.

Finding #5: There Are Multiple Strategies Available to Address the Problem

Forty-eight potential retention strategies were reviewed by staff, with three identified as critical by a majority of service providers: regularly scheduled raises, cost of living increases, and loan forgiveness for practice in federally underserved areas.

An Introduction to the Children's Mental Health Workforce & The Challenges of Staff Turnover

Over 12,000 New Hampshire children and their families seek mental health services from the State's 10 community mental health centers each year[4]. The overall goal of community mental health care is to maximize each person's health and well-being and to help individuals avoid costly and traumatic hospitalizations and other forms of out-of-home care. In order to attain this level of community-based care, the community mental health system must continuously develop and maintain a highly skilled workforce with adequate capacity to meet the needs of its community. The centers rely on highly trained staff to address their needs. They invest in costly staff training in core competencies for children's mental health care as well as the development of staff expertise in specific, highly complex evidence-based practices.

Data Collection and Methodology

In order to better understand the current state of the children's mental health workforce, the NH Children's Behavioral Health Collaborative, in conjunction with the Endowment for Health, the Institute on Disability at UNH, and Antal Consulting, LLC pursued a four-part strategy to understand the scope of the challenge and to identify potential solutions.

- A review of the research literature on the causes of, consequences and solutions to staff retention and turnover
- A survey of CMHC Executive and Children's directors, conducted in the spring of 2015, to identify current trends in policy implementation, and directors' perceptions concerning the factors that influence staff turnover. Of 10 CMHCs asked to provide their feedback, all 10 participated.
- A survey of human resource directors at the CMHCS to identify trends in turnover rates, pay, and benefits. Seven of 10 CMHCs participated in this portion of the study.
- A survey of CMHC staff providing direct services to document staff perceptions of issues related to turnover and retention. Of 335 potential staff, 73% participated in this portion of the study. Of note, the results presented in this report are not weighted by center size. They provide a direct summary of the individual level feedback provided by participating staff.

4 Data provided by NH Bureau of Behavioral Health, 2015.

Finding # 1: Staff Turnover Disrupts Quality Care

The research shows that there are negative effects on providing quality care when turnover rates are high, including: reduced productivity (Aarons & Sawitzky, 2006); financial stress, fractured client relationships, and disrupted clinical teams (cited in Woltman, et al., 2008); disrupted care (Paris & Hoge, 2010); as well as increased workplace demands on remaining staff and decreased perceptions of support (Knight, Becan, Flynn, 2012).

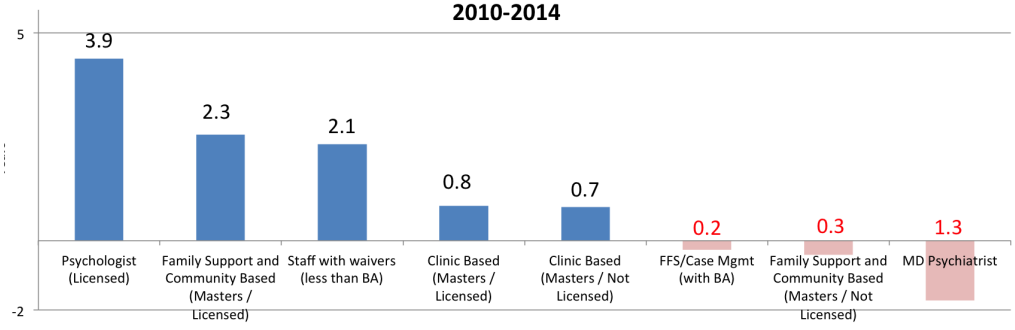
Our survey results confirm these concerns for New Hampshire and add additional factors to consider. Specifically, **substantive impacts of staff turnover may cause: a loss of critical professional experience among staff, lost opportunities to strengthen the care environment, declines in staff competency, experience and productivity, excessive financial burdens for agencies, negative impacts on workplace culture, failure to improve outcomes for children, youth, and their families, and lost opportunities to integrate and improve services.**

A Loss of Critical Professional Experience

One of the readily observable impacts of high staff turnover rates is on staffing experience levels. Figure 1 provides a summary of the weighted average for median years of experience in each direct services cohort with at least 5 full time equivalent staff in 2014 among participating centers. Based on a review of the provided data, **several types of positions struggled to maintain even a zero growth experience gain over a five year period.**

If everyone within a group stayed over five years, we would see an average change of 5 years of increased experience for that group. Instead, the average increase in years of experience for most direct service professions fell far short of this outcome, with three experiencing a net decline in cohort experience despite the passage of five years of time.

Fig. 1 Direct Services Staff Change in Years of Experience 2010-2014



Despite a five year opportunity to increase experience between 2010 and 2014, certain types of positions:

- saw a drop in median experience (functional support workers/case managers with BA, family support and community based support staff who are licensed and have a Masters degree, as well as psychiatrists);
- gained about a year of experience on average (clinic based with Masters degree (licensed and not licensed))
- gained only two years (Staff with waivers (less than BA), Family Support and Community Based Masters Licensed));
- one category gained four years (Psychologist).

Lost Opportunities to Strengthen the Care Environment

Feedback from CMHC directors noted that staff productivity is negatively impacted by turnover because program directors and supervisors are continuously devoting significant time to hiring, orienting, training and mentoring new staff. One director estimated they spent about 30 hrs on recruitment, 50 hrs on orientation, and 35 hrs on training for each new staff hired. All of this takes away from the director's ability to provide more targeted supports to remaining staff who often take on an increased and more complex case load.

