Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut

CHILD HEALTH AND DEVELOPMENT INSTITUTE

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Executive Summary

Like nearly every other state in the country, Connecticut is facing dual crises: (1) rising behavioral health needs among the state's children; and (2) a shortage in the workforce who serves children with behavioral health needs. These combined challenges are resulting in long waitlists and delays in care. Connecticut's system of care for children has many strengths, including a robust continuum of services, a specific focus on the child and youth population, a dedicated network of providers, and comparitvely high rates of implementation of evidence-based practices. Until workforce needs are addressed, however, the timeliness and effectiveness of services provided to children in the state will continue to be challenged. *Meeting the behavioral health needs of children in Connecticut is contingent upon addressing the workforce crisis.*

These concerns were raised by stakeholders during convenings of Children's Behavioral Health Plan Implementation Workgroups. In response, the Department of Children and Families contracted with the Child Health and Development Institute (CHDI) to develop a strategic plan for the children's behavioral health workforce in Connecticut. CHDI partnered with Dr. Michael Hoge as well as a group of Strategic Plan Advisors to engage in a process of identifying best practices and innovative solutions that will address both the immediate and long-term needs of the pipeline, recruitment, retention, diversity and competencies of the workforce. Methods included a survey of stakeholders, a review of national and out-of-state initiatives, an inventory of existing initiatives within Connecticut, and interviews with key experts.

Findings regarding workforce challenges included the following: (1) rising acuity and staffing shortages are creating a cycle of workforce burnout and delays in care; (2) insurance reimbursement rates do not reflect true costs of services, and are restricting the ability to offer competitive salaries; (3) telehealth has presented the workforce with more flexible opportunities in outpatient and especially in private practice that cannot be matched throughout the system of care; (4) there is an ongoing lack of parity between mental and physical health insurance in spite of existing laws; (5) behavioral health workforce demographics are less diverse than the population served and there are systemic barriers to pipeline entry; (6) training on specific competencies to improve services is needed; and (7) there are gaps in Connecticut's workforce data that need to be addressed.

These challenges are significant; however, Connecticut is not alone in facing them. Other states are grappling with this crisis and offer examples as to how to address it. The following recommendations (and associated implementation considerations within the plan) provide Connecticut with a blueprint for addressing the current needs and developing an infrastructure that will support a strong, diverse, and competent workforce, and in turn, timely, responsive, and high-quality services for children, youth, and families.

RECOMMENDATIONS

1. Increase reimbursement rates for children's behavioral health services to cover actual costs and establish a transparent and systematic rate-setting process.
2. Make immediate and significant investments in behavioral health workforce recruitment and retention.
3. Develop a children's behavioral health workforce center that can track and respond to trends in supply and demand and sustain workforce development efforts.
4. Develop a statewide, cross-agency, children's behavioral health workforce plan.
5. Grow and diversify the children's behavioral health workforce pipeline.
6. Increase behavioral health training across the child-serving workforce.
7. Remove administrative barriers to workforce entry and retention.
8. Expand the youth and family peer support workforce.
9. Increase prevention and early intervention provided by community-based organizations.

Introduction

Throughout the country, staffing shortages are plaguing the children's behavioral health sector resulting in declining access to and quality of services for children and families. Connecticut is no different. A recent survey of Connecticut non-profit providers found more than one in five positions were vacant and there was a 39% rate of staff turnover in the last year.[1] This workforce crisis is the result of years of chronic underfunding with reimbursement rates failing to keep pace with inflation and the true costs of delivering care,[2] combined with increasing needs and changes to care delivery associated with the COVID-19 pandemic. For example, the annual Youth Risk Behavior Survey conducted among a representative sample of Connecticut high school students has found rising rates of youth reporting feeling sad or helpless (increasing from 25% in 2005 to 36% in 2021),[3] with even higher rates among females, Black and Latinx youth, and lesbian, gay and bisexual youth.[4] These dual crises of children's rising needs and workforce challenges have resulted in an escalating cycle of high vacancies, higher caseloads and burnout among remaining staff, greater staffing shortages, and longer waitlists.

These concerns have been voiced locally by providers, families, researchers, and other stakeholders across the children's behavioral health system, including during Behavioral Health Plan Implementation Workgroups held by the Department of Children and Families (DCF) and the Connecticut Children's Behavioral Health Plan Implementation Advisory Board (CCBHPIAB) in 2021 and 2022 to develop recommendations related to strengthening implementation of the Behavioral Health Plan for Children (see sidebar). Workgroup members raised alarms regarding workforce shortages, and the need for service expansion to be accompanied by significant investments in workforce development. While subsequent state legislation addressed several of the recommendations related to service expansion, there has been limited parallel action to address the workforce needs.

