Community Ment Health J (2016) 52:323–331
DOI 10.1007/s10597-015-9953-6

ORIGINAL PAPER

Workforce Development and Mental Health Transformation: A State Perspective

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Received: 3 February 2015 / Accepted: 23 September 2015 / Published online: 26 September 2015

Abstract The existence of a workforce crisis in behavioral health has been recognized for decades. However, workforce problems often have been viewed as too large, too complex, and too daunting for individual states to tackle. This article reviews the progress of one state in systematically strengthening its workforce as part of a federally supported effort to transform mental health services. The workforce priorities in Connecticut are identified and the specific workforce transformation projects and their impact are described. The success in sustaining these initiatives after cessation of federal support is reviewed. The authors conclude by offering five recommendations to guide comprehensive state workforce development. This work has particular salience for the many states across the nation that have identified behavioral health service and workforce needs as obstacles to comprehensive health care reform.

Keywords Workforce development · Mental health · Transformation · States · Health care reform

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Introduction

In 2003 the President's New Freedom Commission issued its report, *Achieving the Promise: Transforming Mental Health Care in America* (DHHS 2003). The Commission concluded that while recovery from mental illness is possible, the mental health system was a fragmented "patchwork relic" that presented barriers to access and burdened individuals and their families. Declaring that piecemeal reforms would be inadequate, it called for fundamental transformation of the nation's system of services centered around six major goals (see Table 1).

Drawing on this report, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued the *Federal Action Agenda, Transforming Mental Health Care in America* (SAMHSA 2005b). As part of its effort to implement the Commission's call for transformation, SAMHSA awarded over $100 million in Mental Health Transformation State Incentive Grants (MHT-SIGs) to nine states beginning in 2005. These 5-year grants to develop infrastructure were to "transform state mental health service delivery…to systems driven by consumer and family needs that focus on building resilience and facilitating recovery" (SAMHSA 2005a).

The State of Connecticut organized a proposal under the auspices of the Governor's office and was awarded an MHT-SIG of $13.7 million. Fourteen Connecticut Executive Branch agencies along with the Judicial Branch entered into a Memorandum of Agreement to transform the mental health system to provide citizens with "…meaningful choices from among an array of effective services and supports responsive to diverse cultural backgrounds and across the lifespan." (Rehmer 2006, p. 2). While the Department of Mental Health and Addiction Services (DMHAS) led the inter-agency collaboration, the most

Table 1 New Freedom Commission Goals

Goal 1: Americans understand that mental health is essential to overall health
Goal 2: Mental health care is consumer and family driven
Goal 3: Disparities in mental health services are eliminated
Goal 4: Early mental health screening, assessment, and referral to services are common practice
Goal 5: Excellent mental health care is delivered and research is accelerated
Goal 6: Technology is used to access mental health care and information

Department of Health and Human Services (DHHS) (2003)

significant effect of the Governor's office involvement was that state agencies collaborated in subsequent planning and implementation at a level that far exceeded previous efforts at cooperation. The lack of coordinated action in systems of care nationally, as noted by the New Freedom Commission, was addressed in Connecticut by bringing representatives of state agencies, provider agencies, and consumer and family advocacy organizations together in planning groups on each of the six New Freedom Commission's goals.

Based on a conviction that workforce development was a central issue in improving the system of care, DMHAS Commissioner Thomas Kirk, along with Deputy Commissioner and MHT-SIG Project Director Patricia Rehmer, added a seventh goal and planning group on workforce development. Each workgroup proposed projects that were reviewed and ranked by an inter-agency oversight committee. Workforce development emerged as one of the four most highly ranked and funded areas among Connecticut's transformation priorities, together with others focused on consumer, youth, and family-driven services; community education; and data-driven decision making (Silveira et al. 2007).

This article reviews the workforce improvement initiatives implemented in Connecticut with a focus on the problems they were designed to address, the nature of the interventions and their impact, and sustainability once federal support ended. The transformational aspects of the interventions are discussed. Drawing on this experience, the authors conclude by offering five recommendations to guide behavioral health workforce development within the states. The Connecticut approach and accompanying recommendations have immediate relevance since federal health care legislation has prompted many states across the nation to increase their focus on behavioral health workforce challenges that impede the delivery of comprehensive and integrated health care.

