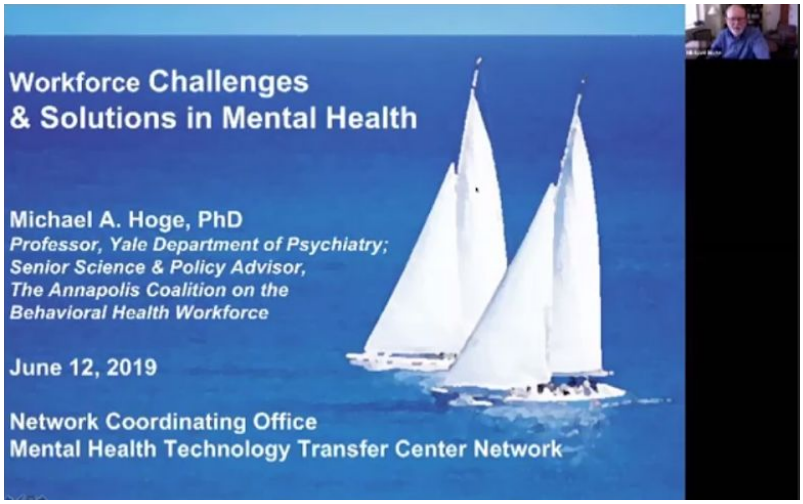
Slide 1: Workforce Challenges & Solutions in Mental Health



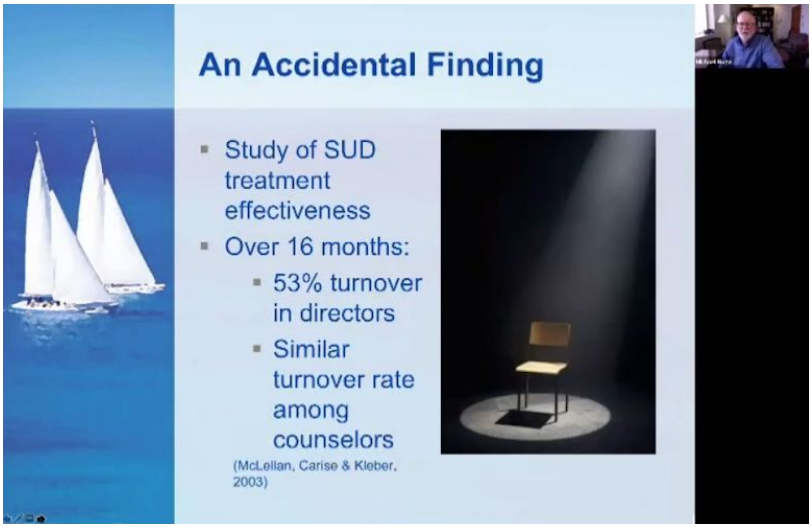
We are going to be talking about the workforce in behavioral health. We'll be discussing some of the challenges, but along the way I'll also be sharing with you some of what I believe are some of the most innovative solutions to the workforce crisis in the mental health field.

Slide 2: (The New York Times Magazine cover)

This is a picture of the cover of the New York Times magazine from 2003. The picture is meant to depict a medicinal leech on the back of a woman. Medicinal leeches were used in plastic surgery until very recently and the quote at the bottom of the cover is half of a famous quote from a medical educator, and he said "half of what doctors know is wrong, the problem is we don't know which half". This represents an area of public concern that emerged around the turn of the century, which was concerned that health care providers were not fully competent, that healthcare practices could be dangerous and it really marked the beginning of an era in which

there was much more focus in looking at the quality of care including the quality of mental health.

Slide 3:The Accidental Finding



A second stream of findings that I'd like to tell you a little bit about is this accidental finding that came from a study of substance use disorder treatment. Dr. McLellen, a famous researcher in [the] substance abuse area was looking at quality care in substance abuse treatment organizations over a period of 16 months and his method was to interview directors and staff and to come back a little over a year later to look at how, if at all, quality has changed. But the surprise finding for him, and the accidental finding, was that when he came back 16 months later, basically half of all the directors of these agencies and half of these counselors in these agencies had left, and he began to write and talk about the fact that if we did not have stability in our behavioral health organizations, that it was going to be very hard for us, if we did not have stability in the workforce, it would be really hard for us to really sustain and improve [the] quality of care.

Slide 4: (U.S. job openings hit a record 7.1 million, exceed number of unemployed Americans article)

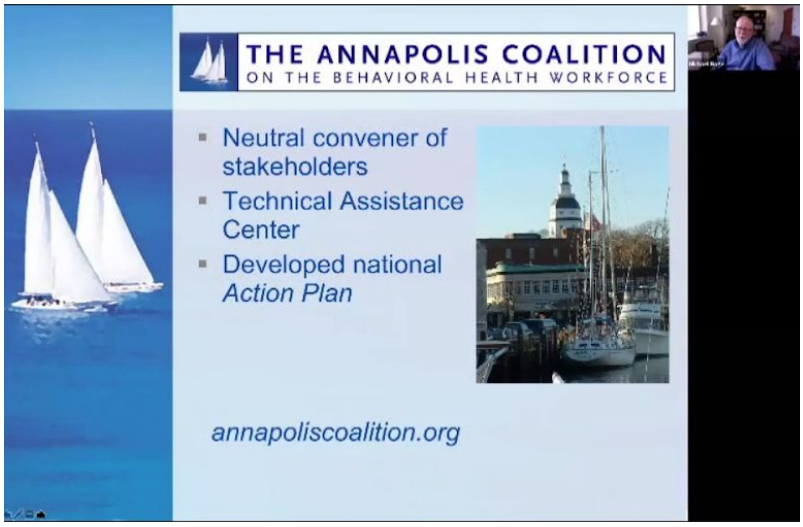
Things are actually much more challenging right now for the behavioral health field for a very simple reason, which is the economy in the United States is very very strong. There are now more open jobs across the entire economy, not just behavioral health, than there are unemployed Americans which makes it a great economy for people who are looking for jobs or looking to change jobs.

Slide 5: Say Goodbye- Highest percentage of U.S. employed quit their jobs in July since 2001

What this also means is that the "Quits Rate", which is the frequency by which people are quitting their jobs and taking other jobs is the highest it's been in almost 20 years. And we see

this now in mental health and addictions [as very significant training of the workforce?], with greater turnover rates from people looking to take other opportunities.