Connecticut's Behavioral Health Plan for Children

In response to the tragic murders that took place at Sandy Hook Elementary School in 2012, the Connecticut General Assembly passed Public Act (PA)13-178, which required creation of a state Behavioral Health Plan for Children as well as the Connecticut Children's Behavioral Health Plan Implementation Advisory Board to monitor its implementation. Since its enactment in 2014, it has served as a blueprint for the state's work to strengthen systems and services for children's behavioral health.

In response to the concerns raised within the workgroups, DCF contracted with the Child Health and Development Institute (CHDI), which partnered with Dr. Michael Hoge (Yale School of Medicine and the Annapolis Coalition on the Behavioral Health Workforce), to develop a strategic plan for the children's behavioral health workforce. The resulting plan identifies short- and long-term strategies to address the needs related to the workforce pipeline, recruitment, retention, diversity, and competencies.

Methodology

The Annapolis Framework for Workforce Planning in Behavioral Health[*] was adapted for the child, youth and family (CYF) focus (see Attachment A) and used as a guiding document throughout the strategic planning process. CHDI convened a small group of leaders within the state representing diverse stakeholder groups. These Strategic Plan Advisors (see Acknowledgements for full list) provided critical input during the planning process, as well as feedback on draft recommendations.

[*] © 2022 The Annapolis Coalition on the Behavioral Health Workforce. Adapted from Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N., 2007. An Action Plan for Behavioral Health Workforce Development. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

The following methods were used to inform the plan's recommendations:

1. *Children's Behavioral Health Stakeholder Survey*
   The survey questions solicited information on what respondents identified as the most pressing challenges facing the workforce as well as suggested solutions. The survey was shared widely with children's behavioral health providers, family advocate organizations and families with lived experience, higher education faculty, professional associations, Black and Latinx professional associations, trainers, and technical assistance providers. All stakeholders were asked to share the survey with their networks, and it was also posted on the CHDI website, shared on social media, and presented at stakeholder group meetings.

   The survey resulted in 176 individual responses and 23 responses submitted on behalf of an organization. Of the individual responses, 77% identified as a current member of the workforce (including both direct service and supervisory positions), and 16% identified as family members of a child receiving behavioral health services, 6% as family advocate staff or volunteers, and 8% as higher education faculty. The other categories of stakeholders (e.g., students and trainers) had limited representation among survey responses. Note that respondents were able to select more than one role.

2. *Review of National and Out-of-State Initiatives*
   A comprehensive review of investments in behavioral health workforce development across the country was completed to identify best practices and innovative approaches. Since most if not all states are experiencing both rising behavioral health needs and workforce shortages, many states as well as national organizations are exploring solutions, and in some cases, making *significant* investments in the behavioral health workforce. The review found more than 40 different initiatives across 14 states and several national organizations and federal agencies. The strategic themes found from the review have informed the selection of recommendations. Throughout the recommendations examples from the review have been included as a *"strategies in practice".*

3. *Inventory of Connecticut Efforts*
   This plan and the included recommendations are building upon a strong and nationally recognized infrastructure of behavioral health services for children in the state, as well as prior and current efforts specific to the workforce. The recommendations are intended to leverage and, in some instances, expand but not duplicate what has/is being implemented.

4. *Expert Interviews*
   Twenty interviews were conducted to inform development of the recommendations. Interviewees were selected as national experts on specific components of workforce development, key stakeholders within the state of Connecticut, or represented states identified through the review of out-of-state initiatives having particularly innovative or significant investments in the workforce.

Findings

Across interviews and survey responses, the urgency and extent of the crisis within Connecticut and beyond was stressed. A national expert working with behavioral health across the country stated that "the *number one problem in every state* is the workforce shortage". Findings from survey responses, interviews, and out-of-state initiatives regarding challenges in recruitment and retention, pipeline shortages, staff diversity, and workforce competencies are identified below.

Recruitment and Retention

The lack of competitive pay was noted by many interviewees and was among the most cited challenges from survey respondents (both from staff seeking better pay as well as supervisors and agency leadership unable to attract qualified applicants to open positions). In multiple interviews, experts contended that current salaries among both clinical (licensed/license-eligible) and non-clinical staff (direct care staff, etc.) are insufficient to attract and retain staff, have been relatively flat for years, and that in some cases nearly doubling the salaries was necessary to effectively recruit staff.

Compared to private practice where many clients pay out-of-pocket and insurance may not be accepted, nonprofit community-based services and hospitals rely on public and private insurance reimbursement payments to cover their costs. These providers are serving the state's highest need children and families, are more likely to provide evidence-based (and more effective) treatments and offer comprehensive care (inclusive of family services and coordination with schools, pediatricians, etc.). But due to low reimbursement rates, these providers cannot pay staff sufficiently to sustain staffing levels much less to support increasing caseloads and rising acuity.