Connecticut Workforce Planning and Priorities

DMHAS contracted with the Yale University School of Medicine Department of Psychiatry to manage the workforce development component of the MHT-SIG. The university team convened a workforce workgroup that evolved from 30 members to a 100-member public/private oversight structure known as the Connecticut Workforce Collaborative on Behavioral Health (www.cwcbh.org). Participants included persons in recovery, family members, advocates, state administrators, providers, educators, researchers, and workforce experts. As part of a workforce assessment, members of the initial workgroup conducted over 40 focus groups across the state. A consumer was hired to organize and conduct focus groups with persons in recovery in order to ensure their full input. Prior state reports and data on workforce problems were reviewed, followed by a series of retreats and planning sessions that led to the selection and eventual approval of a set of interventions focused on the workforce that cares for individuals across the lifespan and on strengthening workforce roles for persons in recovery and their families. Each intervention is described below.

It is important to note that SAMHSA did not clearly articulate the meaning of "transformation" or create a logic model for the concept (Leff et al. 2014). It did emphasize that changes should address the infrastructure supporting behavioral health service delivery rather than directly funding services. As interpreted in Connecticut, transformation came to mean major changes in mental health system structures and processes that constituted significant departures from business as usual.

Connecticut Workforce Initiatives

Supervision Standards and Competency Development

Problems and Objectives

Supervisors were identified as one of the most influential segments of the workforce given their role in staff recruitment, orientation, supervision, performance evaluations, and administration (Hoge et al. 2011). Direct care staff, agency leaders, and policy makers expressed strong concerns that the routine provision of supervision had declined significantly within the state and that the majority

of supervisors had never been trained in how to supervise. Drawing on an implementation science framework (Fixsen et al. 2005), the Yale Program on Supervision (www.supervision.yale.edu) was launched as a statewide initiative to improve the competence of supervisors and create stronger supervision standards within service agencies, along with a *culture of supervision* in which this practice was valued and occurred routinely (Hoge et al. 2014).

Interventions and Outcomes

With assistance from a national expert, Dr. Lawrence Shulman, a model evolved that incorporated 3–5 days of problem-oriented supervisor training; learning communities for supervisors to explore and sustain new skills; and a focus on the supervisory functions of ensuring quality of care, providing support, promoting professional development, and managing administrative tasks. With consultation from the Yale program, agency leaders formed change management teams that developed and implemented comprehensive supervision standards including: an informed consent process for establishing supervisory relationships; specification of the minimum duration, frequency, and format of supervision; procedures for documenting supervision; and minimum qualifications and preparation of supervisors.

During the transformation grant, 269 supervisors and 311 direct care staff participated in the training. These were drawn from 12 service agencies and hospitals, the majority of which significantly strengthened their existing supervision standards. Participant ratings of this process were consistently high. An evaluation conducted by Tebes et al. (2011) found significant increases among participating supervisors in perceived ability to manage supervisory relationships and job performance and to promote supervisee professional development.

Multiple aspects of the supervision initiative were designed to be transformative. New supervisors were trained as supervisors, rather than simply appointed without preparation. Direct care staff members were trained in how to use supervision, rather than being passive recipients. Brief didactic training, which research has shown to be ineffective in changing professional behavior (IOM 2010), was replaced with evidence-based teaching approaches that involved sustained learning through structures such as supervision learning communities. Laissez-faire approaches to the amount and type of supervision being delivered were replaced with clear supervisory standards and expectations.