A Substantive Drop in Staff Competency and Productivity

One center director noted that it can take as many as 3-4 months before a new staff member is at full productivity. The center cannot bill Medicaid or other insurers for time spent in training or other non-direct service activities, and this negatively impacts the center's income to support staff. Directors noted that seasoned staff must also cover for staff that leave while new staff are trained. As a result, more experienced staff must frequently take on the most complex and high risk cases, creating significant stress among the seasoned staff.

Negative Financial Impacts

Directors noted that there are substantial costs to hiring any new staff member including the cost of advertising job openings, conducting criminal and motor vehicle background checks, providing organizational materials and orientations, and credentialing costs. One agency director noted that the lowered productivity and time spent in training and orientation can last up to 6 months. High turnover keeps billable time at below optimal levels because staff who are in their resignation period need to reduce their caseload, and newly hired staff require non-billable time for activities such as job shadowing and take on smaller caseloads. It was also noted that billing funds may be lost as clients seek services elsewhere.

Negative Impacts on Workplace Culture

Agency directors highlighted a range of concerns about how staff turnover impacts workplace culture. Directors noted that high turnover rates increase stress and anxiety among staff (particularly when multiple staff leave at the same time), and increase staff concerns about the stability of their agency. Three challenges were shared: 1) a view from staff that the agency is a training ground, not

a long term place to develop a career; 2) a shift in prioritization to documentation efforts to manage the higher caseloads at the expense of collegial consultation and self care; 3) and impacts on how the agency is able to interact with the community.

Negative Impacts on Children, Youth, and their Families

When asked about what the impact of staff turnover is on the children and families who rely on CMHC mental health services, director feedback included: interruption of care continuity, increased family frustration and distress, setbacks for the youth and their family, as well as increased risk of lack of engagement or drop out as youth may be unwilling to continue with therapy with someone new. Further, directors report that high turnover rates reduce their ability to meet the needs of children and families, who often need to wait longer than they should to see their therapist or case manager, and it increases the waiting lists and wait times for new clients to be seen.

Lost Opportunities to Integrate Services

Of critical importance is the ability of the CMHC to effectively collaborate with partners in the community. According to some of the feedback received from the mental health directors, the centers cannot spend time on collaboration when there is significant pressure to produce billable service units. New staff may have limited understanding of how best to access and coordinate community resources. Additionally, the agency directors noted that, due to high staff turnover rates, multiple partner agencies feel that they cannot refer children and families to the CMHC. Lastly, the high turnover rate gives the appearance of instability and slow response time.

Finding # 2: There is a Lack of Service Capacity in a Range of Areas

A critical question to address is whether New Hampshire has the workforce capacity to meet a diverse range of complex mental health needs. Between SFY 2005 and SFY 2014, the number of children served increased from 11,224 to 12,128.[5]

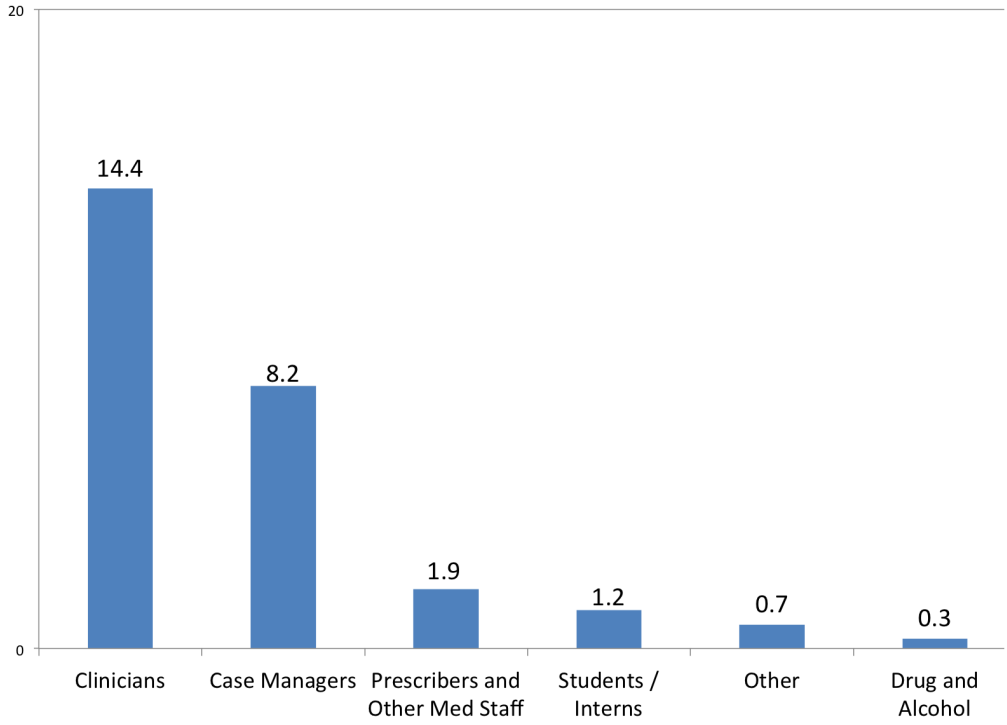
Fig. 2 provides a breakdown of staff employed in seven community mental health centers in FY 2014[6] by type of position. Of 254 direct services staff serving 9,494 children, the highest rate per 1,000 children served is among clinicians (14.4 full time equivalents), followed by case managers (8.2), prescribers and other medical staff (1.9), students/interns (1.2), other (0.7), and drug and alcohol counselors (0.3).[7]

5 Much of this increase occurred through FY 2011(12,636) after which it dropped down slightly. During this same time period, the number of children statewide decreased overall, from 300,918 to 267,141, resulting in an overall rate increase per 1,000 children served from 38.4 in FY 2007 to 45.4 in FY 2014.

