SUPPORTING THE DIRECT-SERVICE WORKFORCE IN BEHAVIORAL HEALTH PROGRAMS FOR CHILDREN AND YOUTH IN NEW HAMPSHIRE

A Report to the New Hampshire Endowment for Health

New England Network for Child, Youth & Family Services

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More than 65 administrators and staff working
at child- and youth-serving agencies in New Hampshire contributed to this project.
We thank them for sharing their time and expertise.

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EXECUTIVE SUMMARY

This report examines the condition of the direct-service workforce in children's behavioral health settings in New Hampshire. We have focused primarily, though not exclusively, on agencies providing residential services. These agencies are of particular interest because they employ large numbers of direct-service workers, and those workers provide intensive support to highly disordered children over long periods of time. Our findings, based on interviews with agency administrators and direct-service workers, indicate that many programs are under significant stress for two reasons: the tightening fiscal climate of the state, which is having a serious impact on all social service agencies; and changes in state policy that increasingly favor intensive in-home services over residential treatment for children diagnosed with mental, emotional and behavioral problems. This contraction in residential services is a national phenomenon and has many implications for children, mental health providers, and states, some of them still unknown. But regardless of recent trends, residential service providers, particularly those working with acutely disordered children, will by necessity remain a part of the state's system of care.

Workforce instability, long an issue in residential agencies, is exacerbated by the fiscal and policy changes taking place in the state. Staff in residential agencies report that they are working long and erratic schedules, and that their programs are understaffed and under-resourced. Despite their generally high educational levels, direct-service workers are poorly paid and some benefits, such as tuition reimbursement, are eroding. Weaknesses in the workforce are expensive for agencies and can affect client care. Yet it is likely that they will grow more crippling in the near future, as residential treatment becomes a last resort reserved for the most challenging young people. We recommend a series of supports to bolster the direct-service workforce, and urge agencies to use this transition in services to craft creative solutions to their workforce problems. Improvements include reducing the costs of staff turnover by recruiting and retaining the workers most likely to stay in their jobs; creating high-quality volunteer programs to reduce burden on staff and free up dollars for higher salaries; establishing peer-auditing programs; creating an online direct-service community with opportunities for exchange and mentorship; and supporting the direct-service worker certification efforts already underway at the state and national levels.

INTRODUCTION

Mental, emotional and behavioral (MEB) disorders are common in children and teenagers. In a comprehensive analysis of existing data, a 2009 National Academy of Sciences report concluded that in any given year, between 14 and 20 percent of young people in the United States suffer from one or more MEB disorders.[1] This estimate includes common MEB disorders such as attention deficit/hyperactivity disorder, anxiety disorders, post-traumatic stress disorder, depression, and drug dependence, and those that are less common but potentially more devastating, such as autism, pervasive developmental delay, schizophrenia, and bipolar disorder.

One way to estimate the scope of the problem is by assessing demand for treatment. Recent federal data indicate that 13.3 percent of all teens between 12 and 17 received services in a specialty mental health setting (inpatient and outpatient) in a 12-month-period spanning 2005 and 2006. Twelve percent received services in school, and three percent from a pediatrician or family doctor. (Treatment was for problems not related to alcohol or drugs.)[2]

The quantifiable cost of MEB disorders in 2007 was $247 billion.[3] Harder to calculate are the costs to young people themselves, who are disproportionately likely to experience social and academic problems and who may never achieve adult self-sufficiency. The effects are also borne by their families, who struggle with the financial and emotional demands of their children's illnesses.

Based on prevalence statistics, an estimated 51,000 youth in New Hampshire could be expected to have an MEB disorder, with 16 percent of those cases involving either a significant or extreme functional impairment.[4] This paper is concerned with this subset of children and adolescents: those whose emotional and behavioral disorders are severe enough to warrant intensive services over periods ranging from several months to many years.

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[1] National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. O'Connell, M., Boat,T., and Warner, K., Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. The National Academies Press: Washington, DC.
[2] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (Sept. 25, 2008). *Mental Health Service Use among Youths Aged 12 to 17: 2005 and 2006*. Rockville, MD.
[3] National Research Council and Institute of Medicine (2009).
[4] Tappin R. & Norton S. (2007). *Children's Mental Health in New Hampshire.* New Hampshire Center for Public Policy Studies, Concord, NH.

Like all serious illnesses, MEB disorders are deeply private. But because of their relatively high public cost, they are a matter of great societal importance as well. In New Hampshire as in other states, treatment for young people with serious MEB disorders is heavily subsidized by the government. Intensive, long-term mental and behavioral health services are expensive, and coverage by private insurance providers is usually extremely limited. Furthermore, most adolescents who receive intensive services do not enter treatment voluntarily but are court-ordered to do so, with their families sharing costs only if they are financially able. Because of the high costs of treatment, the state struggles to provide enough care, and over long enough periods, to effectively treat all the children and youth who need it.

To understand why children's mental health care is so entwined with the public system, consider how most children with acute problems come into intensive treatment:

- they are referred by public school districts to specialized educational settings because of developmental and academic difficulties;
- by courts because of delinquency or criminal activity, sometimes coupled with substance abuse;
- or by the child welfare system because of abuse and neglect.

There is a particularly clear relationship between poverty status and use of mental health services. In its 2007 report on children's mental health care in the state, the NH Center for Public Policy Studies found that 17,600 children – a quarter of all those enrolled in Medicaid, the public insurance system for the poor – accessed mental health services in 2005.[5] It is unclear whether so many children on Medicaid require services because of their personal circumstances, or whether they access mental health services in such large numbers because of its low cost to them. In any case, it is important to understand that most people seeking mental health services, regardless of income level, do so for sub-acute issues – for relatively minor anxiety disorders, for instance, or emotional problems resulting from family conflict. These problems are important and cause undeniable suffering to the individuals experiencing them. But this report focuses on more serious disorders – those that require a range of services over long periods of time, and that, if untreated or inadequately treated, have the potential to destroy a child's chances for healthy development.

[5] Tappin R. & Norton S. (2007). *Mental Health Services for NH's Children.* New Hampshire Center for Public Policy Studies, Concord, NH.