Slide 6: The Annapolis Coalition on the Behavioral Health Workforce

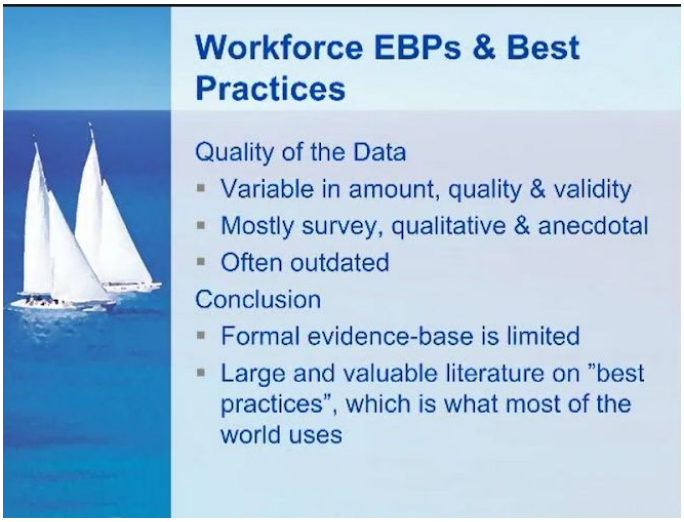


So these are the challenges that we have faced for a long time and are really acute for us: which are first making sure that the workforce we have is competent in providing quality of care and the second is to make sure we have sufficient numbers in the workforce and can work to retain them in the workforce. So my colleagues and I, about 20 years ago, created the Annapolis Coalition on the Behavioral Health Workforce as the vehicle for bringing together people from all professions and all parts of the mental health and addictions field to look at the growing workforce crisis to provide technical assistance on understanding these problems and also disseminating information about best practices on how to deal with the workforce crisis. We developed four SAMHSA and national action plans for the nation.

Slide 7: The Annapolis Framework

And out of this national action plan emerged something called the Annapolis Framework, which is a framework or conceptual model for understanding the workforce crisis and areas of intervention. And it's made up of nine different objectives that is organized into three very broad categories. The first of which is to really think more broadly about the concept of workforce and who's in the workforce. The second is to strengthen what we think of as traditional workforce and the third category of objectives has to do with building structures to better support the workforce. And what I'd like to do for you, is walk through the nine goals and share with you the opportunities we have in the behavioral health field to strengthen the workforce in these various ways.

Slide 8: Workforce EBPs & Best Practices



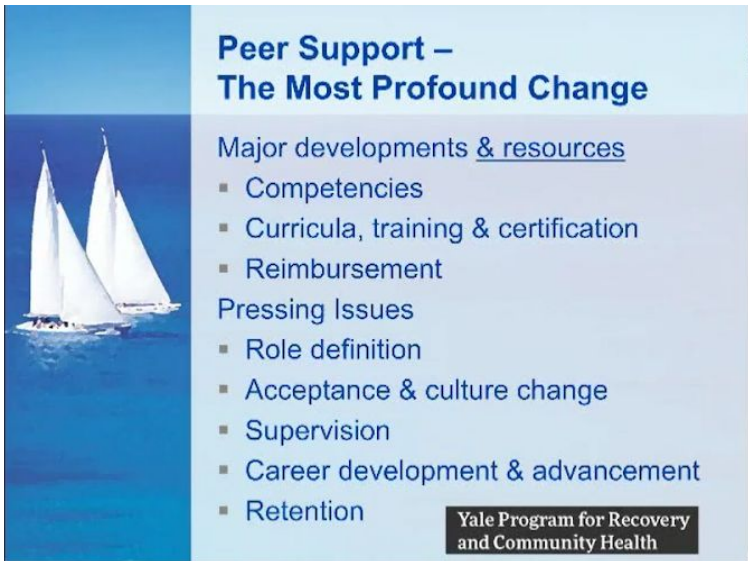
Before doing that, I want to just comment on the nature of the data that's available on workforce evidence based practices or best practices. The data is variable, depending on the topic and its amount and its quality and some of it is not very rigorous, so there are questions about its validity. We mostly have survey data and qualitative and anecdotal data around workforce interventions and unfortunately some of the data becomes quite dated very quickly sort of after it's released. So you can be sort of negative about what we have and say the formal evidence base on workforce practices is limited, but I would argue that there is actually very large and valuable literature on best practices and that most of the world, healthcare and in business, relies on best practices that have been identified over the generations in thinking about how we recruit, retain, and develop the workforce that we have.

Slide 9: Goal 1: Workforce Roles for Patients & Families

So, let's move forward and look at some of these objectives and some of the innovations within them. So, in thinking about broadening our concept of workforce the notion here is that we will never have enough professionals coming out of our traditional disciplines to meet the needs for mental health care in the United States. And expanding workforce roles for persons in recovery and families, we view as perhaps the most important, number one sort of priority, as we move forward in developing our service systems and the workforce within it. The specific objectives that have emerged in this area are to first educate people in recovery and families about self care, the second is to build their competence in shared decision making, having them be a much more engaged in making decisions about the type of healthcare that they want. The third area here is to expand peer and family support services, both formal, organized efforts, as well as informal support mechanisms. The next, is to increase the employment of people in recovery

and their family members as paid staff in our systems, and the last, sort of innovative area, is increasing use of people in recovery and family members as trainers of what we think of as the more traditional workforce.

Slide 10: Peer Support- The Most Profound Change



I would argue that peer support, and the development of peer support, peer support workers, is the most profound change that we have seen in the mental health workforce over the last 20 years and there have been enormous developments, and there are a wide range of resources available to you to help in this endeavor; there are multiple competency sets that have been developed, there are formal curricula and training programs, certification processes for peer support workers, and there are reimbursement mechanisms for the time of peer support workers, which makes it a particularly viable intervention in our systems of care. These things have all led to a number of pressing issues that are before us now. We continue to struggle as a field to define the role of peer support workers in our systems of gaining their acceptance by others that were already working in these systems and bringing about change in organizational culture that supports peer workers being in these service settings. People are beginning to develop models for supervising peer support workers and addressing questions around who should supervise peer support workers and what the focus of supervision should be in an intervention that involves primarily the provision of peer support. We have questions before us about career development advancement for peer support workers, because we have created frontline peer support work positions but there are not a lot of opportunities for people to grow

through a formal career ladder and advance in these roles, and lastly we are beginning to see a turnover as peer support workers lead these positions, and so retention is something that becomes paramount for us to think about as well.

I highlighted here the Yale Program for Recovery and Community Health, based here at Yale under the leadership of Dr. Larry Davidson, who's been a primary leader in this area and also runs one of the mental health technology transfer centers. They have created a wealth of resources for not only training individual peer workers but also for making entire systems of care and organization much more recovery oriented and I would encourage you to look at their resources and reach out to larry if you're interested in learning more about the resources that are available.

Slide 11: Goal 2: Workforce Roles for Community Groups

In thinking about broadening our workforce, another very innovative area has to do with expanding the workforce role for community groups. And the idea here is to build competencies in naturally occurring communities and community groups and also to teach behavioral health providers to work with those groups. This is an intervention that is very common in prevention and in the areas of substance use and rural health, perhaps it's most prominent application has to do with the development of anti-drug coalitions in communities. The innovation I have highlighted here is from CADCA, an organization that has really pioneered training community groups in a competency based way on how to form a coalition, how to assess a community's

needs and how to address those needs with interventions, and evaluate the impact of those interventions. So, I would direct you to look at some of the CADCA resources if you are interested in this idea.