6 Three of 10 centers opted not to participate in this portion of the study.

7 Clinicians include clinic based therapists, family support and community based therapists, and psychologists. Case Managers include Functional Family Support Case Managers and staff with waivers (less than a BA).Prescribers and Other Medical staff include MD Psychiatrists, APRNs, and Psychiatric Nurses. Drug and Alcohol includes MLADCs, LADCs, and unlicensed alcohol and drug counselors.

Fig. 2 CMHC Full Time Equivalent Workforce Distribution Across 7 CMHCs Rate Per 1,000 Children Served, SFY 2014



Based on a review of these staffing levels, most New Hampshire's CMHC directors agree[8] that, although a few centers may have sufficient supports within a particular area (such as nursing), **there is a general shortage of all positions across the state, with particular shortfalls in the area of drug and alcohol counseling.**

When data were reviewed by license status by individual professions over time, a subtle shift was observed. Employment of Masters-level, non-licensed family support and community based staff increased by 6 staff (26 to 32, or an increase of 23%) between 2010 and 2014 while employment of licensed Masters-level staff dropped from 13 to 9 (a drop of 31%) during the same time period. Similarly, clinic based masters level licensed staff changed from 48 in 2010 to 43 in 2014 (a drop of 10%) and their non-licensed counterparts increased from 29 to 46 (increase of 59%).This represents subtle shifts in the workforce as CMHCs may have lost some of their licensed staff and hired newer, less experienced staff to replace them.

8 Based on directors represented at a Director's Meeting discussion on 2/17/16.

Finding # 3: Voluntary Turnover Rates Vary Substantively By Position

Based on our review of five years of data from seven participating CMHCs, state level voluntary turnover rates across all direct services staff range from 15% to 25% per year. When the data are separated out by job category or position, average voluntary turnover varied substantively across 2010 and 2014. This ranged from less than 10% (for staff with waivers, program directors and supervisory staff) to over 20% (including licensed psychologists and family support / community based masters level unlicensed staff).

Table 1: Annual Average Voluntary Turnover in Seven CMHCs, 2010-2014

	Average Turnover
All Staff	18.4%
Direct Services Staff	20.1%
Psychologist (Licensed)	22.2%
Family Support and Community Based (Masters / Not Licensed)	21.0%
FFS/Case Mgmt (with BA)	19.2%
Clinic Based (Masters / Not Licensed)	19.0%
Clinic Based (Masters / Licensed)	18.2%
MD Psychiatrist	13.6%
Family Support and Community Based (Masters / Licensed)	11.1%
Staff with waivers (less than BA)	6.2%
Support and Managerial Staff	11.3%
Support Staff	18.4%
Supervisory Staff	8.0%
Program Director	5.7%

* Table does not include subcategories for Students and Other which typically have much higher expected turnover rates as well as groups with N of less than 5 in 2014 (Alcohol/Drug Counselors, Unlicensed Psychologists, APRNs, Psychiatric Nurses).

Finding #4: There Are Very Specific Reasons Why Staff Leave

The national literature highlights a range of factors which contribute to staff turnover, including culture and work climate, staff attitudes, commitment of the organization (Aarons & Sawitzky, 2006), job satisfaction, burnout, employment alternatives (Mor Barak, Nissly & Levin, 2001), staff decision making and self empowerment, and other management practices at the organization (Knudsen, Ducharme, & Roman (2006). The Knudsen, Ducharme, and Roman study highlights the importance of locus of decision making, noting that those agencies with greater centralized decision making are also more likely to have staff with higher levels of emotional exhaustion. Again building on the research, we updated our survey tools and asked both directors and service staff to provide feedback on these areas.

Director Feedback on Barriers to Retention

In our survey of center directors, we asked them to rate 35 potential barriers to employee job retention. These addressed areas related to factors at the agency level, issues related to provision of services, financial factors, socio-emotional factors, professional development opportunities, and external opportunities.

The following areas had more than 5 agencies indicating that the issue was a major or critical barrier

- *Agency Related: Competition with schools and private practice to provide services*
- *Provision of Services: State documentation requirements*
- *Financial Factors: Low salary relative to cost of living*

Staff Feedback on Factors Related to Satisfaction

CMHC direct services staff were asked to review 52 items found to be related to staff satisfaction in the workplace (please see Appendix A for a full list). Among these, staff identified items that they felt were not a problem, a minor concern, moderate concern, or a major/critical concern.