Residential Treatment Programs

Residential treatment programs, an important but sometimes overlooked part of the state's fragmented system of care for children with MEB disorders, provide an array of services to young people and their families. They provide emergency and longer-term therapeutic care to youth who either cannot be maintained safely at home or whose families cannot manage them. They provide clinical assessment and stabilization, and for the most acute clients, provide specialized education programs. All residential programs employ clinicians and most have program coordinators and specialists, but the majority of their workers are direct-care staff who work closely with young people on the tasks of daily living – grooming, hygiene, schoolwork, recreation, meals, and chores. Direct-care staff provide on-the-spot counseling and support, help youth learn how to interact with others appropriately, oversee their medication, de-escalate aggressive behavior and help resolve conflicts, transport them to and from meetings, liaison with school and court officials, and assist youth who are aging out of the system in learning the skills they need to live independently. These frontline staff are the direct link between clients and clinicians, and their reports influence clients' treatment plans.

Some of the state's residential programs specialize in children and youth with neurological and developmental disorders. Most, however, work with youth who are court-ordered as delinquents or as "children in need of services" (CHINS). These young people typically exhibit a range of issues, including attention deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorders. High numbers are on psychotropic medication, have histories of criminal activity, running away, and substance abuse. Nationally, in the only large, multistate study comparing youth in residential treatment with youth in therapeutic foster care (the next lower level of care in most states) youth in residential treatment were found to be significantly more disordered.[6] That finding is particularly pertinent now, at a time when New Hampshire and many other states are shifting resources away from residential treatment and into less intensive services. "At this time," the authors write, "demands are underway in some states for reducing RTC (residential treatment center) placements in the interest of cutting costs and reducing institutional placements for youth. If this occurs without compensatory services in community settings, a large and severely disordered number of children and adolescents will be inadequately served, treated and cared for."

[6] Baker. A., Kurland, D., Curtis, P., Alexander, G., and Papa-Lenini, C., *Problems of Youth in the Child Welfare System: Residential Treatment Centers Compared to Therapeutic Foster Care in the Odyssey Project Population,* in Child Welfare, 86, 3, May/June 2007. Child Welfare League of America, Washington DC.

Because the debate over the role of residential services has become so heated in New Hampshire, it is instructive to look at the case of Maine, which a few years ago decided to strongly shift away from residential services for youth and into less expensive community-based services. The state restructured its child welfare system and rewrote its policies to require that, in all but the most extreme cases, children remain at home. Intensive, multi-tiered services would be directed at families; only if the work was unsuccessful would children be removed to either residential care or treatment foster care. Forty-four residential programs (a total of about 200 beds) disappeared, and residential placements decreased by one-third.[7] But while residential care in Maine contracted, it did not disappear. In fact, while "easier" children have been diverted out of residential care, the tougher cases remain, and programs that work with highly disordered children in staff-secure settings have been operating at full capacity for two years.[8] Maine's effort to reduce residential care has paradoxically proven that some level of residential care will always be needed.

In this study, we have focused primarily on direct-service workers in New Hampshire's residential facilities, though we have also collected limited information on workers in community-based programs providing case management to children at home or in foster care. As noted, the state is increasingly favoring such home-based services over residential services, and client placements are down significantly in some programs. Stays for some children who do go into residential treatment are becoming shorter as well. These trends, coupled with the economic downturn, have put residential programs under particular stress. Yet they continue to work more intensively, and over longer periods, with MEB-disordered youth than any other programs in the state. Furthermore, the youth in these programs tend to be at the more-acute end of the spectrum. Given that residential programs will remain a necessary service for at least some of the state's most troubled children and youth, any effort to improve the quality of the state's mental health services must include a focus on how to strengthen these programs.

Workforce Stability

A stable, trained workforce is critical to the provision of high-quality child welfare services.[9] Yet many child care agencies, in New Hampshire and elsewhere, have trouble recruiting and retaining high-quality workers. Nationally, the turnover rate among direct-service residential and youth care workers in 2002

[7] David McCluskey (personal communication, Feb. 23, 2009)
[8] Ibid.
[9] Child Welfare League of America (2005). Workforce Recruitment and Retention in Child Welfare: A Review of the Literature. In consultation with Pennsylvania Department of Public Welfare,Office of Children, Youth and Families and the Pennsylvania Child Welfare Training Program. Child Welfare League of America, Washington, DC.

was 57 percent[10]. One mid-sized New Hampshire agency lost 44% (36) of its workers in 2006. Fifty-eight percent had been in their jobs for less than one year. Turnover rates of this magnitude have significant implications for both the agencies and their clients. Formulas for calculating replacement costs of direct-service workers commonly put the cost of recruiting and training new workers at between 33% and 50% of yearly salary[11]. Using the most conservative figure and assuming a salary of $20,000 per year, turnover cost this agency $238,000 in 2006. There are, of course, "softer" costs of workforce instability: loss of experienced workers, loss of continuity for clients, and loss of morale for staff, who tend to work as tightly coordinated teams. These issues are of particular concern, because they can lead directly to an erosion in the quality of care for children.

PROJECT DESCRIPTION

This study attempts to answer the following questions:

- What are the characteristics of the direct-service workforce in New Hampshire?
- How are direct-service workers educated and trained?
- How are they compensated?
- How long do direct-service workers stay in their jobs, and why do they leave?
- What systemic issues create high turnover?
- What impact does high turnover have on clients and agencies?
- What, if anything, can be done to enhance recruitment and retention of high-quality direct-service workers?

In order to answer these questions, we conducted interviews with administrators at 15 private nonprofit agencies providing services to children and adolescents with MEB disorders in the state. (We originally sought interviews with 24 agencies. We interviewed a sixteenth agency that is licensed in the state but currently not getting New Hampshire referrals. Data from that agency was excluded.) Depending on the size of the agency, we interviewed executive directors, human resources directors, or managers at the program level, sometimes seeking information from more than one source at the same agency. For instance, at one agency we interviewed four program managers and a human resources specialist. Typically, though, we spoke with the one administrator at each agency most knowledgeable about the

[10]Child Welfare Workforce and Training (2003). Child Welfare League of America, Washington, DC.
[11]George, J. (2003, October). Target the turnover: retaining employees has far-reaching effects. *Indiana Business Magazine*. Reprinted in AllBusiness: http://www.allbusiness.com/human-resources/workforce-management-hiring/680390-1.html

hiring and retention of direct-service staff. Twelve interviews or sets of interviews were conducted by phone, the rest in person.