Non-profit community-based providers, which provide the majority of publicly funded behavioral health services within the state, cannot compete with flexible schedules, the comparatively minimal administrative burden, lack of requirements around evidence-based practice, and lower acuity of cases offered by private practice, nor with the salaries being offered by public agencies. Additionally, telehealth has changed the workforce landscape, expanding opportunities for clinicians to work from home for national telehealth companies. While the expansion of telehealth during the pandemic has been beneficial in expanding access to services,[5] it is not accessible or effective for all treatments and clients, and national companies often do not accept insurance, which increases disparities in care for marginalized populations.

Interviews with experts working to expand school-based health centers (SBHCs) within Connecticut noted that demand for behavioral health care within SBHCs is high with pressure from parents who have increasing concerns about the mental health of their children. Funding has been dedicated in recent years to expansion of SBHCs, however staffing shortages have made implementation challenging. Centers find that while the reimbursement model generally works for primary care, it is burdensome and may not be worth the work for behavioral health services. Reimbursement is often significantly lower than the cost of the service and, compared to primary care, requires more administrative processes and justification by the clinician. While mental health parity is a federal law, the reality of billing for and receiving approval for services is not comparable to primary care. In one interview, a national expert referred to mental health parity as laughable given the lack of enforcement.

Considering the extensive education and licensing requirements associated with becoming a behavioral health clinician (e.g., clinical social worker, marriage and family therapist, etc.), the inherent pressure of these positions, added stress of high caseloads and high acuity cases, it is understandable that members of the workforce are feeling burnt out and seeking other opportunities. In general, the comparably low pay

Comparative Salaries

Position	Low	High
Non-Profit	$58,839	$72,905
Private Practice	$82,400	$117,350
Public Agency	$80,489	$109,50

Living wage annual salary in Connecticut for one adult and one child is $78,475

(see sidebar)[†,‡] is a deterrent to entering and remaining in the behavioral health field overall, and especially to serving children and adolescents and working in settings serving high need populations. Considering the critical contributions this workforce makes to children's wellbeing[6] and long-term outcomes as adults,[7] the pay does not reflect the training required, job demands, or recognition of the significant value clinicians provide.

Families and family advocates who responded to the survey were less likely to directly mention salaries or reimbursement rates, however they regularly referenced the service shortages in the state that are the result of inadequate funding, including long waitlists and turnover of staff. Staffing shortages keep families waiting for care while their children's acuity may increase, resulting in a need for higher levels of care that are more costly.

Both members of the workforce and families identified gaps in available care for specific populations, including families needing services in a language other than English, children with developmental disabilities, undocumented families, children with co-occurring diagnoses and complex needs, as well as a shortage of acute and sub-acute levels of care (e.g., inpatient, in-home, intensive outpatient, psychiatric residential treatment facilities, etc.). This in turn leads to placement of children in outpatient settings as a last resort when their needs are often not appropriate for that level of care. Unfortunately, it is challenging to disentangle the staffing shortages from service shortages (e.g., is there a long waitlist due to vacancies within the given service? Or is there not sufficient service availability *even when fully staffed*?). Systematic, integrated data collection on service referrals, waitlists, and staff vacancies – which is not currently available in any fashion for the state – would help discern where additional service availability is needed vs. where additional staff recruitment is needed. Interviews noted that the lack of predictive models to scale levels of care based on observed changes in need is a challenge nationally as well.

Workforce Diversity

Families and family advocate staff as well as many of the hiring provider organizations, emphasized the need for more diverse and bilingual staff representative of the clients served. Actively working to increasing the diversity of the CYF behavioral health workforce in Connecticut both addresses system inequities for the existing and potential BIPOC[§] workforce, and also can support engagement of diverse children and families in behavioral health care.[8] Among licensed behavioral health professionals in Connecticut, approximately 80% are White, with 6% identifying as Hispanic or Latinx and 15% identifying as Black or African American.[9] In contrast, only about 50% of the child population in the state identifies as White Non-Hispanic.[10] The state has recently invested in prioritizing workforce initiatives for students from low-income families and historically marginalized populations (e.g., CT Health Horizons, loan repayment programs, etc.). To expand the diversity of the workforce, it will be critical to continue to make intentional investments to address the systemic racism that has created barriers to accessing education and career advancement opportunities in the field.

Interviews emphasized the need to diversify the workforce as well. For SBHCs, there is a particular need for bilingual clinicians and other staff to work effectively with monolingual family members who speak a language other than English. They view this as a higher priority in behavioral health than primary care because they typically offer family therapy. They report it is also hard to find referrals to other levels of care within the system. The focus on pipeline growth presents a strong opportunity to intentionally recruit BIPOC and bilingual individuals into the field. It is also critical that providers work to offer an organizational culture that is inclusive and celebrates diverse and intersecting identities.

[†] Average salary ranges based upon search of full-time licensed/license-eligible positions, excluding managerial or supervisory positions, using *Indeed* job search website (https://www.indeed.com/). Public agency positions from Connecticut's state employment portal (https://www.jobapscloud.com/CT/). Note that Private Practice positions are less likely to provide benefits (although some do), and non-profit positions are more likely to allow applicants with associate licenses.