Sustainability

Despite the dire economic climate and budget cuts within the state due to the recession that began in 2007, this intervention was sustained after the MHT-SIG ended. High levels of satisfaction with this intervention and a widely held belief that supervision needed to be strengthened fueled continuation and expansion of the project. Some private non-profit agencies began to purchase the training and consultation services directly. DMHAS entered into contracts with the Yale Program on Supervision to modify and apply the model with the nursing discipline in Connecticut's state psychiatric hospital and also used it to assist community provider agencies in developing supervisory capability in programs serving individuals with co-occurring conditions. The Connecticut Department of Correction purchased the training for its addiction counselor supervisors and then extended its use to correctional supervisors. As a direct result of the MHT-SIG, this work came to the attention of a foundation, Casey Family Programs, which funded the use of the model in child welfare systems. This initiative included a 4-year effort to train essentially every senior administrator, program manager, and supervisor within Connecticut's Department of Children and Families, and to develop supervision standards and a policy guide for this agency. In addition, with the foundation's support, Yale recently undertook 2 years of consultation and staff development with the Arizona Department of Child Safety.

Higher Education Curriculum Reform

Problems and Objectives

There are obstacles inherent in any effort to reform curriculum in higher education programs. Individual faculty members or subgroups of faculty may oppose an addition or a change for many reasons: philosophical objections or lack of familiarity with the new curriculum content; competition for students; fear that the new offerings may displace the courses that they teach; or distrust of external forces, such as public mental health systems, that may be pressing for curriculum reform. Accreditation requirements prescribe much of the course content that must be offered, which poses a challenge for efforts at innovation. Even if there is broad support for a change, any new curriculum faces a bureaucratic and often lengthy process of review and approval at both the department and college or university level.

However, at the beginning of this initiative Connecticut faced a challenge that called for curriculum reform. Despite the large number of graduate level training programs for behavioral health professionals in the state, there was a shortage of master's level clinicians entering the behavioral health workforce with knowledge of and interest in working with evidence-based models of in-home treatment for children and families. This was an acute problem since Connecticut had invested heavily in funding

the broad implementation of these treatment models. Many graduates appeared to lack a solid grounding in the fundamental concepts of evidence-based practice (EBP), which spoke to the need to strengthen the capacity of graduate programs and their faculty to offer training on this topic. As part of the transformation initiative, stakeholders prioritized the development of a state-of-the-art, graduate-level curriculum on both EBP and intensive in-home treatments, and in devising strategies to promote effective adoption of a course on these topics in graduate programs for diverse mental health disciplines.

Interventions and Outcomes

With consultation from the developers of EBPs for children, a Connecticut expert on EBPs based in a community provider organization, Wheeler Clinic, led the development of a full semester course titled *Current Trends in Family Intervention: Evidence-Based and Promising Practice Models of In-Home Treatment in Connecticut* (Cannata and Hoge 2012). The highly detailed curriculum, complete with an Instructor's Toolkit containing slides and lecture notes for every class, was designed to expose students to: core concepts of evidence-based practice; nine specific evidence-based or promising practice models offered in the state; and core competencies shared across models. EBP providers, as well as families that had received EBPs, were included as presenters in the course. A statewide strategy was developed for recruiting, coaching, and supporting family presenters in this teaching role. Their involvement was one course innovation that students valued highly.

To facilitate adoption and effective course delivery, a Faculty Training Fellowship was developed with 30 hours of instruction for each faculty cohort, along with ongoing individualized consultation from the curriculum developer. Stipends of $3000 were provided to faculty fellows and, in a few instances, an additional $5000 to the participating University to support the initial implementation of the new course. Locally, the curriculum developer facilitated information exchange between graduate training programs and provider agencies in an effort to link students taking the course to internship and job opportunities.

During the federally funded phase of this work, success in engaging graduate programs to adopt this curriculum far exceeded expectations. A total of 11 graduate departments embraced the curriculum and offered the course, representing programs from the fields of social work, marriage and family therapy, counseling, and psychology. Across two cohorts, a total of 17 faculty members were trained through the fellowship and subsequently offered the course 19 times to over 250 students. Ratings of the course by faculty and students were high. In a review from a 3 year compilation of course evaluations from 144 students, which included ratings of ten different faculty members teaching the course in nine programs, 92 % of the respondents reported that the course had improved their clinical skills and 90 % indicated that they would recommend the course to other students (Cannata and Hoge 2012). It is notable that two graduate programs adopted this course as a requirement for all students, in part because it demonstrated to educational accreditation organizations that these graduate departments were teaching evidence-based practices.