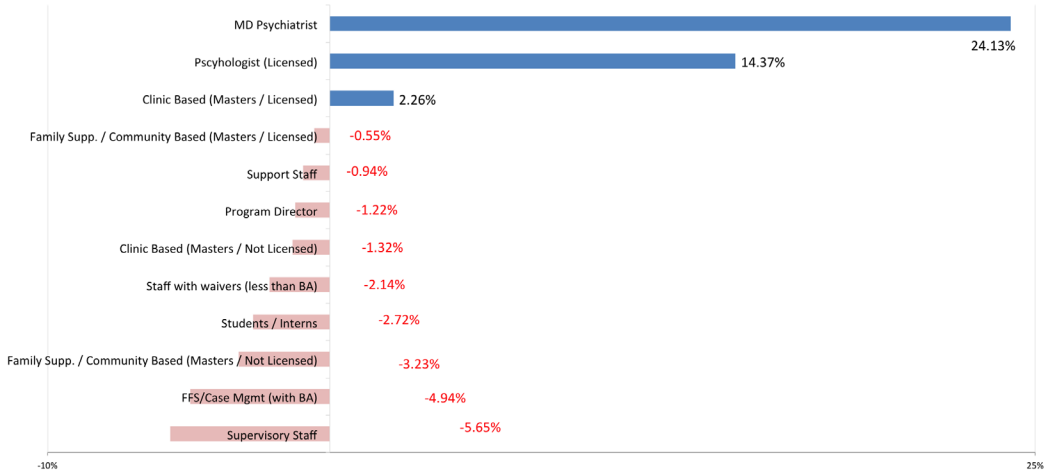
From the items reviewed, over 50% of staff identified four areas as a critical concern related to their job satisfaction:

- *two of these areas were related to finances (low salaries relative to cost of living, no step raises),*
- *one was agency related (excessive documentation requirements),*
- *and one was related to the provision of services (budget issues that limit community services for clients).*

A Closer Look at Staff Pay

As documented in the staff and director survey responses, staff pay is a major issue related to staff satisfaction. Unfortunately, between 2010 and 2014, staff increases in median salary failed to rise sufficiently for many in NH, as only 3 of 12 position categories reviewed[9] saw their salary increase[10] relative to inflation of 8.6% for this same time period (see Fig. 3).

Fig. 3 CMHC Workforce Change in Salary Relative to 8.6% Inflation, 2010 to 2014



As shown in Fig. 3, salary changes between 2010 and 2014 differed substantially by position:

› *substantively improved (14%+ over inflation of 8.6%): MD Psychiatrist and Psychologist Licensed*
› *minor improvement above inflation (2%): Clinic Based Masters Licensed Staff*
› **median pay for all other job categories did not keep pace with inflation**

These issues are compounded by the fact that median salaries for many direct services staff within the CMHCs are substantively lower than what these staff could earn in other settings such as private practices, schools, and area hospitals. For example, median pay for a clinic based, master's level licensed CMHC staff in New Hampshire was $41,596 in 2014[11] - while the annual mean wage for a NH-based clinical, counseling, and school psychologist is $69,150 (Bureau of Labor Statistics, 2014), a nearly $28,000 difference. Of note, psychiatrists, who experienced the highest increase in median salaries, had an average pay of $197,337 across seven centers in 2014, putting them only slightly above the annual mean wage for all State psychiatrists in 2014 ($190,970).

9 This review does not include Students/Interns, Other as well as categories where less than 5 full time equivalent staff were employed in 2014 (Drug and Alcohol counselors, Unlicensed Psychologist, APRN, Psychiatric Nurse).

10 Important Data Note: data on median salaries reflects a range of experience levels at participating centers that can impact pay (it is not an estimate of starting salaries). Factors such as varying turnover rates per profession area as well as overall longevity can, respectively, deflate or inflate salaries relative to inflation. In a follow up survey of HR departments (N=5) requesting data on starting salaries, trends identified in the earlier analysis are consistent -only MD Psychiatrists and Psychologists saw starting salaries increase above inflation. However, starting salaries for clinic based masters level licensed therapists only increased by 2.5% against the 8.6% inflation rate. Starting salaries for all other professions failed to keep pace with inflation.

11 Based on 2015 survey results from 7 community mental health HR Directors

Finding #5: There Are Multiple Strategies Available to Address the Problem

A number of research studies show that there are several common factors that improve staff retention in community mental health. Strategies include: supporting educational and career development, increasing wages and benefits, creating workforce development partnerships, promoting training in evidence based practices and fidelity, strengthening supervision, employing people in recovery in direct care roles (Dailey, Morris, & Hoge, 2014), employing payment strategies that provide meaningful employment for certified peer, family and recovery workers (Roberts, et al, 2011), expanding the role of communities in promoting behavioral health and wellness, enacting systematic recruitment and retention strategies, fostering leadership development, creating infrastructure for workforce development (Hoge, et al, 2009), and increasing use of emerging tech such as tele-medicine, web-based health care, smart phones, and electronic medical records (Roberts, et al, 2011).

Knowing that these are documented elements of improved staff retention and development, we asked the agency directors and staff to rank the importance of these strategies and their thoughts on the impact this would have on staff retention.

Director Feedback

CMHC directors were asked to review 41 items related to specific retention strategies employed at their center in 2014.