[‡] Estimate from Living Wage Calculator operated by the Massachusetts Institute of Technology Living Wage Calculator - Living Wage Calculation for Connecticut (mit.edu).

[§] Black, indigenous and people of color

In addition to strengthening the pipeline of licensed clinical staff, there is an opportunity to address portions of the staffing shortage and to diversify the workforce by investing in non-clinical positions, such as peer supports and community health workers. States such as Maine and Iowa have programs that support entry-level positions through community college and training programs, as well as career pathways for those staff to continue to advance. Indiana found success during the pandemic in recruiting peer supports into the workforce to fill portions of the staff shortages.

Competencies

While addressing staffing challenges is critical to ensuring access to timely care, the quality of care must continue to be a priority as well. Interview and survey findings highlighted the following priorities in addressing workforce competencies:

- *Expand Training on Evidence-Based Treatments:* Connecticut stands out in its training opportunities, in particular the number of clinicians trained on evidence-based treatments (EBTs), with 54% of children in outpatient clinics reportedly receiving at some EBT as part of their treatment[11] and research showing that these EBTs were reducing outcome disparities for children of color.[12] The state also supports a range of in-home EBTs, however more access to these high-quality treatments is needed. Many EBTs have been shown to significantly reduce future healthcare, social system, and employment costs.[13]
- *Invest in field placements.* Providers reported challenges with new graduates having less experience in the field due to virtual field experience that took place in the initial part of the pandemic. Field placement is an important aspect of workforce preparation; however, it necessitates support from provider agencies to allow field placement within their agencies and an inherent cost for supervising students. Incentives for offering CYF-focused field placements could support quality opportunities in the field prior to graduation.
- *Build Skills to Improve Health Equity.* Respondents stressed the need for more culturally responsive care and skills to serve LGBTQ+ and gender minority youth. Research has demonstrated differences in outcomes for clients depending on their skills regarding cultural humility.[14,15] One of Connecticut's strengths in its behavioral health system is the dissemination of Culturally and Linguistically Appropriate Service (CLAS) Standards. These national standards have been updated within Connecticut to reflect a racial justice framework and offer a blueprint to organizations to implement racially just and culturally and linguistically appropriate services. Ongoing dissemination of this model will benefit the state.
- *Strengthen Services to Children with Complex Needs.* Challenges regarding access to and quality of services families with children with intellectual or developmental disabilities were raised within the survey; while some of these relate to exclusion criteria for specific levels of care, there is opportunity for improved services for these populations by strengthening the skills of the workforce. There are existing trainings within the state funded by DCF to address these competencies, as well as efforts to expand the content and audience of these trainings. This can be monitored for any additional gaps to address. Additional complex needs, such as children involved in juvenile justice, those with co-occurring medical needs, as well as substance use disorder should be addressed as well.
- *Improve Supervision.* While formal education provides the skills necessary for roles as clinicians, as staff advance in their careers, training for roles in supervision and leadership is limited. Effective supervision and leadership in CYF behavioral health is critical for strengthening recruitment and retention in the field.
- *Broaden the Audience.* As appropriate, expand the audience for trainings to include direct care staff (staff providing non-clinical supports to children to supplement clinical services), include school-based behavioral health staff, and the broader CYF-serving workforce beyond behavioral health (e.g., primary care, juvenile justice, school nurses, etc.).

Recommendations

Given the focus of this strategic plan, the recommendations are presented specific to the CYF behavioral health workforce. The behavioral health workforce, however, is in crisis across settings, levels of care, and populations served (adults *and* children). In reviewing workforce development initiatives in other states, most strategies targeting the CYF behavioral health workforce were broadened or scaled to impact the behavioral health workforce as a whole (those

serving adults as well as children). Connecticut may choose to apply the identified recommendations across the full behavioral health workforce; however, it is critical that the unique needs of the CYF population and the staff who serve them not be lost in broader workforce efforts.

In developing the following recommendations, addressing the need to increase workforce diversity and improve health equity is included within each of the strategies. This approach, as opposed to a separate recommendation, was taken to promote intentional integration of efforts to increase diversity, improve health equity, and strengthen the quality of care throughout CYF behavioral health workforce development investments.

While there is no "quick fix" to the workforce challenge, an immediate and sustained commitment is necessary to begin turning the curve and to prevent the current crisis from becoming a catastrophe. The following nine recommendations have been developed through extensive engagement with stakeholders and the comprehensive review of best practices and innovative strategies from across the country as the nation grapples with this significant threat to children's wellbeing. For those dedicated to the health of children and families in this state, this plan must be read as a *call to action* for a meaningful and long-term state response that reflects the current needs and chronic neglect of funding for the children's behavioral health system.