Slide 12: Goal 3: Roles for Health & Social Service Professionals

The third way we have been expanding the behavioral workforce is by expanding the roles of health and social service professionals who are not in the behavioral health field. As you likely know, there has been a lot of work with primary care providers in implementing integrative care that teaches them to be able to screen and asses and do brief interventions with individuals presenting in primary care settings who happen to have behavioral health problems. We've had a lot of development around screening and brief intervention techniques. There has also been work on co-location and consultation and referral models, though those have proven to be less effective than truly integrated care approaches. A lot of the screening and brief intervention have been focused on training emergency department personnel to be able to recognize behavioral health problems that present in emergency rooms. And with the Sandy Hook tragedy, the killings that occurred here in Connecticut some years ago, there's been a national effort to greatly expand the training of teachers and other school employees as first responders around mental health issues.

Slide 13: Resources

There's a lot of resources here to draw on. SAMHSA has funded, and HRSA, has funded the center for integrative health solutions and this is one of their webpages on workforce development. Highlighted on the right are the core competencies for integrative behavioral health and primary care that are useful for training in both pre-service and continuing education. Those are competencies that my colleagues and I developed for the center about five or six years ago. Other places within this website have job descriptions, sort of ideal job descriptions for integrative care environments. Also highlighted here are some of the expert resources and youth mental health first aid which has been the youth aid model that has been most prominently disseminated since the Sandy Hook Tragedy.

Slide 14: Goal 4: Recruitment and Retention

So we've talked about expanding the concept of the workforce, and I want to move on now to look at the second bucket of objectives which has to do with strengthening what we think of as the traditional workforce, and the first of those goals in that bucket is to focus on recruitment and retention. These are seemingly simple ideas, but there are many different objectives that we have here in this particular area and that has to do with expanding the workforce by bringing people into the behavioral health field in general. There's initiatives to bring people into specific professions, there's similarly initiatives to bring people into specialty areas such as working with child populations or older adults. We have the challenge of bringing people into or keeping them into geographic locations, often rural areas where recruitment and retention can be difficult. We have the specific challenge of recruiting and retaining individuals in faculty roles. The crisis in nursing for example has been driven in part by the difficulty in finding faculty educators so that educational programs could expand. And then the challenge you'd be most familiar with is recruiting and retaining people in specific behavioral health jobs at the direct care, supervisory, and managerial levels. And then across all of that, we have the challenge of trying to diversify the workforce creating more diversity of all types, not just racial and ethnic cultural diversity in our workforce which tends to be still predominantly Caucasian.

Slide 15: (Image of kids)

This is a vision I had for recruitment in our field. These are young children signing up with their letters of intent, their applications, to work in our field. [...]While it's pretty well-known from research that if you want to shape someone's ideas about a career, you must begin early in the course of their lifetime. This is what the science researchers found out in terms of interesting

young individuals entering scientific careers. We have a couple states, California and Nebraska, that have educational initiatives that touch high school populations and educate them about mental health professions.

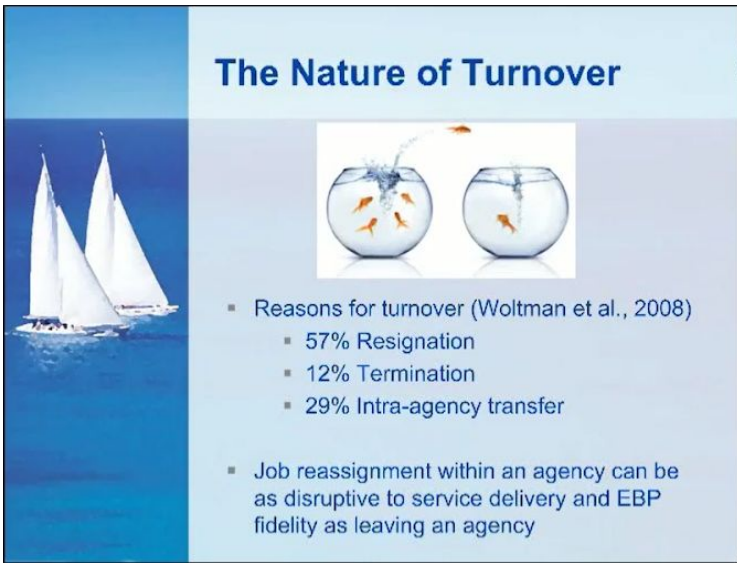
Slide 16: (Image of men fishing)

In contrast to this, this more characterizes the models we use in behavioral health, which are referred to as catch and release. So we spend a lot of time finding people for jobs, but we have fairly high turnover rates, so having invested in the effort to find them and orient them, bring them onboard, we sort of lose them back into the workforce; sort of a major issue we need to increasingly confront in mental health.

Slide 17: Range of Turnover Rates

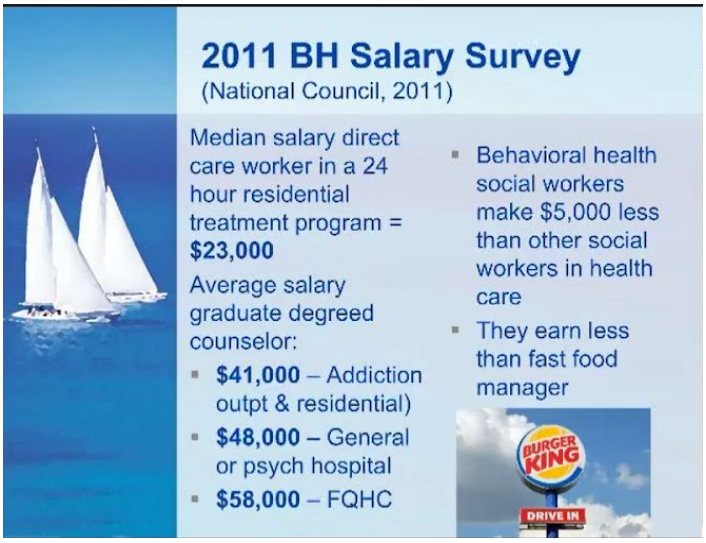
If you look at the research, you can find turnover rates as high as 73% per year and I've had organizations that I've worked with where the turnover rate has been as high as 150% per year. Not completely sure on my math here, but my initial calculation was that this was going to be equivalent to full turnover in the organization every 9 months. So, pretty dramatic picture for some of the organizations and particularly for direct care, non-degreed workers at the front lines of the mental health system.

Slide 18: The Nature of Turnover



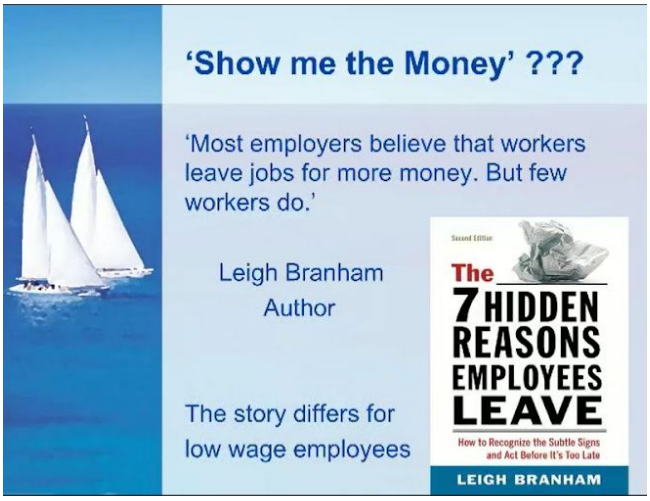
If you dig a little deeper into the nature of turnover, a study by Woltman in 2008, chose this way to look at turnover. 57% of the people leaving the organization had resigned, 12% had been terminated, there our question would be "what was the recruitment of this person?, did we do a good job bringing them into the organization?". But Woltman also decided to capture the percent that stayed within an organization but had been reassigned via transfers, and that was 29% in a given year. And this last bullet here highlights something that everyone should know, which is that job reassignment within an agency can be very disruptive and has been shown to disrupt the fidelity to evidence based practices. So, if you have a member of your workforce and you teach them an EBP, and then reassign them, their expertise they had for that particular role working for that particular population is often disrupted.