The 15 agencies that contributed to this study are diverse in terms of size and geographical location. The majority have multiple programs and work with children experiencing a range of problems. Our study encompassed programs for delinquent youth; for developmentally disabled children with autism-spectrum disorders; for children with acute psychiatric issues such as firesetting and sexual behaviors; for homeless teens transitioning into adulthood; and for teens with co-occurring disorders. Referrals to these agencies predominately come from school systems, the Division of Children, Youth and Families and the Division of Juvenile Justice Services.

Participating agencies ranged from large, multi-service organizations to small, stand-alone agencies providing one type of program only. Three agencies were small, with budgets under $1.5 million; one had a budget of $1.5-3 million; one had a budget of $3.1-5 million; four had budgets of $5.1-10 million; and six had budgets of over $10 million. In all, among the 15 agencies, we collected data on 41 different programs employing about 700 direct-service staff. Rural, suburban and urban programs were all represented, though the majority of programs were in urban or suburban locations.

We also conducted interviews with 44 direct-service workers representing six agencies in different geographical areas of the state. Interviewees were chosen from lists of employees provided by cooperating agencies. The lists were general and inclusive; in a few cases, they named all direct-service employees on staff. Each interviewee was offered a $20 stipend and promised anonymity. Twenty-seven of the interviews were conducted by phone, the other 17 in person.

Of the 44 workers, 28 were female and 16 were male. Their average age was 32, though 12 were under the age of 25. Ten of the workers had been at their current jobs for less than a year, and 28 – more than half – for less than five years. Five workers had high school diplomas, five had associate's degrees, 32 had bachelor's degrees, and two had master's degrees. Eight were taking college courses in their off-hours, and 13 had firm plans to pursue an advanced degree in the future.

FINDINGS

Administrative Interviews

Administrators believe their workers are integral to the quality of their programs.

Administrators say that their programs are only as good as their direct-service workers, who after all are the staff most responsible for carrying out treatment plans, for modeling behavior and for maintaining consistency. A program manager at a large agency operating several shelters and schools in the North Country said: "If you don't have good direct-care staff, then the kids leave the same exact way they came in, and you haven't resolved any of those issues or decision-making skills that got them to the court that placed them in the first place. Our counselors do all that work. They are with the kids 24-7, and without them, the kids won't make progress."

The typical direct-service worker is female and under 30, though a significant minority of workers are older and have been in the field for many years.

Ten of the 15 agencies said their usual direct-service hire is a female under 25 with less than 18 months of experience in the field. However, in some programs, workers are far likely to be older and to have been in the field for several years. Studies confirm this correlation between age, length of time in the field, and likelihood of staying in the field.[12] The older a worker is, the more likely he or she is to be highly experienced and to plan on staying in his or her current job.

Most workers have bachelor's degrees, about half in social work, psychology, counseling or some relevant field.

At 10 of the 15 agencies, most newly hired direct-service staff have associate's or bachelor's degrees; one agency specializing in community-based work generally hires only staff with master's degrees. Two large agencies said that most of their entry-level staff had only high school diplomas; the rural location of one of them makes more-educated staff hard to find. Regardless of these exceptions, the majority of entry-level workers at most agencies exceed the state's minimum educational standards. Those standards stipulate only that workers have at least an associate's degree with 12 hours of coursework in a relevant area; two years of full-time experience working with children; or seven years of parenting experience.

[12] Colton, M. and Roberts, S. (2006). *Factors contributing to high turnover of residential child care staff,* in Child and Family Social Work 2007, 12, pp 133–142.

In populous areas, it is usually easier to recruit direct-care workers than to retain them. In rural places the opposite is often true.

Most agencies advertise aggressively for workers, posting ads in newspapers and on internet job websites, and relying on word of mouth and agency reputation to attract applicants. Large agencies are sometimes at an advantage because they are able to hire staff from other in-house programs. Still, eight of the 15 agencies said finding new workers is "somewhat difficult," and two said it is "extremely difficult." "It is almost impossible" to recruit staff in the North Country, said an administrator at a mid-sized agency with locations throughout the state. "It's easier in the southeastern part of the state because of greater population, schools, and proximity to Massachusetts. The southwestern part of the state is somewhere in between." Another agency that works in the North Country confirmed that filling a position in the rural areas of the state can take weeks or months. A small, rural agency confirmed this, saying that it had "drained" its local area of qualified workers and that small-town suspicions about social services make people reluctant to apply. A recent job opening went unfilled for two months, she said. But once staff are found, they often stay longer than in other parts of the state, partly because other jobs are so scarce. One large agency in the North Country typically retains staff for three to four years, and about half its direct-care workers get promoted into other positions in the organization. No other agency reported such a high rate of upward mobility.

Other factors influence hiring and retention as well. At another program in a rural area of the state, staff are both hard to find and to keep, turning over about every six months. The reason, according to an agency administrator, is the particularly difficult clients the program serves, and an in-house culture that has become negative, attracting "depressed" workers who infect the rest of the staff with the same attitude. The same agency, on the other hand, operates another program for older youth with less intensive problems. Staff in that program are all over 40 and have stayed in their jobs for several years, due to an undemanding "asleep staff" schedule that allows them to work second jobs or go to school during the day.

Salaries are extremely low.

The average hourly wage for direct-service workers in the residential programs in this study was $10.54, or approximately $22,000 year. This is low by any measure. In 2006, the average for all female full-time workers in New Hampshire was $34,719; women with bachelor's degrees made $40,120. [13] Masters-level staff working with families in community-based programs are somewhat better-paid than their direct-service counterparts; two agencies reported that such workers earn about $35,000 a year. But these

[13] The New Hampshire Women's Policy Institute (2008).*2008 Update on Women's Economic Status.* Concord, NH.

workers also fare poorly in comparison to similarly educated peers, since the median income for all women in the state with master's degrees was almost $51,000 in 2006.