Utilized by 10 Centers

- Supervision for license eligibility
- License achievement

Utilized by 7-9 Centers:

- Staff recognition at anniversary
- Monies for conferences
- Agency based CEU training
- Agency based non-CEU training
- External agency non-CEU training
- Health care coverage
- Consultation groups
- Help staff in developing specialty
- Evidence Based Practice fidelity monitoring and support
- Collegial relationships

Utilized by 4-6 Centers:

- Improved decision making ability at multiple levels of the organization
- Improved openness and communication about management decisions
- Tuition reimbursement funds
- Productivity compensation
- License renewal fees
- Training budget
- Paperwork support
- Workforce development partnerships
- Licensing Fees
- Effective communication strategies
- MFT license supervision
- Opportunities for Career Growth
- Cost of living
- Opportunities for Personal Growth
- Individual recognition / appreciation
- Training of primary care, NP, PA

Utilized by 1-3 Centers:

- Organization wide lunch and learns related to diversity topics of race, ethnicity, culture, religion, or sexual orientation
- Manager staff performance bonus
- Recognition award with staff
- Loan forgiveness federally underserved
- Longevity raises
- Telemedicine
- Federal rate for mileage reimbursement
- Foster leader development
- Performance-based raises
- Integration of PEER support
- Online web-based health care

Utilized by 0 Centers

- Regularly scheduled pay increases
- Child care supports

The centers indicated that they consistently employ only two strategies - supervision for license eligibility and support for license achievement. Of note, **no centers reported implementing regularly scheduled pay increases** or child care supports as a retention strategy.

Staff Feedback

" [Working] with a diverse client population is very rewarding and helpful to gain considerable knowledge and experience. As someone who has never struggled w/ school/college or previous work expectations, however, I have yet to find a way to balance over the past ... years at the agency. The paperwork is time consuming and the EHR tends to be very slow and inefficient. If I'm caught up on paperwork, then I'm not meeting productivity expectations, which are also quite unattainable as it doesn't factor in no-shows and cancellations which are out of our control for the most part. Additionally, the pay and benefits are almost insulting. I see an issue with having gone to school for six years to work in the human services field and still living pay check to pay check."

Feedback received from staff concerning retention covered two critical areas: 1) strategies that staff believe would help them stay in their jobs 3 or more years; and 2) for staff who have been employed for 5+ years, reasons why they stayed.

Strategies to Maintain Employment for 3+ Years

CMHC direct services staff were asked to review 48 potential strategies for improving staff retention (please see Appendix B for a full list). Specifically, staff were asked to rate the extent to which each of the proposed factors would play a contributing role in their decision to stay with their agency for 3+ years.

Three strategies were identified as Critical by 50% or more of participating staff, these were:

- **regularly scheduled raises,**
- **cost of living increases, and**
- **loan forgiveness for federally underserved areas.**

Why Staff Stay or Leave

We asked CMHC staff that had been with their organization 5 years or more why they chose to stay with their agency.

Much of the feedback highlighted a range of positive factors, for example:

> *"I have stayed at this agency for as long as I have due to many reasons. I have a strong desire to assist the client population that we serve and believe this is the most important work that I can do within the mental health system. I also enjoy constantly learning about new developments within the field as well as new clinical challenges. I have also stayed at this agency because of my outstanding, dedicated coworkers and the collegial relationships I enjoy with those with whom I work. "*

Overall, 86 staff provided feedback, highlighting a range of positive contributing factors including:

- Meaningful relationships (61), highlighting with colleagues (50) and helping clients (25)
- Support from the agency (30), including Supervision support (22) and transparency (4)
- Scheduled Flexibility (22)
- Enjoy the work (19)
- Belief in work (19)
- Benefits (18)
- Career growth (17)
- Location (13)
- Feeling valued (10)
- Alignment of values (10)
- Financial stability (7)
- Hope for change within the agency (1)

However, a number of staff (N=20), also raised concerns:

> *"I have stayed [with agency] for [over 5 years] because I felt supported by my youth and family team. The team I have worked with has provided me with a sense of peer support, and with consistent clinical processing. Unfortunately I have recently made the decision to leave. This is in part because when I started I felt management at all levels appreciated the work of the direct service provider. I no longer have that feeling. This, combined with the new inflexibility of my schedule has pushed me to make the difficult decision to leave"*

Themes of concerns raised included: management, resource support, personal stress, working environment, job flexibility, and why they haven't left yet.

Management

- » case managers not understanding roles of direct service providers
- » lack of 2 way communication
- » heavy focus on productivity
- » multiple shifts in management policies
- » higher pay being given to new staff with similar training

Resource Support

- » lack of renewal of benefits
- » low pay rate
- » staying only because of the student loan forgiveness program

Personal Stress

- » high stress
- » needing to work more than one job
- » changing family dynamics

Environment

- » hoping for change but not seeing it
- » decreasing faith in the agency by the community
- » staff turnover

Limited Flexibility

- » limited flexibility in work schedule
- » high case loads
- » lack of support for starting families

Why They Haven't Left Yet

- » staying primarily because of the need for health insurance
- » lack of local job opportunities

Five of the staff providing feedback indicated they were actively looking to leave their organization due to their concerns.

The Potential of Decentralized Organizational Decision Making

As referenced earlier, there is a potential link between centralized organizational decision making structures[12] and an increased incidence of staff burnout and emotional exhaustion.

Direct service staff were asked whether they thought decisions about patient care at their organization were primarily top down, bottom up or a hybrid of the two. Responses at each center were mixed. While 2% of respondents rated their agency as having a bottom up decision making structure for patient care, 46% responded with hybrid, and 52% with top down. The percent of staff indicating that they felt decision making regarding patient care was a hybrid approach varied substantively across the CMHCs, ranging from a low of 22% to a high of 66%.