Slide 19: 2011 BH Salary Survey



When we talk about recruitment and retention, everybody wants to focus on salaries, the best data that we have is from 2011, done by the National Council. We can see that the salary for direct care, non-degreed workers was very low, probably not what we consider to be a living wage. Below that, on the left column, we can also see that average salaries for graduate-degree counselors vary significantly by what is likely the economic health of the organization. So, addiction, outpatient and residential programs had the lowest salaries and FGHC's which have, these are federally qualified health centers, have among the highest reimbursement rates for mental health services and in turn the highest salaries for graduate-degreed counselors. Another interesting finding was that behavioral health social workers working in a health system for example, were making on average $5,000 less than comparably trained social workers that were perhaps working on a medical unit. And the finding that they like to highlight, the sort of catchy finding was that social workers in general were making less than a fast food manager at the local fast food joint, despite the fact that advanced education was not required for those managerial positions in the restaurant industry.

Slide 20: ‘Show me the Money’???



Everybody thinks of money as the recruitment, retention driver; this quote from Leigh Branham, as research in the business industry says, “Most employers believe that workers leave jobs for money. But few workers do.” That generally appears to be true with the exception of employees who are making very very low wages. They may move jobs for slight increases, in order to better their position given how much they may be struggling to cover their living costs. So what does Leigh say people leave for? What are the reasons?

Slide 21: The 7 Hidden Reasons Employees Leave

These are his seven hidden reasons. The job or workplace is not what they expected it to be, there is a mismatch between the job and the person, there are complaints that they get too little coaching or supervision or feedback, that there aren’t enough opportunities to grow, that they

feel devalued and unrecognized, stress from overwork and work-life balance, and the last here: loss of trust and confidence in senior leaders.

Slide 22: Other reasons for turnover

My colleagues and I have delved through the literature in mental health and have found these other reasons cited for. The departure-the turnover rates, high caseload sizes, the impact of vacant positions, which put a greater burden on the people still in the organization, mental health workers sometimes complain that their roles are not adequately clear or defined, the lack of varied work opportunities, a work environment that does not have supportive teams; supportive teams are something that seem to be quite valued by workers in our field. And for supervisors and managers, there is a lot of evidence that some of them are assigned a very high, reasonably high, of individuals to supervise and in addition to that might have direct care workload which might take up at least half of their time. So, this is another factor that can lead people to part an organization.

Slide 23: SAMHSA Recruitment & Retention Toolkit

So in terms of the solutions and resources that are available, SAMHSA funded the development of a recruitment and retention toolkit. This is available to you, no charge, at the web address listed below. And it lays out an approach that involves the steps here: which you build a plan, focus on recruitment, focus on how you select people that apply, improve your efforts at orientation or onboarding and then offer more training, supervision, support, recognition, and career development opportunities. The beauty of this is that if you follow this kind of model, you in essence are creating not just a recruitment and retention plan but a workforce development plan for your organization.

Slide 24: An Innovation

Another innovation here, in this area, on recruitment and retention, is a small company called Occumetrics. They were developed by Mental Health Association, this one, Mental Health America of Franklin County in Columbus, Ohio, funded by the Ohio Mental Health and Addiction Services, which is the state agency in Ohio that oversees mental health care. And they have developed a model for coming in and assessing workforce using standardized survey instrument. They then engage the workforce in a process of focus groups, and bring back to management a report that shows were your workforce ranks on a variety of dimensions compared to the workforce of other organizations, and those are tied to a lot of recommendations that they then offer about where you should focus your attention to improve your recruitment and slow the departure of individuals from your organization.

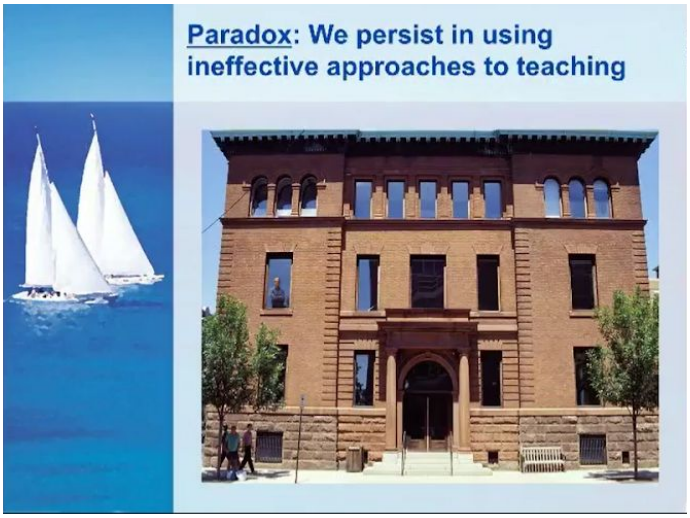
Slide 25: Annapolis Coalition Learning Collaborative

I represent the Annapolis coalition. And this past year, with support from the Great Lakes Addiction Technology Transfer Center and the Central East Mental Health Technology Transfer Center, we've launched recruitment and retention learning collaboratives in the states of Maryland and Ohio. Organizations compete to participate, they then create small change management teams that spend a day with us learning about best practices in recruitment and retention. They begin to develop and then go on to implement a recruitment and retention plan tailored to their needs. And we provide them with ongoing technical assistance, individually and we bring them together for collaborative conference calls, all agencies together to talk about their success and obstacles and challenges they've had in improving their recruitment and retention practices.