Numerous aspects of this intervention were transformative in their departure from business as usual. Graduate level curricula, often criticized for their lack of relevance, were modified to teach essential knowledge about current concepts of evidence-based practice and to address an immediate workforce need. The historical difficulties of achieving adoption of model curricula in graduate programs were overcome through the use of a comprehensive implementation strategy. Standard classroom teaching models were modified by shifting the role of family members from service recipients to educators.

Sustainability

Despite the economic recession, the Connecticut Department of Children and Families decided to sustain this initiative after the MHT-SIG ended by providing annualized funding at the same level as during the grant. This funding remains in place and has supported the engagement of an additional three graduate departments and the training of an additional 8 faculty. Since the MHT-SIG ended the course has been offered an additional 17 times to over 200 students.

Peer Run Employment Services

Problems and Objectives

Connecticut had embraced the value of consumer employment in fostering individual recovery, and DMHAS had funded numerous supported employment programs. It also had recognized the value of peer support and the role of people in recovery within the behavioral health workforce. The MHT-SIG initiative addressed these values simultaneously by establishing the Connecticut Recovery Employment Consultation Service (C-RECS), a peer-run intervention designed to increase competitive employment of persons in recovery in public and private nonprofit behavioral health provider agencies and to promote their full inclusion within those organizations.

Interventions and Outcomes

Following a competitive bidding process, Focus on Recovery-United, Inc. (FOR-U), a non-profit, peer-run organization, was selected to develop and implement the C-RECS project. Using a coaching approach that focused on personal and work goals, C-RECS peer staff partnered with people in recovery seeking work to create an individualized, person-centered employment action plan. A web-based job bank facilitated job searches and placement. Technical assistance and staff training were offered to provider agencies on integrating persons in recovery into their workforce and building a recovery-oriented organizational culture.

Post-employment coaching and peer employment support groups were offered in three locations. During the course of the grant the on-line job bank had 59 jobs posted by 44 employers, 339 registered job seekers, and 20,592 hits by 5163 unique visitors. Approximately one hundred individuals participated in statewide in-person training and webinars on peer employment.

During project operation from May 2008 to September 2010, C-RECS met or surpassed its goals. Approximately 300 individuals received assistance and 27 % secured employment. Forty-five participants obtained positions in behavioral health (14 full-time; 31 part-time). An additional 36 individuals obtained employment outside the behavioral health field (11 full-time; 25 part-time). At least 8 of those hired discontinued their SSI or SSDI entitlements and 6 obtained employer-sponsored benefits, including health insurance. Despite the severe economic recession, employment results were more than double those anticipated. A follow-up survey of 36 respondents after 2 years of program operation found that 69 % were still employed (FOR-U 2010).

Transformative elements of the C-RECS project were: use of peer coaching for employment preparation and job seeking; the intentional choice of a peer-run organization to help people in recovery find employment in "traditional" provider organizations in a range of positions not limited to peer roles; and peer-delivered consultation to community provider organizations regarding organizational culture change to support and sustain peer workers (Wolf et al. 2010).

Sustainability

The economic recession precluded continuation funding to sustain C-RECS and the project ended in January 2011. Program participants received transitional support and some C-RECS peer staff members moved to a federally funded FOR-U peer leadership project. A Recovery Employment Consultation Service Guide developed under C-RECs remains available at http://www.cwcbh.org/projects/consumer_employment. The job bank has been sustained by Advocacy Unlimited, another Connecticut peer-run organization.

Experience gained and capacities developed during the C-RECS project strengthened FOR-U as an organization and enhanced its competitiveness in securing subsequent contracts. Peer employment coaching methods have been utilized in subsequent FOR-U projects funded by the state and federal government. In the spring of 2014, FOR-U was the successful bidder for approximately $1 million in state funds to create a peer bridger program in three locations. In addition, DMHAS subsequently funded another peer-run organization, Advocacy Unlimited, to develop Recovery University, a peer training and certification program. This program serves as a pipeline for a recently established position within state service, the Recovery Support Specialist, which has an annual salary range of $42,000–60,000. Private non-profit agencies also hire Recovery Support Specialists at varying salaries.