The recommendations identified in this strategic plan are individually beneficial to Connecticut's CYF behavioral health workforce, however, to maximize and sustain impact on the workforce, the recommendations should be seen as interdependent. Each of the recommendations include implementation action steps, identified leads, timelines, and estimated costs when available. The information below serves as a summary of guidance for coordinating implementation of the recommendations. Each recommendation has been identified as requiring the state to do one of the following:

Take Legislative Action. These recommendations should be acted upon by the state legislature in the 2024 legislative session to avoid additional staffing shortages and longer waitlists.

Make Administrative Changes. These recommendations can be coordinated through revising state agency policies, practices or contracts.

Convening and Planning. These recommendations would benefit from additional development through collaborative input from key stakeholders. Ensure these are inclusive of those most impacted: members of the workforce and families and youth with lived experience.

RECOMMENDATION 1: Increase reimbursement rates for children's behavioral health services to cover actual costs and establish a transparent and systematic rate-setting process.

Salaries will need to increase to attract and sustain a sufficient workforce to support timely and high-quality services to children, reduce turnover, and attract new entry into the field. *Providers cannot offer competitive salaries without sufficient increases to reimbursement rates and state grants.*

Building upon past legislation that required a review of reimbursement rates for behavioral health services (and review of parity with medical services), the Department of Social Services should increase reimbursement rates to reflect actual costs of services. Other states have made substantial rate increases since the pandemic. In fact, a survey of states by the Kaiser Family Foundation found that 28 of the 44 responding states were increasing Medicaid rates for behavioral health services as a strategy for addressing workforce shortages.[16] Underfunding of behavioral health services has accumulated over many years resulting in salaries that cannot compete in the current labor market. The impact of low reimbursement rates not only depresses wages, but disincentivizes providers from accepting insurance. Many private practice providers find it unsustainable to accept insurance (or specific insurers as rates vary dramatically from one company to another), and instead only accept clients paying out-of-pocket. This places pressure on other parts of the system and decreases access to care, especially for the most vulnerable. In a survey of psychologists in Connecticut, many reported dropping at least one insurance panel in the prior year due to low rates.[17] The data on the number of providers accepting insurance is not systematically collected and is complex given that providers choose which insurers to accept. The impact, however, is a lack of parity with physical health services (17% of individuals saw out-of-network providers for behavioral health services, vs. 3% for primary care and 4% for specialty care).[18] Therefore, while Connecticut children have high rates of behavioral health care coverage,[19] the proportion with feasible access to covered care is unclear.

STRATEGY IN PRACTICE

OREGON HEALTH AUTHORITY. In 2022 the state of Oregon allocated over $500 million for behavioral health services, which included $155 million for higher Medicaid reimbursement rates for behavioral health services (increasing rates by an average of 30%).

MAINECARE RATE SETTING. The Office of MaineCare Services (OMS), Maine's Medicaid authority, was honored by the National Association of Medicaid Directors for its transformation of its rate-setting system which included adjustments to address immediate workforce needs as well as a process to increase based upon inflation and other factors.

ARIZONA'S JAKE'S LAW. Arizona passed a law in 2020 to increase state agency authority to enforce parity law, require submission of parity compliance reports, prohibit insurance denials of covered services delivered in an educational setting, and created an $8 million fund for behavioral health services for children who are uninsured or underinsured.

States such as Maine and Massachusetts have adopted transparent and systematic Medicaid rate-setting processes to ensure that rates are regularly addressed through a consistent process that accounts for changes due to inflation or other factors impacting the cost of services; these established processes help avoid ad hoc rate adjustments. The process must be clearly documented through legislative action that authorizes the Department of Social Services (DSS) to make such changes, and changes in rates accounted for in the state budgeting process.

States have tended to focus on Medicaid rates because of the direct role they have in the rate-setting process, however existing laws on parity and state oversight roles should be employed to the extent available to address private insurers' rates. Connecticut is among higher ranking states in regard to access to behavioral health care among youth with private insurance,[20] however behavioral health care coverage does not guarantee either approval of a given recommended service for a child or reimbursement reflective of actual cost to the provider. The denial of services was raised regularly as a primary concern by both members of the workforce and family members in the survey conducted as part of this strategic planning process. As appropriate, the Office of Health Strategy, the Connecticut Insurance Department, and/or the new Behavioral Health Advocate position should enforce parity laws that can be enforced and gaps in policies that

support coverage and rates. Grants for specific behavioral health services provided by state agencies should also be assessed to ensure costs of required activities are fully funded.

As reimbursement rates for behavioral health services to CYF are reassessed, there are aspects of care for youth and families that need to be considered that may not be traditionally included as a direct cost for services. These may include costs associated with: living wages for entry level direct care staff (care coordinators, peers, etc.), variability in acuity and complexity of both child and family needs, lower caseloads necessary for EBT implementation as well as overall staff wellness and retention, staff training, staff supervision, collaborative care models (e.g., primary and behavioral health care, schools and behavioral health care), flexibility in setting (e.g., home, school, clinic, etc.), and flexibility in use of telehealth and/or phone consultation as appropriate.