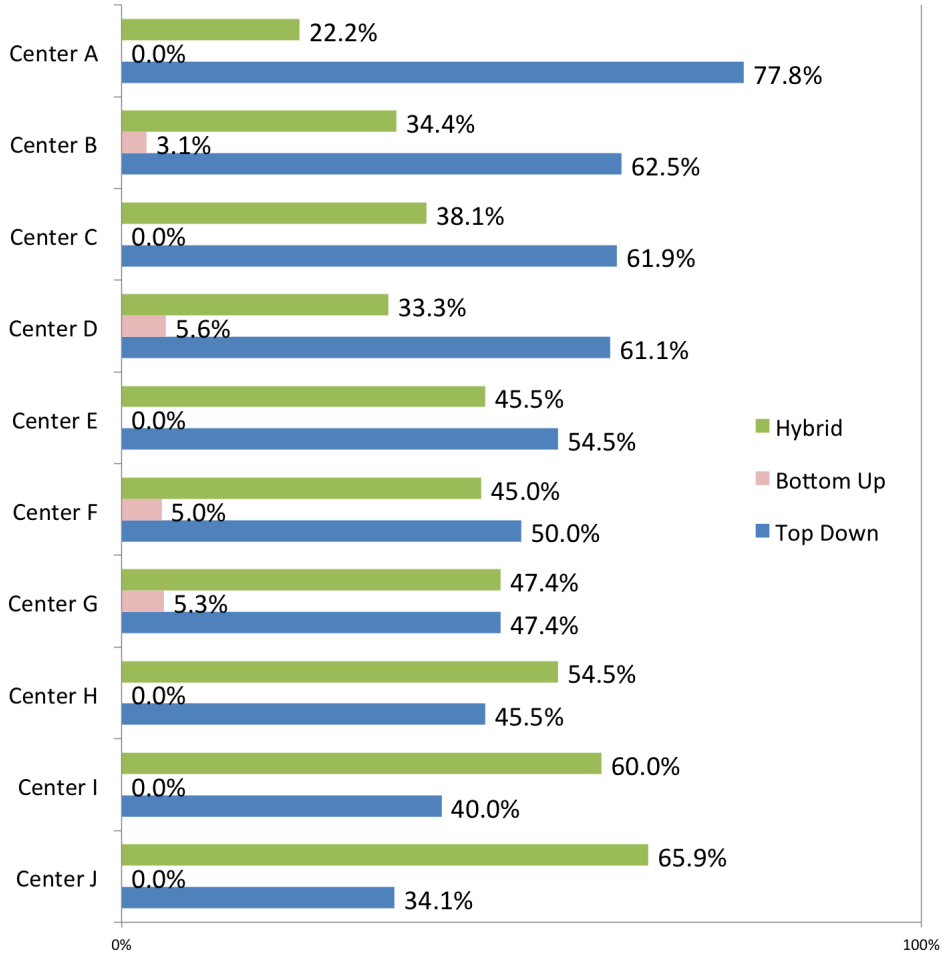
Of interest, staff who viewed patient care decision making as primarily top-down rated 35 of 52 barriers at least 10 percentage points higher in the major/critical category than their colleagues who viewed patient decision making as a hybrid approach. Similarly, when it came to issues of strategies for retaining staff over a 3+ year term, staff who held a top down view of their organization were

12 In this context, decentralized decision making refers to an organizational process where decision making authority or influence over key aspects of the organization or patient care is distributed beyond management to those directly involved in providing services.

again more likely to rate certain strategies as a critical benefit. These 18 areas included factors related to decision making and communication, raises, reimbursements / fee coverage, training, professional development and career growth, as well as personal care, recognition, options to work at home, access to current technology, and improved health care coverage.

This issue is of critical importance because of previous research that's been done in the area that ties the lack of staff decision making and self empowerment to increased incidence of staff exhaustion and burnout (Knudsen, Ducharme, & Roman (2006). In addition, this study indicates that **how a staff member views decision making around patient care in his/her agency is strongly related to staff perceptions on multiple satisfaction barriers and retention strategies.**

Fig. 4 Staff Perceptions of Decision Making Structure Concerning Patient Care



Discussion

National research on the human service and community mental health workforce, as well as our local research of CMHC staff provide a clear call for action. In New Hampshire, the demand for children's community mental health continues to increase as cases within the CMHC services system are becoming more complex, leading to the need for more advanced training and supervision. These challenges are being met in a care environment characterized by high turnover rates among providers and insufficient professional staff/expertise in areas of critical need by the patient population. But there are solutions, and they exist at multiple levels of the mental health services system.

As discussed in this work, it is clear that there is a complex array of factors shaping the mental health workforce, only a portion of which is impacted by the CMHCs. Some of these apply directly to the workforce serving children, while others (such as issues of staff pay, credentialing, and documentation burden) impact the adult workforce as well and represent broader challenges within the system. Related to this, there is a collective need for culture change at the federal, state, and organizational levels to better balance the needs for documentation and oversight with staff drive to work with and improve the lives of their clients; as well as to financially support staff at a level appropriate to their training and the value of their work.

Next Steps For Advocates, Service Providers, and Legislators

As the mental health services landscape continues to evolve across the state, it will be critical for advocates, services providers, and legislators to utilize these findings within the context of several factors shaping current mental health policy and services in New Hampshire.

1) New Hampshire's behavioral health community has come together to develop and endorse the NH Children's Behavioral Health Plan (2013). As part of this effort it is critical that our community mental health providers collaborate with other child-serving systems including school, child protection, juvenile justice, early childhood programs, among others.