Slide 26: Goal 5: Training: Relevance, Effectiveness, & Accessibility

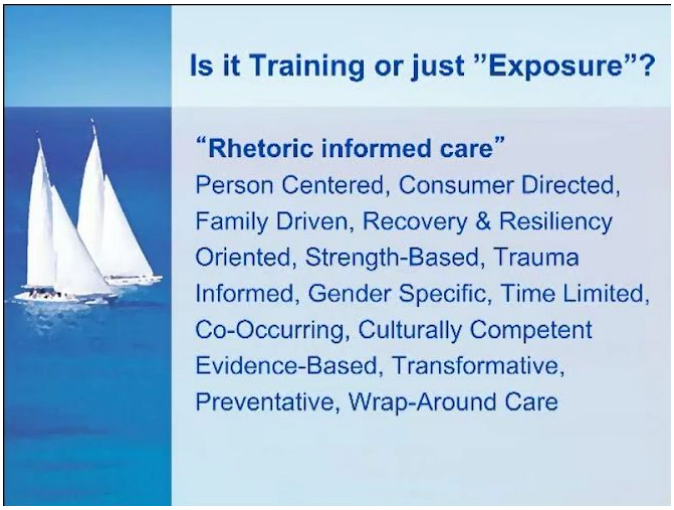
So, we've talked about recruitment and retention. The next task has to do with, the next goal has to do with improving training, making it more relevant, making it more effective, and making it more accessible to individuals in the field. The basic model here is that there's a big push to identify competencies for training and build and tie curriculum to those competencies. We're learning a lot more about evidence-based training methods, effective training methods. We have increasing opportunities to use technology to assist in instruction. The area and art of assessing competencies is growing quite rapidly. We have a dire need to make sure all members of the workforce have co-occurring competencies in both mental health and in addictions, since those two conditions more frequently than not occur in individuals that are presenting for our care. And we have a long overdue need to provide much greater training to the direct care professional workforce at the frontlines of our system, which usually only get a day or two of training, on the job, for their very challenging roles.

Slide 27: Paradox: We persist in using ineffective approaches to teaching



Another famous educator said that our approach to education is about as effective as having an educator, pictured here standing in the [left upper floor window?] shouting at the students pictured here walking on the sidewalk “try this, try that”, throwing out ideas that we do not adequately engage in true competency based, true skill and performance based development of our workforce.

Slide 28:Is it Training or just “Exposure”?



It raises the question about whether we’re really providing training to individuals or whether we’re just exposing them to ideas. And my thought about that is what we are mostly engaged in with many of our educational efforts is what I call, at least creating what I call “Rhetoric informed

care", in which we teach people a little bit about a lot of things so they have heard and could possibly mention things like *person centered, consumer directed, family driven, recovery & resiliency oriented, strength-based, trauma informed, gender specific, time limited, co-occurring, culturally competent, evidence-based, transformative, preventative, wrap-around care*, but may have only surface-deep knowledge about what these concepts mean or how to apply them in their daily practice.

Slide 29: Effective Teaching Strategies

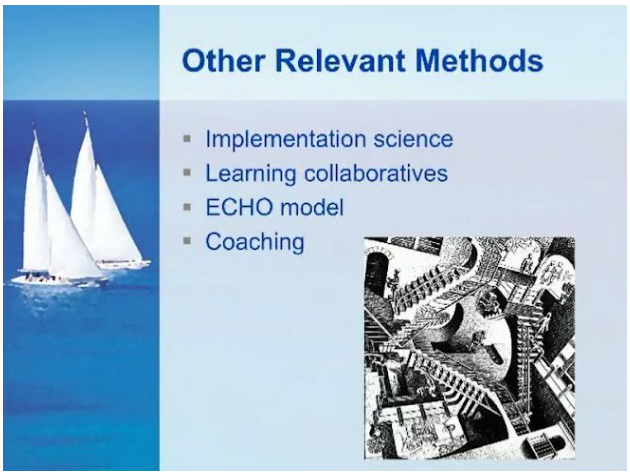
There is a fascinating literature on effective teaching strategies and it teaches us that there are no magic bullets; there is not a single thing that you can do that will guarantee that someone will take the knowledge that you give them and be able to apply it to practice. But what it does show is that there are a whole bunch of interventions and each one has a small effect and the more of these you build into your educational approaches, the more effective the education of your workforce will be. So we know that interactive session in trainings are much more powerful than didactic trainings, we know that academic detailing or outreach visits (brief visits to coach them on a particular practice) has an effect, we know that giving people reminders or auditing their work or their charts and giving them feedback on what they're doing has an effect. The use of opinion leaders involves finding people in an organization where training has occurred who are revered and respected and engaging them in the process of encouraging others to adopt the practices you are promoting through your training. We know that we can change what workers do by working through the patients or consumers; so if I give information to consumers about available vocational services that may be as effective in increase in use of vocational services

as giving the information to the staff. And lastly, social marketing is a fancy term for the notion that if we want something to be adopted we must engage in a market and approach that convinces our workforce that this is a valuable thing for them to learn and understands what their reluctance may be, understands and addresses what their reluctance may be to adopt these new practices.

Slide 30: (image of brain scan)

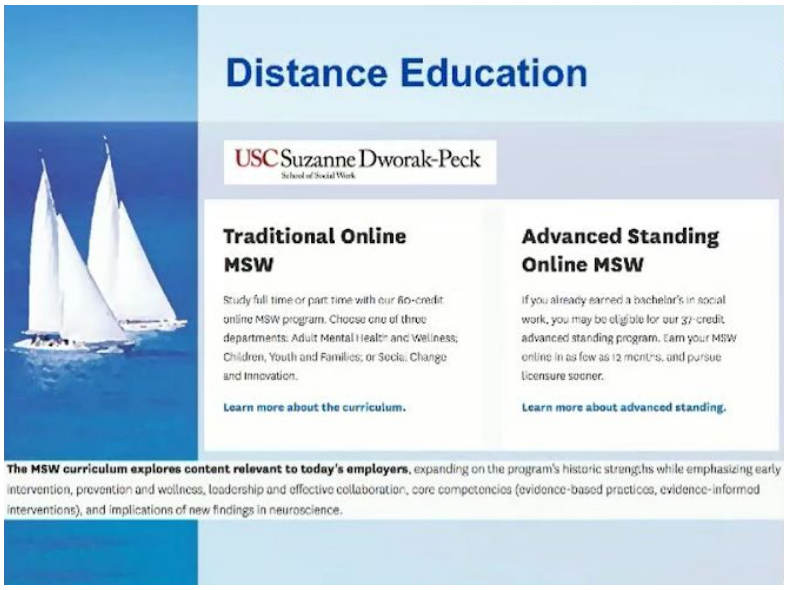
An interesting fact is that research also shows that if you show people pictures of brain scans while giving them information, they're more likely to believe that that information is true, that you've taken your information from brain research. So I encourage you to stare at this slide for 1-2 seconds so that you will increasingly believe the information that I am providing here to you today.

Slide 31: Other Relevant Methods



There are other relevant methods for teaching and for changing behaviors. Implementation science is the area of work that has tried to perfect approaches in which we not only teach our workforce but we change the organizations in which they work, which often unfortunately sort of block or defeat efforts of the workforce even when trained to engage in new practices. Many of our organizations look like the Escher drawing that's pictured here on the slide. And the basic point again is that you must work with the organization and create organizational change in terms of changing worker knowledge in order to be successful in changing the performance of your workforce. I've mentioned the learning collaboratives that we are doing on recruitment and retention were you bring different organizations together to learn and then build plans for their organizations. So these are quite common approaches. The ECHO model brings members of the workforce together to learn about a specific practice and then allows them to stay connected through teleconferences that are case conferences in which they can get ongoing consultation about their application to work. And there has been a resurgence of interest in the practice of coaching where individuals get intensive, sort of, guidance and support typically around implementation of a certain practice or around becoming better problem solvers in the day to day work that they do.