DSS and other state agencies are currently engaged in planning efforts related to innovative strategies that support provider payments for some of the additional costs noted above (e.g., collaborative care in primary care settings, billing for school-based behavioral health services, etc.). Alternative payment (or value-based) models are a strategy that can be used to support bundled reimbursement and outcome-based incentives.[21] DSS should continue to explore these opportunities, however given the recommended incremental implementation of alternative payment models, it is critical that reimbursement rates be addressed simultaneous to design of these models.

IMPLEMENTATION PLAN

Action Steps:

1. DSS recommends Medicaid rate increases for behavioral health services that reflect the requirements of the current labor market and costs associated with providing effective, evidence-based and coordinated behavioral health services for children. Submit for review by OPM and approval by the state legislature.
2. In consultation with stakeholders in the state and out-of-state experts, DSS develops a systematic and transparent Medicaid rate-setting process that is responsive to annual increases in costs. Submit for review by OPM and approval by the state legislature.
3. Identify opportunities to mirror Medicaid rate increases among private insurers, and to enforce parity laws.

Timeline:	*Cost:*
Initial rate increases to be approved during 2024 legislative session. Rate-setting process to be approved during 2025 legislative session.	Review of rates already addressed through prior legislation; Cost of staff or consultant support for developing rate-setting process to be determined by DCF; Cost of increased rates to be determined through approved process and will require bi-annual legislative approval as part of the budgeting process.

RECOMMENDATION 2: Make immediate and significant investments in behavioral health workforce recruitment and retention.

In contrast to funding of reimbursement rates which provides a long-term sustainable approach to increasing salaries for the workforce, this is a targeted and time-limited strategy involving grants to agencies to explicitly address worker recruitment and retention through direct payments to the workforce that can help the state address the immediate staffing shortages and reduce waitlists. Other states, such as Massachusetts and Oregon, offer a roadmap for this strategy.

The State of Connecticut should make emergency awards available for the next three years to CYF-serving behavioral health providers. Accepting awards should be contingent on the majority of funds being used directly for recruiting or retaining staff. Priority of funds should be given to providers serving higher proportions of underserved populations, such as BIPOC children and youth and those with more complex needs, such as children with intellectual or developmental disabilities.

STRATEGY IN PRACTICE

MASSACHUSETTES. The state legislature approved two one-time payments to providers calculated as 10% of agency expenditures. Awards were contingent upon use of 90% of the payments toward recruitment and retention.

OREGON. House Bill 4004 allocated $132 million for *Workforce Stability* Grants for behavioral health providers serving majority uninsured or publicly insured adults or youth. Grants to providers were contingent upon 75% of the funds being used for employee compensation, and the remainder for other recruitment and retention strategies.

Flexibility in the grants should allow for the variability in need across providers (e.g., some providers may need to hire new staff by offering sign-on bonuses or expanding loan-forgiveness options, while others may need to offer longevity stipends to incentivize retention or offer schedule flexibility to improve staff wellness). Funds may also be used to incentivize hiring that will meet specific gaps in available services [e.g, bilingual staff (inclusive of American Sign Language), staff with expertise in serving children with developmental and intellectual disabilities, justice-involved youth, or gender-minority youth].

Following receipt of grants, additional insight on effective recruitment and retention strategies for providers can be gained from the Annapolis Coalition on Behavioral Health Workforce Development. The coalition created an intensive quality improvement intervention for provider organizations to address recruitment and retention challenges. It uses the evidence-based *learning collaborative* approach to change. The collaboratives range from 9 to 18 months in length and have been offered in Connecticut, Delaware, Maryland, Ohio, Pennsylvania, and Washington, DC.

IMPLEMENTATION PLAN

Action Steps:

1. In consultation with providers and OPM, and informed by efforts in other states, DCF develops a budget for recruitment and retention stipends that will be effective for short-term staffing increases, as well as the requirements and prioritization of recipients associated with the awards.
2. Legislative approval of the emergency funds for distribution in 2024.
3. Prior to the 2025 – 2027 budget cycle, assess the need for additional grants and approve funding as needed during the 2025 legislative session.

Timeline:	*Cost:*
Develop budget for emergency awards prior to 2024 legislative session; reassess for additional need in preparation for 2025 – 2027 budgeting process.	No cost for planning; Cost of awards to be developed and should be proportional to need.

RECOMMENDATION 3: Develop a children's behavioral health workforce center that can track and respond to trends in supply and demand and sustain workforce development efforts.