Agencies are well aware that their pay is low and a few have made efforts to raise salaries in recent years, with five paying between $11-12 an hour and offering regular raises. (Four agencies said they offer no regular increases, and others said they had frozen salary increases because of the economy.) Yet, in a good economy when jobs are plentiful, at least two administrators said they compete against local fast food outlets for workers. Administrators recognized the paradox that, while the majority of agencies in the state have raised the educational bar for direct-care staff in an attempt to professionalize the workforce, no agency is able to pay wages commensurate with those educational levels. "We get a lot of applicants, but it's still difficult to hire – the problem is that we have an inability to pay people for the work they do," said the human resources director of an urban agency. "And they usually come out of college with greater salary expectations and student loans to pay off."

Almost all agencies offer initial and ongoing training.

All the residential agencies in this study provide formal training. New staff attend orientations lasting up to a week that teach skills related to positive youth development, client trauma, physical intervention, CPR, and water safety, among other topics. Staff at many agencies are also offered a six-part training course created by NH Partners in Service, an association of residential service providers. Some agencies readily send staff out to any specialized training in which they are interested; other agencies have cut back their training budgets and find it difficult to pay for off-site training and to cover the shifts of staff who attend them. To make training less expensive, some agencies have contracted with online learning companies that provide flexible, web-based workshops.

Few job applicants are specially credentialed in direct-service work.

Though still relatively new, residential care and youth work certification programs are underway nationally and in many states. Yet direct-service workers in New Hampshire don't seem aware of such programs, and administrators in the state say that, while the specialized training might be useful, they cannot pay extra for credentialed employees. Only two of the administrators we interviewed said that certifications might improve a worker's initial salary; others thought that certification was an intriguing idea, but perhaps unnecessary because of the training already provided by agencies. Despite concerns about whether agencies could afford to boost salaries for certified workers, one program supervisor saw certification as a potential cost-saving tool, since it would reduce training costs and translate to consistent quality of care for clients.

Benefits package vary, but all agencies offer health insurance and paid vacations.
The quality of insurance coverage varies, of course, and some agencies require employees to share the costs of premiums. 403(b) and 401(k) plans are not a typical component of benefit packages; only two residential agencies said they offered the plans to direct-service workers.

Low salaries can lead to compromised quality of care.
Because the salary for direct-care positions is so low but the relative educational requirements so high, agencies hire the only type of worker available and interested: new college graduates, who come with enthusiasm, but are inexperienced and often uncomfortably close in age to the clients with whom they will be working. One administrator acknowledged as much. "If we were able to hire more highly qualified, mature staff, not people directly out of college but after 20 or 30 years in the field, I think it would have a direct impact on our clientele. At times staff becomes overwhelmed, especially new staff, and people with a little more maturity and perspective don't get quite so overwhelmed so easily. In terms of the day-to-day operational chaos we call a group home, we'd be in better shape." An administrator at another agency asked rhetorically, "Do we sometimes fail a kid through inexperience? The answer is yes."

A group home supervisor who works closely with adolescent clients said staff experience makes a dramatic difference in the entire tone of a program: "I can see during one weekend here when you have new staff how different it is – how much more kids get in trouble and push the limits. If your program is *all* inexperienced staff, it would harder to get a core foundation of control. When the staff don't even have enough confidence to believe in themselves, if they don't feel like, 'Yes, I can handle this,' then how are the kids going to feel (the staff) can handle it?"

Tuition reimbursement, an important benefit for workers who want to continue their education, is often only available under certain circumstances, or when economic times are good.
Eight agencies said they offer tuition reimbursement to qualified personnel interested in pursuing higher degrees; four agencies used to offer tuition reimbursement but currently do not, citing the tightening financial climate; and three others offer it only under certain circumstances. For instance, one agency makes reimbursement available only to workers who already have bachelor's degrees. The irony is that, once workers with bachelor's degree get their master's degrees, they have to leave the agency to find higher-responsibility jobs. One staffer acknowledged that, if her agency would help her get a master's degree, she would apply for a guidance counselor's job in the public school system. Some administrators question the wisdom of paying to educate a worker who will only leave them for jobs in better-paying organizations.

There is very little upward mobility in agencies. To increase salary or responsibility, workers have to move elsewhere.

Most agencies have many direct-care positions but relatively few clinical or administrative positions. Administrators and clinicians also tend to stay in their jobs for far longer than direct-care workers, meaning that vacancies in-house occur only rarely. Some agencies have partially solved the problem by creating tiers in which direct-care workers can become program coordinators, liaisons or specialists, and one extremely large agency reported trying to improve retention by creating a system of graduated competencies with small salary increases for each new level attained. Notably, the goal in this agency is not to move direct-care staff into positions of more responsibility, but to reward them for advancing within their own level.

Private agencies often lose workers to community mental health centers and public school systems, both of which pay more and offer better benefit packages.

The New Hampshire Community Behavioral Health Association, a consortium of the ten community mental health centers, chose not to participate in this study. The one community mental health center administrator we did interview reported starting salaries for entry-level workers in the mid- to high $20,000 range. The agency's benefits package is "better than the salary," the administrator said, and includes tuition reimbursement, "very good" life insurance, a 403(b) plan with agency matching contributions, and paid vacation of several weeks a year. While no one believes that CMHC workers are well-paid in any objective sense, it is easy to see why direct-service workers in the state's residential programs would consider the centers a step up.

Depending on location, recruiting other types of staff is also difficult.

Agencies operating in the North Country complained about the extreme difficulty of finding qualified clinicians, occupational therapists and other specialists. A mid-sized agency providing community-based services said that the pool of recently graduated clinicians is also shrinking, and that graduates who do sign on stay just long enough to get licensed and then leave. "People seem to be leaving the state," she said. In the southeastern part of the state, the agency has difficulty finding clerical staff to fill part-time positions, probably because of other better-paying clerical positions in the area.

Declining financial resources and changes in state placement philosophy are putting agencies and their direct-care staff under stress.