Slide 32: Distance Education



Distance education has become very powerful in our field. This is an example of two online MSW programs, so you can take a shorter program, the one pictured on the right if you already have a bachelors in social work, and a longer program online if you are coming with another

degree. This particular program, out in California, was funded by, in part by the federal program as a startup and you'll notice the words below talk about the focus of the program on not only expanding the programs historic strengths, so this is sort of traditional social work, but also emphasizing early intervention, prevention, wellness, leadership, and collaboration, core competencies, and implications of new findings in neuroscience. So this program is really stepping out in trying to be at the vanguard of, sort of, innovation and making their graduates highly productive and relevant to the current market that most employers are providing services in.

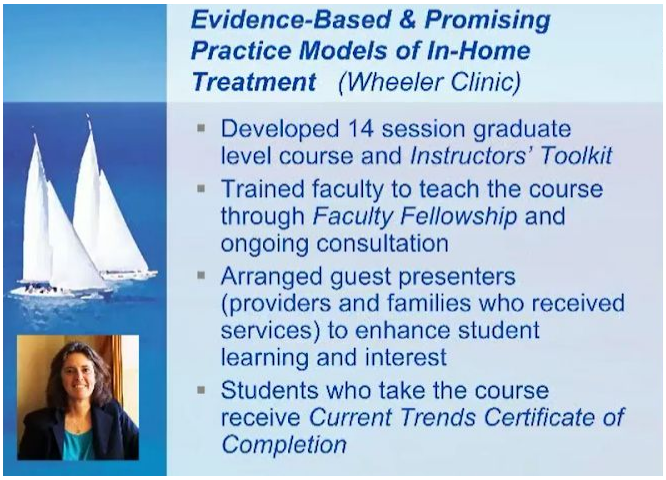
Slide 33: Associate of Applied Science in Behavioral Health Support Program

Another initiative attempting to grow the workforce is in Missouri, the state of Missouri through its Department of Education and I believe through its Medicaid arm have created a track so that individuals can get an Associate of Applied Science and Behavioral Health Support over two years and are eligible to provide services in positions that were previously only eligible for reimbursement through bachelors trained staff members. And there are lots of these training programs available at the different community colleges now in Missouri.

Slide 34: Interface between Academia & Employers

We hear a lot of complaints at the interface between academia and employers. The *employers* are often dissatisfied with the professional preparation of graduates saying that they were not prepared for the real world and *educators* who are very innovative are often dissatisfied with the lack of best practices in the employers setting; so if they train a student in an EBP and that student goes into a community practicum they may not see that type of EBP or other EBPs in practice. We unfortunately see employers decreasing the number of students or interns that they take into their settings because of restrictions on the interns time, the burden of having a student, and unfortunately many organizations have less staff availability to supervise students. But the real tragedy here is that many employers fail to see the value of student placements as a recruiting strategy. That old adage that ‘to know us is to love us’ is very true in the sense that students who train in the organizations often become quite fond of them and can be a major pipeline for new recruits in your recruitment efforts.

Slide 35: Evidence- Based & Promising Practice Models of In-Home Treatment



I wanted to just talk briefly about an Evidence-Based & Promising Practice Model of In-Home Treatment, this was developed in Connecticut to address the absence of individuals trained to work in our large in-home treatment system for kids who are in trouble with the legal system. And Elizabeth Cannata, pictured here on the left, a psychologist who developed a 14 session graduate level course and a very comprehensive instructor toolkit to go with that. There was a 26 hour faculty fellowship that was created that faculty would go through in order to learn how to deliver this course. And she arranged a system of guest presenters made up of providers of in-home services and families who had received those services to go to the colleges and teach some of the sessions. And then offered a certificate of completion for students who went through this particular course.

Slide 36: Achievements To Date

This data is about 9 months old here, but as of nine months ago, Elizaebth had trained 32 faculty fellows across 14 graduate programs in 9 universities in 3 states. Those other states are contiguous to Connecticut. 3 of the universities or graduate programs made this a required course because it addressed their accreditation need to demonstrate teaching and evidence based practices. It has been a regular elective in 8 programs, over 600 students have completed the course and families have felt very empowered through this experience, as educators and the students rate family and provider lectures as the, sort of, best part of this educational experience.

Slide 37: Ingredients for success

I never thought this would work. Academia changes slowly and so we spent a lot of time figuring out why was this so successful. And I think there's some key lessons here; the resources that were created are comprehensive and very practical, we focused on faculty development in this Connecticut initiative really teaching people how to be able to teach the courses, the alignment of graduate program needs from an accreditation perspective made it very palatable to the educational institutions. Small financial incentives were offered for startup to the faculty and their graduate programs. The curriculum was meaningful. The provider and family involvement really attracted and resulted in the high praise from the students. There was a lot of social marketing involved and this training aligned with job opportunities that existed in the marketplace.

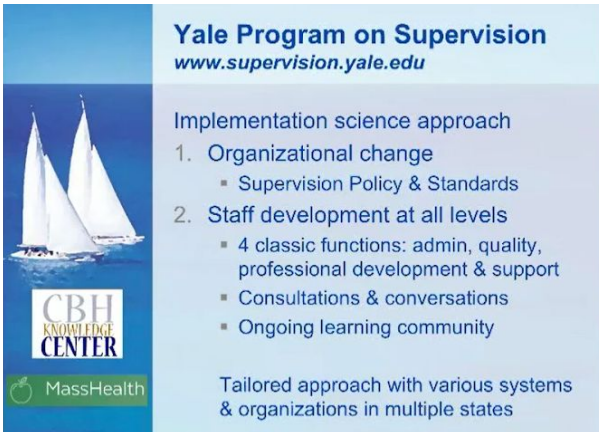
Slide 38: Direct Care workers

Imagine the dire need to train direct-care workers. There is a readily available service online called the ‘Road map of core competencies for the direct-service workforce’, these are competencies you can use to guide your training of this frontline workforce. We also have some competencies that are available online, developed in Alaska, these were cross-sector competencies addressing mental health, substance abuse, developmental disabilities, and long-term care and part of Alaska’s initiative to strengthen their frontline workforce in their state.

Slide 39: Goal 6: Leadership

A 6th area of focus in strengthening the workforce has to do with leadership and supervisory development. A core need here is to improve an organization's supervision policies, standards and support to identify the competencies you are going to teach and then to have curricula and programs that are the bedrock of, sort of, ongoing leadership development that starts with supervision in your organization. And all those steps make succession planning possible. An example of an innovation here, something the Annapolis Coalition cited as an innovation a number of years ago, was the leadership program in Aurora Mental Health Center, outside of Denver. They allowed staff to or invited staff to apply for this leadership experience, which involved spending 3 days over a long weekend together being educated about leadership principles and quality improvement principles and then also having guest lectures from local leaders about their perspective about the concept of leadership. Those would be people like the superintendent of schools or the police chief that would come and share their ideas with the Aurora Mental Health Center Staff. Participants in the initiative then engaged as a group on equality improvement project for the organization over about nine months and presented the outcome of their work to the agencies leadership and any other staff that wanted to attend at a summative meeting of the leadership program. It's been a few years since I've talked with the Aurora folks, but at the time that I did they were spending about $6,000 a year on this initiative and staff hotly competed to get into this initiative. And one of the things I found most interesting is that they, leadership of the agency really felt that it changed, moved staff from, sort-of, a one-down, sort of whiny feel about the organization to feeling more ownership and control of the organization, no matter what level they worked in the hierarchy of the Aurora Mental Health Center.