2) At the state level – it will be important to review opportunities for: conducting periodic assessments of financing to ensure effective supports for a quality system; where appropriate, restructuring financial supports for children's mental health services; centers and stakeholders to increase quality of services; conducting administrative reviews of documentation and time spent by staff with consumers with an eye towards achieving a better balance; as well as exploring opportunities for creating greater parity between public and private systems among child serving agencies.

3) As efforts to improve staff retention take hold, it will be critical to ensure that retained staff have access to high quality training and coaching in best practices in order to best meet the needs of children living with mental illness. Currently, there is limited state support for training and coaching in best practices despite increases in demand to: implement evidence-based practices,

demonstrate accountability for service provision and treatment outcomes, shift from institutional to community-based care for all children, shifts from agency-driven treatment to family-centered, youth-driven care (Schoenwald, Hoagwood, Atkins, Evans, & Ringeisen, 2010; Stroul & Friedman, 2011). Such efforts are supported by several NH-based studies recommending that NH create an infrastructure and increased resources to train and support the staff in children's mental health agencies (Antal, 2013; Covert, 2009: Norton, Tappin, & McGlashan, 2007).

To help ensure these changes happen, it will also be important to ensure that awareness of the multiple impacts of staff turnover and the long term costs to the State are integrated within the State's mental health system. To this end, it would be particularly helpful to create a strategic public-private task force (similar to the partnership that launched the 10 year plan) that will develop and monitor needed changes for the sustainment of NH's mental health workforce.

Next Steps For the Research Community

The research highlights a range of important next steps to consider if the ever broadening gaps in the mental health service system are to be filled.

1) There needs to be an accurate economic assessment of the true cost of staff turnover. Without this, our ability to accurately weigh whether one methodology is better than another or whether its better than doing nothing is severely limited. This study, with the help of a broad range of stakeholders, outlines the initial factors to consider as a part of this assessment.

2) In order to better understand the employment dynamics at work, it would be helpful to do a full market study on the different profession types to determine what the gaps are between those working in similar professions both within and outside of the CMHCs. During the course of this research, different perspectives were offered regarding the extent to which gaps existed; it would be particularly helpful to further clarify this issue and educate policy makers so they can have a better understanding of one of the major factors impacting staffing at the CMHCs.

3) Viable NH-based solutions to the staffing challenge needs to be developed, piloted at the CMHC level, and, if successful, broadly disseminated. Such solutions need to incorporate the perspectives of the CMHCs, area foundations, the State, Medicaid Managed Care organizations, Insurers, and families. These solutions should have meaningful benchmarks defined for both client outcomes and cost savings and the means by which to appropriately assess these areas. Based on the research conducted in this study, it will be critical to assess the long term impact of regularly increasing salaries (at minimum for cost of living) for high quality staff who fulfill job expectations.

4) CMHCs are encouraged to begin taking advantage of the work provided in this document:

a) Consider the potential of improving decision-making at their center and further empowering employees to make informed decisions about aspects of patient care. Start with some basic questions among service staff to get a sense whether potential problem areas exist - for example, are there multiple times where, due to organizational constraints, you have not been able to provide the care you thought someone needed? What were the factors underlying these situations? How might they have been better resolved?

b) Where a commitment to regularly scheduled raises and cost of living increases is not fiscally available in the short term (though should remain a long term commitment), the report presents 48 potential strategies to pursue to improve staff retention. Of these, 24 strategies were rated as having either a major or critical impact on their plans to stay for more than 3 years by 50% or more of participating staff. It would be helpful for CMHCs to review these strategies with their staff to determine which areas are most likely to improve staff retention in the long run.

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Appendix A: Factors Impacting Staff Satisfaction

Domain	Barrier	Major or Critical Concern	N
Financial	Low salaries relative to cost of living	69.4%	219
Financial	No step raises	56.9%	204
Agency Related	Excessive documentation requirements	55.6%	216
Provision of Services	Budget issues that limit services in the community that could help the child/family	50.7%	217
Agency Related	Staff turnover	48.8%	217
Provision of Services	Budget issues that limit services my CMHC can offer	46.2%	212
Socio Emotional	Stress	46.1%	219
Financial	Low salaries relative to other employment opportunities in the region	43.8%	208
Agency Related	Productivity requirements	43.2%	213
Financial	Not enough incentives / no reward for strong performance	43.1%	211
Agency Related	High client to staff ratio	41.8%	213
Socio Emotional	Burnout	39.4%	216
Financial	Lack of productivity compensation	39.2%	204
Provision of Services	Extensive needs of families	39.0%	218
Provision of Services	Limited access to other services needed by child/family	38.4%	211
Socio Emotional	Lack of opportunities for focus on self care	36.2%	213
Provision of Services	Extensive needs of children	32.6%	215
Financial	Decrease in benefits package	32.0%	194
Financial	Lack of tuition reimbursement	30.6%	180
Financial	Managers lack flexibility in developing a reward system	30.3%	201
Agency Related	Program hours not compatible with family life	30.3%	208
Socio Emotional	Challenging and complex client situations aggravated by limited resources	30.0%	213
Financial	Training monies reduced	29.1%	196
Agency Related	Time constraints inhibit community collaboration	28.8%	212
Agency Related	Agency in Transition	25.9%	205
Socio Emotional	Compassion fatigue and vicarious trauma	23.8%	214
Financial	Lack of license renewal monies	22.9%	153
Ext Jobs	Other local mental health jobs	22.8%	206
Ext Jobs	Other regional mental health jobs	22.8%	206
Socio Emotional	Challenging and complex client situations aggravated by persistent client behavior	22.3%	215
Provision of Services	Limited family ability to access services due to transportation challenges	21.1%	213
Professional Development	Limited career path	18.2%	209
Ext Jobs	Other regional health jobs	17.0%	194