All residential agencies are licensed for a particular number of client slots and must meet staff/client ratios based on the level of care (intermediate or intensive) they deliver. The current uneven rate of referrals means that instead of having normal days off, staff may be "on-call," simply waiting to be called

in should the need arise. Staff are also regularly asked to pick up extra shifts. Given the already harried pace of their jobs, the extra work hours cause additional stress for staff and affects their availability to clients. One community-based program administrator commented on the toll such uncertainty takes on the agencies themselves: "As the state's budget fluctuates, so does our budget and stability. Our programs that are dependent on state funding find it nearly impossible to keep going – we constantly feel threatened that we will lose funding, and that makes everything more challenging."

The most common reasons staff leave relate to poor salaries and difficult or unsatisfying work. We asked administrators to name the top three reasons workers at their agencies quit their jobs. In order of frequency, the reasons they cited were: low salary; jobs that differed from worker's expectations; and the availability of better employment opportunities elsewhere. Two administrators cited the difficult schedules that direct-service staff are expected to work, and two cited poor support and training. Overall, administrators and program supervisors said that the jobs are so inherently difficult that many workers, after trying them, decide they simply don't want them, even if they continue to be attracted to the field in general. One supervisor said: "I sit with (frontline staff), and they say, 'This job has no rewards.' I tell them it has nothing but rewards, but they can't see it." According to our interviewees, such attitudes seem typical of workers who wash out of their jobs quickly.

Direct-Service Staff Interviews

The vast majority of direct-staff have either associate's or bachelor's degrees, and many are either currently working on master's degrees or have definite plans to get master's degrees. Direct-service workers, particularly the younger ones, are well-prepared educationally for their work, usually well beyond the state's minimum required qualifications. As noted earlier, among the 44 workers we interviewed, 32 had bachelor's degrees and two had master's degrees. As a group, direct-service workers are also educationally ambitious; 21 of our interviewees, almost half, are either taking classes while working or have definite plans to pursue an advanced degree.

Those who stay in the field say that their genuine love of the work is the reason why. Our interviews with direct-care workers make it abundantly clear that for people who stay in the field, the opportunity to connect with youth and improve their chances for living productive, happy lives are overriding passions. A 48-year-old residential counselor at rural agency, reflecting on who does this work, said: "It takes a certain type of person to take abuse day after day from these kids. They're abusive for a reason – they're trying to get to you. You have to have patience, and you have to have a good sense of humor. That's often the clincher in what could be a crisis situation. I believe this is an extremely

important profession, an integral part of society. These kids are our future. If they're not going to be okay, we're not going to be okay."

A high percentage of workers make ends meet by either working second jobs or regularly picking up extra hours at work.

About half of the direct-care workers we interviewed were currently working second jobs. One moonlighted as a landscaper, one as a supermarket cashier, one as "asleep staff" five nights a week at a group home for brain-injured adults, one as private caregiver to a family with developmentally disabled children, one as a personal assistant. Several staff said they pick up as many extra shifts at their regular jobs as they can, effectively making second jobs of the additional hours. A 35-year-old teacher's aide at a specialized school said: "You get people who are working 60, 65 hours a week to make the rent, and they get burnt out. I know before I got switched over from working second shift, I was trying to get as much overtime as possible because my rent's $1,525 a month, and you're making nine-something an hour. How are you going to survive?"

Staff at most agencies complain about difficult schedules and long hours.

Residential agencies employ workers around the clock, and daytime shifts are often reserved for workers with the most seniority. Hours are long and can be irregular, and chronic short-staffing requires workers to regularly pick up additional shifts. The problem is exacerbated by the stop-and-start referrals from state agencies that make it difficult to plan for adequate staffing. One staff worker recounted a scenario in which five long-vacant slots in its group home were filled in just a few days. Because staffing levels had adjusted downward to accommodate the vacancies, there weren't enough workers to help the new clients settle in; the clients didn't adjust appropriately to the program, and several were released almost immediately. One agency, however, had handled scheduling problems creatively, creating regular work schedules that never varied and defining a team of workers who could swap work shifts amongst themselves, creating the flexibility that allowed them to attend to family needs, doctors' appointments and other personal issues.

Staff say that feeling like a valued member of the therapeutic team is critical to them.

Feeling appreciated comes in many different forms, and is often little more than a pat on the back. The comments of a 32-year-old mental health worker at an intensive-level program were typical: "Not many people can do this work. It's like being in an abusive relationship; it takes a toll. Sometimes it affects you. So if there is someone there for you, it's good. Sometimes we get Christmas bonuses, and one time they did an incentive check – it was a thank you, out of the blue; that was nice." Another worker said, "When you're verbally acknowledged for what you do and there's some sense of validation for your presence in

the agency – like, for instance, the CEO here wrote me a random card thanking me for being here, and that was a year ago, and I still have that card. So it's those little things, those fifty cent-type things, that make a difference."

Many workers are frustrated by their inability to put their ideas into action.
One of the workers' most frequently voiced complaints concerned the bureaucratic obstacles that make even small changes in treatment plans difficult to effect. Those obstacles were both inside and outside agencies.

Typical was this comment by a 34-year-old residential counselor at a mid-sized agency: "We spend the most time with these kids. When they're sick, when they have nightmares – we're the ones who are there. But we have no input on where they are going to be placed when they leave here. What I have to say doesn't matter, even if I think it's a bad placement. It's up to clinicians and family workers. I feel like they usually rush things with the kids, they rush to get them placed. When they rush them into change too quickly, they end up coming back."

A worker at a small suburban facility said: "We come up with great creative ideas on how to deal with a kid, but there's way too many hoops to jump through for us to actually put those things in place. Like, wait, we've got to call the JPPO (juvenile probation and parole officer), and then we've got to call this person, and that person, and we've got to call their guardian, and maybe then we can set up this particular structure that would help the kid. But a lot of times, the time involved in contacting everyone and making sure everybody else is okay with our ideas makes it unrealistic."

A program supervisor, reflecting on the level of involvement he would like in administrative systems and programs, said, "I worked with an agency where we were allowed to volunteer for different focus groups, where each different group was responsible for rewriting each aspect of the program, and it really had a lot of motivation because it's like, this is my job, of course I'm going to take it seriously." No such opportunities exist at his current agency, he said.