Parent Leadership Development

Problems and Objectives

While professional mental health services were available for many of Connecticut's children and youth with emotional and behavioral problems, parents were clearly the primary caregivers. Yet parents sometimes lacked the information and skills necessary to address the special needs of their children. To enhance the abilities of parents and to promote a family-driven system of care, a parent leadership initiative was launched with three aims: increase the ability of parents to access services and supports and to advocate for their own children; provide mutual support to other parents; and promote behavioral health systems change through parent membership on boards, councils, and advisory committees.

Interventions and Outcomes

Following a comprehensive review of parent leadership development approaches throughout the country, Connecticut selected the Rhode Island-based Agents of Transformation (AOT) curriculum to train Connecticut parents. The 15 hour, six-module AOT curriculum was adapted to Connecticut and also translated into Spanish. Through a competitive application process, Families United for Children's Mental Health, a parent-run training and advocacy organization, was selected to manage the project, with parent leaders serving as curriculum trainers. Parents participating as learners in the program received transportation assistance, stipends, and childcare, if needed.

They were subsequently recruited to provide support to other families and to serve on boards and committees.

During the grant-funded period, the Agents of Transformation curriculum was delivered to over 260 parents and family caregivers from diverse backgrounds in 14 communities. Approximately 175 participants completed all six training sessions. Ongoing family support network activities were held in six locations across the state. Transformative aspects of this intervention included: training and employing parents as parent educators; educating parents in caregiving and advocacy skills; and expanding parents' influence in shaping the system through their increased participation on advisory boards and committees.

Sustainability

One legacy of this initiative is that DMHAS has continued to provide stipends to support the participation of family advocates on a legislatively mandated Oversight Council for the state's behavioral health Medicaid program. Other than this, funding for this initiative was not immediately continued after the MHT-SIG ended. The recession led to additional reductions in available state and foundation support for family advocacy organizations. Shortly after the grant ended, financial pressures led to the closure of Families United for Mental Health, the agency that managed the parent leadership initiative.

Two years later, however, the Connecticut Department of Children and Families launched an effort to sustain and expand this work. A federal systems of care planning grant supported the training of an additional 65 AOT instructors, using individuals trained under MHT-SIG as the teachers in train-the-trainer classes. A new 4-year system of care implementation grant from SAMHSA awarded in 2014 supports the delivery of the Parent Leadership Development curriculum to a large number of additional family members across the state. A major objective of this revived initiative is to incorporate the newly trained family members as advocates into local system of care collaboratives, which currently lack adequate family representation.

Additional Initiatives

Numerous other smaller-scale workforce initiatives were undertaken as part of the MHT-SIG.

- *First Responder Training* To create a community of first responders with the capacity to support persons in distress, NAMI and Yale partnered to deliver a mental health curriculum to 67 state Department of Labor staff members who assisted unemployed individuals. This effort evolved to a larger initiative to develop certified trainers of Mental Health First Aid (www.thenationalcouncil.org/about/mental-health-first-aid) and to offer this 12 hour educational program to 114 potential first responders. After the Sandy Hook tragedy in Newtown, Connecticut, the legislature funded Youth Mental Health First Aid, which has been delivered to over 1300 individuals, including Safe School Coordinators.
- *Career Pathways Identification* A state workforce board, state university, and the Department of Higher Education partnered with the Yale workforce team to assemble comprehensive information on: educational pathways for behavioral health jobs and careers; 204 behavioral health-related programs of study in 34 Connecticut institutions of higher learning; career blueprints for 16 behavioral health occupations; and 30 personal narratives of individuals in behavioral health roles. Available at www.cwcbh.org/careerpathways, the resources continue to be used in workforce planning and grant-writing, as well as individual career planning and educational program selection.
- *Leadership Development* A yearlong educational program was launched to strengthen the management and leadership skills of senior middle managers in the state behavioral health system and to provide them with a safe environment for peer discussion of organizational challenges. Two cohorts, each comprising 18 managers from state and private agencies, participated in the program under MHT-SIG. A third cohort comprised solely of women and focused on issues of women in leadership completed a subsequent state-funded program offering.
- *Wraparound Initiative* Workforce development was a major element of an initiative to enhance wraparound services for children, youth, and families in one urban and one non-urban community. Over 800 community individuals from 5 key stakeholder groups participated in meetings, trainings, and coaching sessions; 471 completed a 2-day basic training in the Wraparound Child and Family Team process. Ten local trainers and 54 facilitators/coaches were trained in practice improvement sustainability strategies for use after the conclusion of the project.