Slide 40: Yale program on supervision



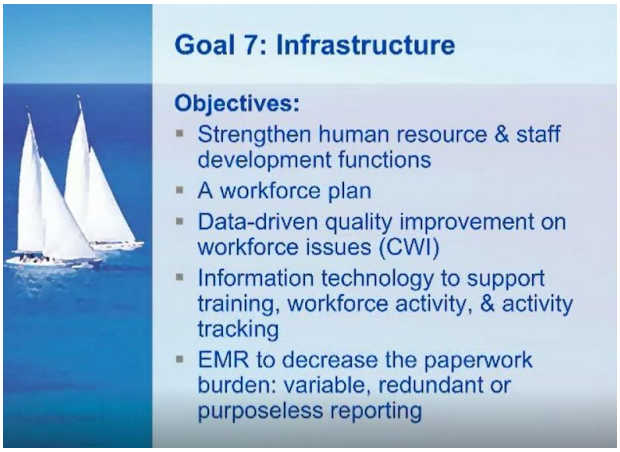
There has been a lot of work on supervision. Here at Yale, we've developed the program on supervision and its essential ingredients are built around implementation science approach.

So we focus on consulting the organizations and helping them to change their supervision policies and standards, making them stronger. And then move to the staff development piece; working at all levels of the organization to train the four classic functions, to train best practices in the four classic functions of supervision, which are administrative, quality, ensuring quality, professional development, and fourth, support of the workers. These are what we call consultations and conversations in which we bring in best practices but also facilitate conversation in which participants share their best practices with others in the room, which has been a very powerful approach.

Slide 41: ATTC Clinical Supervision Courses

In the addictions side, the addiction technology transfer centers, have clinical supervision courses. You complete some of these online as a precursor to being able to participate in the networks face-to-face trainings. The ATTCs have been very strong in the supervision areas and in terms of publicly available resources, these are some of the best that would still have great relevance to your work in mental health.

Slide 42: Goal 7: Infrastructure



So moving on to some of the structures that we need to support the workforce. Organizations desperately need to have adequate human resource and staff development capacity. We argue that every organization should have its own workforce development plan as part of its organization and develop in data-driven, quality improvement on workforce issues just as we do on overall quality of care. There are lots of opportunities for using information technology to support training and workforce activity and activity tracking. And a strong need to strengthen electronic medical records to decrease the paperwork burden which staff almost uniformly describe in our organizations as variable, redundant, or purposeless reporting. So, a lot of controversy about electronic medical records, but they provide an infrastructure that in many ways can be quite helpful.

Slide 43: (Image of Romans)

This is my image of the impact of paperwork burden on staff productivity; just the notion here that people drown so much under the burden of the documentation that they have to do, that it's very difficult for them to get any traction in their basic functions.

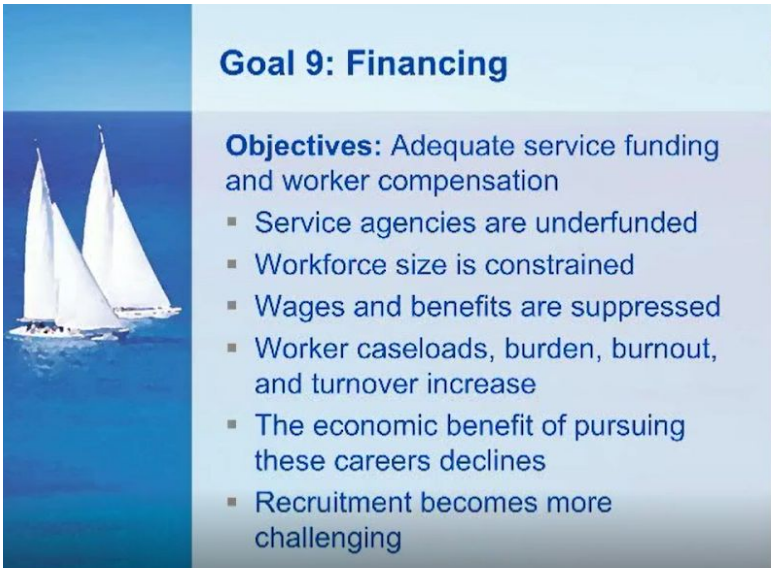
Slide 44: Behavioral Health Education Center of Nebraska

Some other structures that exist; this is the Behavioral Health Education Center of Nebraska. It is a center funded by the state legislature for the sole purpose of promoting the recruitment and retention of the behavioral health workforce. They have done an enormous amount of work in this area and the intervention pictured here is the ambassador program, which is one of those programs that reaches out to younger individuals, which I believe this is primarily high school, to get exposure to behavioral health careers.

Slide 45: Goal 8: Evaluation & Research

Goal 8 is about evaluation and research. A couple years ago the federal government funded the behavioral health workforce research center at the University of Michigan, that we are now getting better data about the workforce across the nation. The most important thing that I would like to emphasize for you is if you embark on any kinds of initiatives or interventions related to improving your workforce to do your best to document the processes [you] are using to evaluate even informally the impact that they are having. And if you have something that you think is worthwhile, to do your best to disseminate that info to others and to share the wealth in that way.

Slide 46: Goal 9: Financing

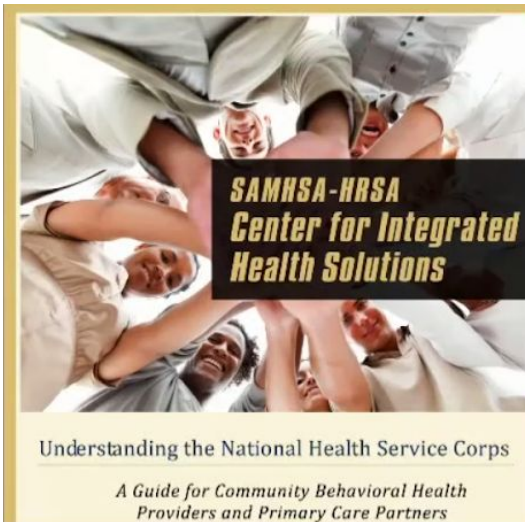


The final goal around structure has to do with our financing structures. We know, sort of, what the dynamics are here with when we have underfunded services, and that is that if the resources are not there, the workforce size in constrained and we simply hire less people, wages and benefits become suppressed and then our caseloads and worker burden, burnout and turnover increase. And overall we know that the economic benefit of pursuing a career in mental health has declined over the years and that makes recruitment more challenging.