Workers say they are disturbed by seeing youth leave their programs to go back to families who are not ready for them, or go to other placements they deem inappropriate.
An assistant program director at mid-size urban agency said: "It's a federal and state mandate to move kids along, out of residential treatment. State and federal government won't or can't pay to keep kids in residential, so they send them back (to their families) when they aren't ready. In 10 years I've seen the

state of New Hampshire change their policies probably seven times. It's what happens. It's frustrating but it's above my head."

Working with families is increasingly the focus of the state's services for youth, and staff uniformly agree that, ideally, families are indeed the best place for young people. Yet, the day-to-day reality of their jobs sometimes suggests the opposite. One residential counselor said: "You take someone who is 14, 15 years old, and they've had 14, 15 years of poor parenting, and not a very good set of life skills, and you bring them in here, and you work with them really intensively for six months, maybe even a year, and you send them back to the same environment. Who is to say that anything is going to change?"Another said: "Part of the frustration is with the court system and the legal system. Their thoughts are, keep the kid with the family at all costs, and with some of these families, that probably isn't the best thing. That's frustrating to see because any progress that you've done with the kid, when they go home and then come back to you, a lot of it has been undone."

Workers voiced a more general frustration about the dearth of services for young people in the state.

Depending on the program, there is often little in the way of follow-up services or supports, even for young people who are exceedingly vulnerable. A 32-year-old case coordinator working with homeless youth, a population that is disproportionately likely to have emotional and behavioral disorders, said she sees little waiting for youth who "graduate" from her program. "You work really hard to set up a plan, then you find out things aren't available for them. We're supposed to be helping them live in the community and there aren't enough supports available. The jobs are scarce and the ones that are available for them are low-paying. It's hard to help them apply for college or any education beyond high school. There are all kinds of barriers. For example, when you're trying to help a youth apply for college, finding funding is a major challenge. Since they are considered 'homeless,' many schools won't even look at them." She pointed out that federal grants to transitional living programs like hers have been cut, with the region losing programs in the last few years. "The money just isn't there. I'm very concerned about the availability of funding – that's the hardest thing to deal with," she said.

Younger workers say they can't imagine staying in direct-service jobs for an entire career.

The majority of young people we interviewed don't see a future in the profession. A 23-year-old residential counselor who is working full-time while getting her master's degree is one of many who said she'd like to stay in her job, but probably won't. "I love this job. I mean, I tell my friends I love this job so much, but I'm to the point where my family is saying, you can't afford to be here." Even some middle-aged workers feel the same way. One 45-year-old worker who has been in and out of the field since his

20s said: "As far as where your status is in society, I mean, you can only get to a certain point, and then you can't grow above that. I think that's why a lot of people leave – they reach a dead end. It's like, okay, I've been doing this for two or three years now, and I'm burnt out on it, and I don't feel like my life is going anywhere." Paradoxically, of the 44 staff we interviewed, 16 had been in the field for 15 or more years. All were in the mid-30s or older; one was 57. So while many young people leave the field quickly, a smaller core of older staff are committed to field, say they love their jobs and plan to stay in them as long as possible.

Workers say that staff shortages affect both them and the clients they serve.

One agency in this study said it has a hard time meeting its client/staff ratios. Most agencies do meet those ratios, which vary with the acuity of clients, but even so, staff in some programs say they simply don't have enough personnel to do quality work.

A 28-year-old supervisor said: "The hardest thing is that we're always short-staffed. In my opinion, our ratios and regulations are not very therapeutic. But they're what the state says is all you need. When you have a dorm with eight, nine, ten kids in it and you're one staff person, you can't make that much of a difference. You can't do as much as you really could do if another staff was with you."

A 23-year old counselor said: "We're just making sure the kids aren't hurting each other or hurting themselves and following the basic rules. We're not able to take them and do more stuff, like the independent living skills they need to learn. We're not sitting down and making sure their homework is getting done thoroughly, that they're understanding concepts. If they need to go into therapy groups or alcoholics groups out in community, we don't have time to go do that. We don't have enough staff."

Safety is an issue for workers as well. Clients can occasionally lash out and injure workers, and two female workers in this study said they had felt physically vulnerable in recent months because of inadequate back-up.

All these problems are exacerbated by high staff turnover; it can take weeks for a new worker to become minimally competent, and in the particularly tightknit atmosphere of programs, where staff work closely as teams, one unskilled staff member creates more work for everyone else. One 38-year-old residential counselor at a small rural program said that when his co-workers leave, it has a palpable effect on him: "We've lost some pretty good staff, some people I was really attached to. We'd developed a strong supportive relationship, and they were always there to talk and process your day. When they leave, it's like, okay, I'm sort of alone now."

Staff overwhelmingly say they are interested in credentialing programs that specifically address the high-risk, troubled or impaired clients with whom they work.

However, the programs would have to be low-cost and ideally lead to higher pay. And, just as important, workers say their agencies would have to give them paid time off to attend classes. A 22-year-old recreational counselor in an intensive program for boys said: "Maybe with a certification everyone would be on the same page with training, they would all have the same approach. It would also help because I just came into this, and some people have been here a long time, but with a certification there would be a baseline of knowledge for everyone."

Themes

In this study, the perspectives of administrators and staff sometimes diverged, with staff expressing, for instance, far more concern than their bosses about communication problems within their agencies. But in general, there was considerable agreement that improvements in the following areas would positively affect the longevity and performance of direct-care staff.

- Better compensation. What salary seems reasonable to workers? When asked, staff in this study named modest sums; several said $15 an hour. The direct-care workers we interviewed obviously knew before taking their jobs that their salaries would be low, and said that they understand the financial constraints their employers are under. What they said they wanted was simply a livable salary, one that allows them to keep gas in their cars and enjoy a day off now and then.
- Adequate staffing and standardized work schedules.
- More communication between administrative and direct-service levels.
- Better communication between shifts and teams of direct-care staff, leading to greater consistency in carrying out therapeutic plans.
- Quality supervision, particularly for young and inexperienced workers.
- A viable career ladder.
- Tuition reimbursement and loan forgiveness programs to ease the impact of low salaries.
- Regulatory and/or bureaucratic modification that makes changing a child's therapeutic plan easier, and that pays closer attention to whether families are ready to receive children once they leave residential treatment.
- Ongoing, consistent training. Though all agencies provide orientation trainings in crisis intervention, CPR, boundaries, and the state child welfare system, and many provide ongoing opportunities for

training, many workers stressed a need for more training, particularly since the type of clients they see tends to change as state placement trends themselves change.