The State of Connecticut should fund a CYF Behavioral Health Workforce Development Center (Center) utilizing examples from initiatives in other states, such as Nebraska or Alaska, but tailored to the CYF-serving workforce. Dedicating an infrastructure to CYF behavioral health workforce efforts would enable Connecticut to address long-term pipeline solutions, implement programs to strengthen recruitment, retention, and diversity of the workforce, and to monitor trends in supply and demand that strengthen the state's capacity to respond to changes in the labor market and/or children's wellbeing before workforce needs reach crisis levels again. The state already has similar models for other fields, e.g., the Connecticut Center for Nursing Workforce. The Center would work closely with higher education and the provider workforce, but ideally be independent and not a member of either so as to avoid perceived or real conflicts of interest. Specific roles of the Center, which would be finalized during a planning phase, are likely to include:

STRATEGY IN PRACTICE

BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA. *BHECN* serves as the state's behavioral health workforce development center. It implements initiatives to strengthen the behavioral health workforce in high schools, colleges, residency programs, and the community of practicing providers. Its $5m annual budget was recently supplemented with $25m by the state legislature to fund competitive grants across the state. While outcomes cannot be directly tied to these programs, Nebraska has experienced a growth in their workforce of more than 30% since implementation.

- Conducting a workforce needs assessment, including identifying, collecting, monitoring, analyzing, and reporting on CYF behavioral health workforce data and metrics (data are not currently collected or reported specific to the CYF-serving workforce). It will be important that data are inclusive of demographic variables to disaggregate and track diversity trends.
- Planning, implementing, and evaluating culturally and linguistically-appropriate training programs.
- Providing feedback to higher education programs to inform curriculum as relevant.
- Developing, monitoring, and updating a strategic plan for the CYF behavioral health workforce.
- Providing technical assistance to CYF providers and state agencies to strengthen recruitment, retention, and diversity.
- Seeking federal and foundation grants to further expand and leverage its work.

IMPLEMENTATION PLAN

Action Steps:

1. DCF, in collaboration with members of the CCBHPIAB:
    a. Review the infrastructure in place within other states.
    b. Identify the Center's specific roles and responsibilities.
    c. Develop a 5-year plan and budget.
2. Recommend legislative action for funding the Center.
3. Following legislative approval, DCF procures a lead entity for the Center.

Timeline:	*Cost:*
Complete planning in advance of 2025-2027 budgeting process.	Minimal resources for planning phase; cost of the Center to be determined through planning phase.

RECOMMENDATION 4: Develop a statewide, cross-agency, children's behavioral health workforce plan.

Growing and strengthening the CYF behavioral health workforce requires a thorough, statewide plan that involves multiple stakeholders, including the many state agencies with roles related to educating, licensing, hiring, or funding agencies that employ the workforce. The coordinated effort is particularly critical for children as their behavioral health may be supported across the varying systems in which they or their families are served (school, clinic or hospital, community- and faith-based organizations, juvenile justice, DCF, etc.).

STRATEGY IN PRACTICE

COLORADO'S BEHAVIORAL HEALTH WORKFORCE STRATEGIC PLAN. In 2022 Colorado adopted state legislation that allocated $72 million for collaboration among the Behavioral Health Administration, higher education, the Workforce Development Council, providers, and law enforcement to develop a Behavioral Health Workforce Strategic Plan to address staffing and pipeline shortages, diversity, cross-training of first responders, peer supports, training on evidence-based practices, and other priorities for the state.

Similar plans, such as those in Colorado and Maryland, have been mandated by governors or legislatures. To be successful, all state agencies involved in Connecticut's CYF behavioral health must collaboratively create a coordinated, statewide workforce development plan that is informed by direct service providers. The plan should be updated on at least a biannual basis. There are 15 state agencies identified as supporting CYF behavioral health per 2022 state legislation (PA 22-47) that updated the original list of 12 in the state's *Behavioral Health Plan for Children*. At minimum, those 15 agencies as well as the Office of Workforce Strategy and Connecticut State Colleges and Universities should be included in developing the workforce plan.

Provider organizations receiving state funding for CYF behavioral health services should be required via contract deliverables to develop and submit individual workforce development metrics and plans to the funding agency on an annual basis. Plans should include vacancy and turnover rates, staff diversity, strategies for recruitment, retention, and training, and encompass the various segments of their workforce. In turn, these provider metrics and plans inform the interagency statewide plan.

Collaborative efforts should include plans related to assessments, strategies, and mechanisms for monitoring, evaluating, and reporting on implementation of workforce development efforts addressing each of the goal areas within *The Annapolis Framework for Workforce Planning in Behavioral Health* as well as the priorities within the state's Behavioral Health Plan for Children. Implementation of the statewide plan and review and support of the agency-level plans will only be successful if supported by staffing. The Center identified in Recommendation 3 would be best for serving this role. If that recommendation is not funded or is delayed, the planning efforts and implementation should be coordinated by a dedicated staff person specifically charged with responsibility for CYF behavioral health workforce development efforts.