Slide 47: States as the Focus

But there are solutions and this is a very recent and very bright one. The state of Maryland recently passed an increase in the minimum wage and the behavioral health organizations though their lobbying group lobbied hard and achieved a 22% increase in behavioral health funding over a period of 6 years to cover the projected increase cost in minimum wage. The governor, of course, vetoed this, but I'm happy to report that legislature overrode the veto and this 22% increase stayed in place.

Slide 48: SAMHSA-HRSA Center for Integrated Health Solutions



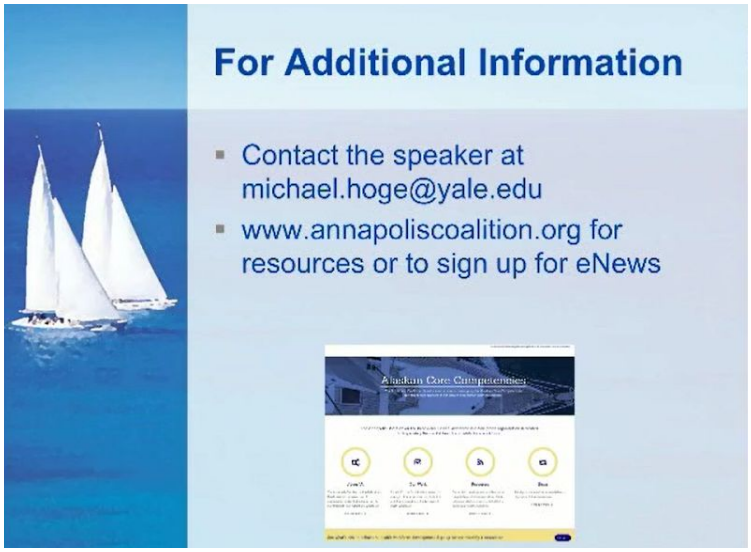
The other major thing that happens in our country around financial support is the National Health Service Corp. This provides loan repayment funds and other types of funds to individuals who agree to work in underserved areas. There is a complex process for becoming qualified as an organization to participate in this program and there are more agencies looking for participants in the program than there are participants. But that being said, for the right organization at the right time, this can be a powerful way to attract somebody or keep somebody among your own workforce. The document shown here is a sort of guide for community behavioral health on the national health service corps is available on the 'Center for integrative health solutions' website, which I highlighted for you earlier.

Slide 49: Advocate and Act

So, just a concluding thought. I used to say that workforce was like the elephant in the room, meaning that the thing that was always there, sort of always in our way, in terms of being successful, but something we never talked about. And then I saw this cartoon in the New Yorker not too long ago, this lovely couple sitting by their elephant saying 'Actually, it's all we ever talk about'. There is a lot of discussion about workforce these days and the challenge now is to actually take action. I encourage you to do what I call *advocate and act* ; if you believe that mental health services are underfunded I encourage you to advocate with your local, state and federal politicians and agencies and whatever, to keep advocating for more and better resources for our field. But at the same time it is imperative to act; there are many things that

you can do to strengthen your workforce with the resources that you have available to you today. So advocate and act is my encouragement to you.

Slide 50: For additional info



If you have questions for me you can email me at this address, you can look at our Annapolis Coalition website and there is a place where you can sign up for our ENewsletter about workforce issues. We issue this no more than four times a year, so it is not something that will overwhelm your inbox. The slides and handouts and the recording from today's presentation will be available online at the MHTTC website in the near future so you can access those as well. And If I am successful here, I am going to turn this back over to Heather.

Heather: Thank You Michael , can you hear me?

Michael: yes I can

Heather: Great. So I wanted to give you a big thanks for the great presentation and wanted to ask, in our remaining few minutes, if there were any questions; if you have questions you can type them in the chat or you can unmute yourself and ask away. So, Michael I did receive a question privately to me through the chat, that asks if you can talk for just a minute about specific strategies for recruitment and retention.

Michael: Wow, that's a big question

Heather: Or key resources for recruitment and retention.

Michael: Well, so the planning document that I highlighted from SAMHSA is the sort of largest publicly available document online. It is sort of a strange web structure that you sort of have to make your way through but there are hundreds and hundreds of resources that are available to you within that. Many of the recruitment and retention strategies that are available to us are really not unique to behavioral health organizations or really even unique to healthcare and they start on the recruitment side on being more intentional about thinking about where you post jobs and in addition create more of a presence for your organization in the community so that people think of your organization when they think about potential employment. And there increasingly lots of social media opportunities at very low costs to increase an organization's presence. Once you find people, there is an opportunity to be intentional about selection, encourage the use of things like job shadowing, where a prospective candidate spends a little time in the organization observing the work, particularly at the direct-care level so that they can understand what the work might entail. Beyond that, being more systematic about not just an orientation but a thorough onboarding process where you really welcome an individual and convey the value the organization places on them and give them a thorough introduction to their work. And then from there on, there are the training and supervision and career opportunities that are the foundation of what I think keep people happy and make them feel like they have the opportunity to grow their jobs and their careers within the context of your organization.

Heather: Excellent. There is a question in the chat, can you speak for a moment about recruitment and retention of local workforce in rural and underserved areas, many localities struggle with programs that incentivize individuals to come work in underserved areas like for example through loan forgiveness but as soon as their obligation is met, those professionals leave. Many localities want to focus more on *grow our own approach*.

Michael: I think that grow your own approach is a fabulous model, and for those that are not familiar with it, it is the concept of finding individuals who live in the area who we call "place committed", they live in this area, this is where they grew up, this is where they want to stay. And so the challenge to *grow on your own,* is that you must have a career ladder that's available for them to climb, so you generally need to have some entry level positions that they can move into and some combination of additional opportunities for education and job advancement so

that they can continue to grow. I've been working up in Alaska for about 10 years, consulting up there and they do a remarkable job with this. Working as a state, they've systematically been filling some of the gaps in their educational systems so that people can start at the bottom end of the ladder and sort of move forward. The loan repayment programs are, can be effective; there is this sense that people tend to leave after a period of years, but I think one of the things I've learned about recruitment and retention from the developmental disabilities folks, the professionals, is that for frontline developmental disabilities position I think the average length of job tenure is under a year and they expect that and they work with that, meaning that if you're going to have fairly high turnover, you have to really ramp up your systems to be effective at finding your next worker, and you also have to become very effective at improving your onboarding process so that you can bring people onboard and get them working fairly quickly. So, I think we all share the idea that we'd like to find people and have them stay within our organizations for a long time, but I think we also have to practice acceptance of the fact that turnover is going to be significant and that means we have that challenge of becoming really good at finding people and really good at bringing new people into our organization and getting them up to speed fast.

Heather: Excellent. Thank you. So we are going to close out the webinar now. Again a huge thanks to Michael, from the Annapolis Coalition for this great presentation. You can catch the presentation and slides on our website shortly, and it is MHTTCnetwork.org . Please also visit the website to find your local MHTTC regional center, there is a section there in the upper left corner that says "your center" and you can click on there and you'll be able to figure out which regional center you have and check out their webpage and see what technical assistance and training resources you can get access to. So, thanks again everyone and hope to speak with everyone soon. Thanks for the conversation.

Michael: ThankYou all. Be well.