PROPOSED ACTION

Positive Change in Challenging Times

There is a natural tendency to assume that the problems described in this report are intractable and so embedded in systemic underfunding that nothing can be done about them. But the good news is that some agencies have contented, experienced staff; have found a way to pay at least a livable wage with decent benefits; have addressed their staff scheduling problems in a way that benefits both workers and the agency; and have developed enough organizational resilience to weather fluctuations in state placements. In this study, we found healthy workforces in both small and large agencies, and in rural, urban and suburban environments. Likewise, we found obviously stressed workforces in both large and small agencies, and in a variety of geographical settings.

There is no doubt that many problems affecting the direct-service workforce are indeed financial, but not all of them are. In fact, many of the frustrations that force workers out of their jobs are entirely unrelated to compensation. When workers complain about irregular scheduling, poor in-house communication, inability to make even small changes in treatment plans for their clients, and lack of internal mobility, they are not talking about money, but about the culture and developmental stage of their organization. In expressing dissatisfaction on these grounds, these direct-care workers are very much in synch with workers in general, who say in study after study that flexibility, support from supervisors, opportunity for learning and advancement, and meaningfulness of the work are considerably more important to their job satisfaction than money.[14]

That said, many workforce weaknesses clearly have their origins in an underfinanced system of care – one that is eroding even further under current economic conditions. Fair compensation for agencies providing services to intensely troubled and even dangerous children and youth is a topic of heated debate in the state, as evidenced by an ongoing lawsuit brought by a consortium of agencies over unpaid rate increases in recent years. Who should pay, and how much, for intensive mental and behavioral services for children? What levels of pay are necessary to ensure quality services? And are those levels

[14] Bond, James T., Galinsky, E. and Swanberg, J. (1998). *The 1997 National Study of the Changing Workforce*. Families and Work Institute, No.2, 1998, in The *New Manager's Tool Kit: 21 Things you need to know to hit the ground running*. AMACOM, New York, NY.

actually being paid? Every year, such questions are debated during the state's budget process. This year, the outlook for residential providers is particularly grim, with budget cuts expected to be over 10%. The direct-care workforce, already stretched, will be asked to do more with even less.

Yet, if agencies are going to survive and continue doing quality work with the state's most troubled young people, problems in the workforce, whatever their cause, will have to be tackled. Given that some residential services will remain a part of the state's system of care, and that compensation for those services may not truly be adequate to ensure a strong, competent workforce, other solutions will have to be found. There is no other choice.

Implementation Project Goals and Recommendations

The goal of this project is three-fold: to improve recruitment strategies; improve staff retention; and improve direct-service worker job performance by reducing burdens related to understaffing. Each goal is established in full recognition of the difficult economy and the transition underway in the state's mental health care system. For reasons not solely related to funding, the system of care for children and youth is evolving, with some sectors contracting and others growing. The proposals below are not intended to preserve the old system, but to maximize the potential of the new one that will emerge. Change is coming to the system, and the consequences for young people in residential care can be either positive or negative. Managing that change, rather than simply reacting to it, improves the chances of an optimal outcome for children and youth who depend on these programs.

As a follow-up project to Advancing Children's Mental Health Care NH, we propose an initiative that consists of nine components running concurrently over three years. We seek five to seven agency partners who are organizationally ready to do this work, and that represent diverse geographical locations, sizes, and program types (community-based, residential, or both). "Readiness" in this context refers to demonstrated support for innovation at all levels of the agency and the ability to meet benchmarks established by the project coordinators.

Pilot initiatives will be executed in at least two agencies each; written reports on process and outcomes will be produced. All partners in this project will meet quarterly and be kept informed of upcoming trainings by a monthly online newsletter.

1) **Pilot: Getting and Keeping High-Quality Staff.** Bolstering recruitment and retention will reduce the costs agencies already pay to replace workers who leave. As noted earlier, the cost

of replacing direct-service workers has been calculated at between 33% and 50% of annual pay; another estimate, from the University of Minnesota's Research and Training Center on Community Living, a leader in research on direct-care workforce issues, puts the cost at about $2,500 per worker.[15] Even using that very low figure, an agency that retains six workers who would otherwise have quit is "earning" about $15,000 a year – money that could be put toward increasing salaries or improving benefits. How can turnover costs be reduced? By recruiting high-quality applicants who are well-suited to the job, and then making intentional efforts to keep them. Innovative recruitment strategies for direct-service workers, pioneered and implemented around the country by the University of Minnesota, have proved successful in reducing the "revolving door" at social service agencies. When Devereux, one of the country's largest direct-service agencies for developmentally disabled children and adults, implemented the measures at its sites around the country, it reduced turnover to around 20%. Though relatively simple and inexpensive, the agency says the strategies have helped it save some of the $10 million it estimated it was losing each year to turnover.[16]

2) **Pilot: Quality Volunteer Programming.** Volunteers are an underutilized resource in agencies providing direct care to children and youth. High-quality volunteer programs would allow agencies to replace a few of their regular staff (respite workers, for instance) with unpaid workers, freeing up dollars to increase hourly salaries. Volunteers would bring more resources into programs for young people, reduce stress for workers, and allow staff to spend more time with each client. It would also allow them to offer more support to each client. If the current economy offers one opportunity, it is a large pool of talented people who, because of layoffs or other economic contractions, are available to work as volunteers in agency settings. CityYear and AmeriCorps, both active in New Hampshire, are another source of quality volunteers, though they have not to date developed strong relationships with the agencies discussed in this study. We do not suggest that volunteers can do the work of experienced residential counselors; we do suggest that their energy and skills as tutors, drivers, respite caretakers, mentors and fundraisers are desperately needed by agencies whose own staffs feel almost impossibly stretched. Add to the new and existing pool of potential volunteers the surge of baby-boomer retirees ready to be tapped for meaningful volunteer work, and the question is not whether such reliable, quality workers can be found; it is

[15] Larson, S. and Hewitt, A. (2005). *Staff recruitment, retention and training for community human service organizations.* Baltimore, MD: Brooks.
[16] Mary Imbornone (personal communication, May 2008). See http://www.nenetwork.org/initiatives/imbornone-retention.html

whether agencies themselves are "volunteer-ready." Our talks with agencies suggest that most understand the value of such programs but need assistance to create them and make them work well.