Discussion

Recommendations

The Connecticut experience in the federal transformation initiative involved a broad array of workforce projects that, as a group, were highly visible and achieved their stated goals. However, many behavioral health workforce

challenges were not addressed. As one example, adequate access to psychiatrists had been a longstanding problem in Connecticut. Yet significant federal and state resources were flowing to medical education, psychiatric residencies, and post-residency fellowships. Therefore, Connecticut transformation grant funds were allocated to less traditional workforce development priorities that had more limited sources of financial support. Also acknowledged in the planning process was the importance of payment reform and of paying members of the workforce a living wage or competitive wage. The stakeholders selecting the priorities for action viewed these issues as unalterable within the scope of this time-limited initiative.

Based on Connecticut's experience with the projects that were undertaken, the authors have identified a set of five recommendations to guide state public sector workforce development. Each is described below.

1. Recognize Workforce Development as a State and Local Priority

Across the country at state and local levels, issues surrounding recruitment, retention, training, supervision, leadership development, and consumer and family employment in the workforce are considered as both major barriers to effective service delivery and major opportunities to strengthen, if not transform, systems of care. Of the nine states that received MHT-TIG grants, 39 % of all reported transformation activity involved workforce training (Leff et al. 2014). This state and local priority contrasts with the consistently low priority given to workforce issues by policymakers at the federal level (Hoge et al. 2013), as evidenced in this instance by the absence of a workforce goal in either the President's New Freedom Commission report (DHHS 2003) or as a federal requirement to address workforce development in the MHT-SIG grant.[1] During the MHT-SIG in Connecticut, of all the possible identified strategies for improving the state's system of care, stakeholders rated workforce development among the highest. This was evidenced by the volume of voluntary stakeholder participation in planning groups, the state Oversight Committee's high rankings of workforce strategies, and the high percentage of Connecticut MHT-SIG funds (34.2 % or $4.7 million) allocated to workforce interventions.

2. Employ Evidence-Based Training and Staff Development Approaches

Behavioral health professionals are experts on behavior change; yet too seldom apply this knowledge when attempting to change the behavior of those within their own profession. Connecticut workforce initiatives focused on transforming traditional paradigms of "training" to a more complex and effective model of "staff development" using evidence-based approaches to teaching, combined with agency-based policy and practice changes that support the use of newly learned skills. For example, the supervision initiative combined longitudinal supervisory skill development with agency-level development of supervisory standards. The higher education reform initiative created a model curriculum and also provided in-depth training and mentoring of faculty instructors and financial incentives for faculty and departments to adopt the curriculum effectively.

3. Target Diverse Workforce Groups

Defining "workforce" broadly and including traditional and non-traditional providers is an important element in building a strong behavioral health workforce. As outlined in Table 2, Connecticut's MHT-SIG initiative focused on workforce development for seven workforce groups, including: prospective students and workers; graduate students in professional programs; direct care staff and their supervisors; program and agency managers; people in recovery; parents of children with behavioral health conditions; and community caregivers. Comprehensive behavioral health workforce development requires efforts that address all workforce sectors within behavioral health.