Domain	Barrier	Major or Critical Concern	N
Ext Jobs	Other local non-health jobs	16.8%	190
Ext Jobs	Other local health jobs	16.8%	196
Ext Jobs	Other regional non-health jobs	15.9%	189
Professional Development	Public perception on value of work/career path is low	15.7%	204
Agency Related	Competition with schools, private practices, etc,	14.8%	209
Agency Related	Staff position cutbacks	13.8%	203
Socio Emotional	Lack of social support	12.7%	213
Agency Related	Limited supervisory support	12.6%	214
Professional Development	Limited supervisory support	10.4%	211
Professional Development	Limited sense of personal accomplishment	9.1%	208
Provision of Services	Lack of time to interact with clients	8.9%	213
Professional Development	Limited EBP training opportunities	8.9%	180
Agency Related	Agency values and commitment	8.9%	214
Professional Development	Limited training opportunities in non-EBP areas	8.2%	184
Socio Emotional	Knowing I can make a difference	7.2%	208
Socio Emotional	Depersonalization	6.4%	203
Agency Related	Limited collaboration among staff	5.1%	216
Professional Development	Limited ability to direct my own work	3.9%	206
Socio Emotional	Aloneness due to under-representation	3.2%	188

Appendix B: Retention Strategies Most Preferred by CMHC Services Staff

Domain	Strategy	Major	Critical	N
Raises	Regularly Scheduled	33.7%	58.2%	208
Raises	Cost of Living	34.8%	56.0%	207
Reimbursement	Loan forgiveness for federally underserved areas	26.5%	52.5%	181
Raises	Longevity	35.3%	48.3%	201
Raises	Performance Based	38.7%	41.7%	204
Professional Development	Opportunities for career growth	42.9%	40.4%	198
Environmental	More flexible work hours	34.0%	38.8%	188
Raises	Level of Responsibility	37.8%	38.3%	201
Incentives	Productivity Compensation	35.3%	38.3%	201
Raises	License Achievement	26.5%	38.3%	162
Professional Development	Supervision for license eligibility	23.8%	35.1%	151
Professional Development	License supervision	26.8%	33.8%	157
Other	Improved Health Care coverage	38.8%	33.0%	188
Reimbursement	Federal rate for mileage reimbursement	33.2%	32.1%	190
Staffing Support	Opportunities for Self Care	42.5%	31.1%	193
Reimbursement	Monies for conferences	41.2%	30.7%	199
Reimbursement	License renewal fees	36.6%	29.7%	175
Reimbursement	Licensing fees	36.7%	28.9%	166
Reimbursement	Tuition reimbursement	38.8%	28.7%	178
Staffing Support	Paperwork Support	38.5%	25.1%	195
Staffing Support	Opportunities for personal growth	46.7%	24.9%	197
Professional Development	Help staff in developing specialty area	40.3%	23.0%	191
Delivery of Services	Work from home	36.2%	20.2%	188
Staffing Support	Individual recognition / appreciation	32.2%	20.1%	199
Other	Child care	20.1%	19.4%	144
Education / Training	Agency based CEU Training	45.0%	19.0%	189
Delivery of Services	Access to current technology / software	30.7%	16.9%	189
Environmental	Actively promoted effective communication strategies	34.2%	16.3%	196
Professional Development	Foster leadership development	38.8%	15.4%	188
Education / Training	Org wide training budget that you can apply to	36.8%	14.2%	190
Incentives	Recognition award with staff	26.2%	13.9%	202
Incentives	Managers receive staff performance bonus	16.0%	13.6%	169
Professional Development	EBP fidelity monitoring and support	34.5%	12.4%	177
Org Culture	Improved openness and communication about management decisions	41.8%	11.4%	201
Incentives	Staff recognition at anniversary	19.7%	11.1%	198
Org Culture	Improved decision making ability at multiple levels of the organization	35.5%	10.5%	200
Environmental	Actively promoted collegial relationships	31.1%	9.8%	193

Domain	Strategy	Major	Critical	N
Education / Training	Agency based non-CEU training	30.2%	9.4%	192
Staffing Support	Consultation groups	39.3%	9.2%	196
Education / Training	External agency supported non CEU training	33.7%	8.3%	193
Org Culture	Org wide informal opportunities (e.g. lunch and learns) related to other professional development topics	29.6%	5.9%	203
Delivery of Services	Training of primary care providers,nurse practitioners, and physician assistants	10.3%	3.0%	165
Delivery of Services	Workforce development partnerships	16.6%	2.9%	175
Org Culture	Org wide informal opportunities (e.g. lunch and learns) related to diversity topics of race, ethnicity, culture, religion, or sexual orientation	19.4%	2.4%	206
Delivery of Services	Integration of PEER Support	13.8%	2.3%	174
Delivery of Services	Video conferencing	15.5%	2.2%	181
Delivery of Services	Telemedicine	8.0%	1.2%	163
Delivery of Services	Online web-based health care	8.3%	1.2%	169