3) **Loan Forgiveness and Tuition Reimbursement.** It is difficult to overestimate the importance of college financing programs to direct-care workers, many of whom say they would stay in their jobs if not for student loans – either the ones they already have, or the ones they anticipate having should they go back to school for an advanced degree. Yet tuition reimbursement is eroding at agencies, and there is almost universal ignorance about existing loan forgiveness programs. This initiative would educate direct-care staff about the various forms of educational financing available to them, and to create, with the state's colleges, a coordinated system of tuition reimbursement in exchange for service in the field or research partnerships.

4) **Pilot**: **Redeploying Residential Workers into Community-Based Programs.** Community-based, family-centered programs are growing while residential programs contract, yet the skills required for work with families are different from those needed for residential care. The state's colleges, already trainers of baccalaureate-level workers in residential programs, can help develop training specifically geared to providing BA-level workers with the skills they need to move into community-based programs. An administrator running a community-based program in the North Country said she was enthusiastic about the potential of hiring from the residential sector. "I have residential experience myself," she said. "It's absolutely a great training ground. If you can survive residential, you can survive about anything."

5) **Pilot: Peer auditing.** The experts on creating quality workplaces are the workers themselves. Long-time professional direct-care staff should make personal visits to participating workplaces to assess staff and productivity issues, reporting back to management on what they've found and what they recommend for improvement. The benefit for the workplaces is receiving objective, constructive feedback from veteran direct-service staff; the benefit for the peer auditors is in developing their own skills as consultants to a changing and professionalizing field.

6) **Direct-Service Online.** The boom in online social networking creates new opportunities for virtual communities to gather and learn from one another, particularly communities of

younger people who have grown up on the internet and already turn to it as a medium of learning and exchange. Most social service programs work in relative isolation, and direct-care workers rarely have chances to meet one another. Furthermore, with so much training now conducted in-house or online, old opportunities to network and revitalize are vanishing. A website can be created to reduce that sense of isolation, plug workers into useful learning opportunities, and create ongoing mentoring relationships. This intentional community, created and facilitated by direct-care workers themselves, could be easily and inexpensively maintained long after this project has concluded.

7) **Agency Showcases**. In the course of this study, it became obvious that certain agencies excel in particular areas. One agency, for instance, maintains an elaborate system of employee recognition that helps it keep veteran workers; another has eliminated chaotic work schedules – a prime source of worker frustration and burn out – with regular, predictable shifts. How did they do it, and how has their work improved as a result? Showcases, Q and A's and the dissemination of written models to participating agencies, with follow-up technical assistance from the showcase agencies themselves, are inexpensive ways to help agencies improve conditions for the workforce.

8) **Certification Program Support.** Inconsistent and inadequate training has been found to contribute to staff turnover in child welfare agencies.[17] In an effort to combat turnover, the Moore Center in New Hampshire, which works with developmentally disabled people across the age spectrum, decided to offer its direct-care staff the chance to become certified in their work. The Center's goal was to reduce direct-care turnover, which was over 50%, by providing standardized training and rewarding workers who attained it with promotions, salary increases and in-house recognition. The online training and certification program, provided through the University of Minnesota's College of Direct Support, has worked. In the three to four years since it began, turnover has dropped dramatically, to between 16-20%.[18] NH Partners in Service, the state's association of residential treatment providers for children and youth, has created its own multi-part curriculum for direct-service workers, delivered several times a year in different locations in the state (currently by Granite State College). The five-module, 30-hour curriculum was originally intended to lead to certification, but so far hasn't. Staff and administrators in our study were far apart on the

[17] United States General Accounting Office (2003) *Child Welfare:HHS Could Play a Greater Role in Helping Child Welfare Agencie Recruit and Retain Staff.* United States General Accounting Office, Washington, DC.
[18] Scott Trudo (personal communication, March 3, 2009)

certification issue, with staff enthusiastic about the idea of certification but administrators doubtful they could pay higher salaries for certified workers. In any system-wide consideration of the value of certification, it should be noted that the link between employee retention and the sort of high-quality training that leads to certification has been clearly documented by research.[19]

9) **Pilot: Seed Grants.** Agencies already under stress will need small amounts of start-up funding to begin making certain workforce improvements. An agency might use a seed grant to hire a part-time volunteer coordinator (the missing piece that prevents agencies from creating volunteer programs), or to purchase "realistic job preview" materials that could help applicants understand exactly what direct-service work is really like. (While the poor economy will drive more applicants to these agencies' doors, the challenge of hiring the right workers will remain as daunting as ever.) Agencies receiving seed grants will be required to meet criteria as fully engaged participants of the project, attend monthly conference calls and quarterly meetings, and document expenditures and progress. They will be required to provide matching funds.

Specialized trainings will be offered to all participating agencies, and will include: Staff Self-Care; Spirituality and Mindfulness Techniques for Clients and Staff; and Establishing an Outcomes Evaluation System to Assess the Progress of Clients (intensive).

CONCLUSION

We believe that stabilizing the direct-service workforce is critical to maintaining the quality of the state's mental and behavioral health services, and to improving those services where they are suffering due to worker stress, inexperience or turnover. We also believe that well-targeted workforce supports can help reorient staff to the new reality of residential and family-centered work in New Hampshire in a way that benefits both types of programs. The recommendations we make above are practical, sustainable and relatively inexpensive, and are flexible enough to meet the needs of agencies as they weather the current transition. If, as one administrator said, "business as usual is over," then agencies will necessarily find new ways of running their organizations and managing their workforces. Innovation in these circumstances is

[19] *Capturing Promising Practices in Recruitment and Retention of Frontline Youth Workers* (2006). The National Collaboration for Youth: Washington, DC.

a necessity, not a luxury. If well-planned and thoughtfully implemented, it will result in better quality of care for the state's most troubled children and adolescents.