4. Use Multiple Strategies to Increase Consumer and Family Direction

Increased consumer and family direction in the design of services and in decisions about their own care (DHHS 2003) is a widely accepted principle of transformation in behavioral health. This is also a goal of the recovery movement, which is quickly becoming the prevailing paradigm in the care of persons with severe mental illnesses (Nelson et al. 2014; SAMHSA 2012). Connecticut's workforce initiatives increased consumer and family direction in a variety of ways. Fifty percent of planning and oversight positions and leadership roles were designated for persons in recovery and family members, and this goal was frequently achieved. Review committees with majority consumer and family membership selected peer and family run agencies to manage two initiatives and selected the provider agencies that received training and technical assistance in a third. Consumers were employed as project managers and staff. One major initiative aimed to expand peer employment in the behavioral health workforce and a second aimed to expand family member workforce and advocacy roles.

[1] SAMHSA (2014) recently added workforce development as one of six goals in its strategic plan, *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015–2018*.

Table 2 Connecticut MHT-SIG workforce interventions by target workforce group

Target workforce group	Workforce intervention
Prospective students and workers	Career pathways identification
Students in professional graduate programs	Higher education curriculum reform
Frontline workers and supervisors	Supervision standards and competency development
Managers	Leadership development
People in recovery	Peer run employment services
Family members	Parent leadership development
Community caregivers	First responder training
	Wraparound training and coaching

5. Build Cross-Sector Collaborations

Connecticut's use of MHT-SIG funding dramatically increased collaboration on behavioral health system and service improvement in general, and on behavioral health workforce development in particular. For example, the collaboration between state agencies with separate missions of behavioral health, child welfare, juvenile justice, and corrections yielded workforce initiatives on supervision and leadership development with a far broader reach within the state's system of health and social services than would have been possible by a single state agency acting alone. Building and sustaining cross-sector collaboration can reduce the barriers and broaden the impact of efforts to transform behavioral healthcare and its workforce in state and local systems of service.

Using Evidence and Experience to Guide State Workforce Initiatives

The Connecticut transformation experience serves as an example of the many strategies available to develop the behavioral health workforce. It demonstrates the high level of state and local interest in workforce issues; innovative approaches to long-standing workforce challenges; and the ability to sustain major workforce initiatives over time.

The lack of more substantive evaluation of outcomes of the Connecticut workforce transformation project, and indeed the MHT-SIG projects in all nine states, is a limitation. The authors of the SAMHSA-funded nationwide MHT-SIG evaluation lamented the absence of a detailed federal logic model for the MHT-SIG initiative and a timely and rigorous evaluation across all states (Leff et al. 2014; Manila Consulting Group and HSRI 2011). The lack of evaluation funding for behavioral health workforce interventions has historically hampered the development of a strong evidence base on workforce practices (Hoge et al. 2009).

It is necessary to call for additional funding to support evaluation and research on workforce development strategies. A stronger evidence base on workforce practices is essential. However, it is highly unlikely, given competing federal and state level priorities, that funding will become available or such research will be undertaken in the near future. While a much stronger evidence-base on workforce interventions is desirable, few managers in the health and social service sectors or in business or industry would demand empirical justification of basic and logically compelling workforce practices such as: systematically recruiting workers; offering training in competencies essential for practice; providing effective supervision; and asking consumers to help influence the nature of the services they receive.

Fortunately, in devising strategies to build and strengthen their workforce, leaders and managers in state and local behavioral health systems can draw on relevant research findings from other fields such as medicine, higher education, and implementation science regarding topics such as evidence-based training, continuing education, and broad scale practice change. Moreover, their work can also be substantively informed by other states' experiences, such as the Connecticut example presented here. The knowledge derived from practical experience can complement the evidence base and serve as a model for launching comprehensive, systematic, and evidence-informed interventions to strengthen and transform the workforce. Addressing the workforce crisis, with all of its complexity, is both imperative and feasible.

Acknowledgments This work was supported in part by the State of Connecticut through the SAMHSA Mental Health Transformation State Incentive Grant (MHT-SIG) No. SM57456. The authors acknowledge Thomas Kirk, Patricia Rehmer, and Barbara Bugella for their leadership in making this work possible.

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