IMPLEMENTATION PLAN

Action Steps:

1. The Governor's office issues a directive to state agencies to:
    a. Collaboratively develop a comprehensive interagency plan to address recruitment, retention, diversity, and training needs of the CYF behavioral health workforce, informed by the agencies' plans.
    b. Require contracted CYF behavioral health providers to submit workforce development plans to address recruitment, retention, diversity, and training needs specific to their agency. Plans must include available data related to workforce size, vacancies, turnover, and training in evidence-based practices. *These requirements should inform and align with statewide workforce development efforts such as reimbursement rate adjustments.*
2. DCF coordinates development of interagency plan across 15 agencies identified as supporting CYF behavioral health as well as the Office of Workforce Strategy and the Connecticut State Colleges and Universities.
3. Identify a lead entity (e.g., the Workforce Development Center identified in Recommendation 3) or a staff position to supervise and coordinate implementation of the interagency plan as well as evaluations of plans' effectiveness, and biannual updates to plans.

Timeline:	*Cost:*
Requirement for agency plans included in FY25 contracts; Statewide plan developed prior to FY25 legislative session.	Up to $30,000 for staff or consultant to convene agencies and write plan

RECOMMENDATION 5: Grow and diversify the children's behavioral health workforce pipeline.

The high cost of education and the comparably low levels of wages in behavioral health make tuition and loan repayment programs a powerful tool in recruiting, retaining, and diversifying the workforce. The State of Connecticut has made investments in these strategies, including the CT Health Horizons program currently underway to support nurses and social workers (though the majority of this funding is dedicated to nursing). In the last legislative session, the state repealed the Health Care Loan Reimbursement Program, which had not yet been funded. To address both overall pipeline concerns and increase diversity of the workforce, the state should create or expand tuition and loan repayment programs for those preparing to enter as well as those already working in the CYF-serving behavioral health field.

STRATEGY IN PRACTICE

HBCU CENTER FOR EXCELLENCE. SAMHSA funds the Historically Black Colleges and Universities Center of Excellence in Behavioral Health to provide training that prepares individuals for careers in behavioral health or advances their careers.

OREGON BEHAVIORAL HEALTH LOAN REPAYMENT PROGRAM. Members of the workforce from historically underserved communities can receive up to two years of funding (up to $50,000) to repay loans contingent on two years of service within a program that does not disqualify clients based on insurance.

MAINE COLLABORATIVE. AdCare Maine and the Co-Occurring Collaborative Serving Maine partnered with the Kennebec Valley Community College to develop and offer a curriculum in high schools. It involves a presentation that covers the varied jobs in this field, inclusive of entry- through doctoral-level positions.

The social work field represents the majority, although not all, of the licensed behavioral health workforce. As data is collected and reported from the CT Health Horizons project, additional needs for tuition stipends, loan repayment, and faculty expansion can be identified and expanded to the broader behavioral health workforce, with specific funding for those hired in CYF-serving positions. Funding for education and training for entry-level, non-clinical positions, such as care coordinators and peer support specialists, can be supported through these efforts as well. Investments can prioritize BIPOC and bilingual students. In 2022, the CT state legislature approved a new requirement that the Office of Higher Education (OHE) offer $20,000 incentive grants to licensed health care providers accepting adjunct professor positions. The impact of this program on both faculty vacancies and the current workforce should be monitored over the next year.

While increasing salaries can support entry into the field, additional marketing of CYF-serving behavioral health professions, and related potential career pathways, can support interest in the field and increases to the pipeline. Messaging that combines both career opportunities and the rewarding nature of the work should be emphasized. Targeted marketing can start with the high school students and extend to colleges and the broader community.

IMPLEMENTATION PLAN

Action Steps:

1. The lead agencies implementing current pipeline-focused initiatives should annually monitor and publicly report findings to identify ongoing needs.
2. Utilize data to identify gaps in investments to support the workforce pipeline and develop a responsive plan and associated budget to fill gaps.
3. The Office of Workforce Strategy, SDE, DCF and other agencies as relevant develop a plan for marketing CYF-focused behavioral health careers.

Timeline:	*Cost:*
Monitor reporting of pipeline initiatives in 2024; identify strategies to fill remaining gaps in advance of 2025-2027 budget process.	Costs to be identified following assessment of existing strategies;

RECOMMENDATION 6: Increase behavioral health training across the child-serving workforce.

The State of Connecticut should identify gaps in training availability and accessibility and increase funding for training of the CYF-serving behavioral health workforce, including professionals, paraprofessionals, peer support specialists, and family support/advocates, as well as for other members of the child-serving workforce to strengthen understanding of children's behavioral health (e.g., school staff, primary care, and others). The strategic plan process identified the following training needs as of high priority across the workforce:

- Expansion of CYF-focused evidence-based treatments (EBTs)
- Cultural humility, racial justice, and culturally-responsive care, including organizational training on Culturally and Linguistically Appropriate Services (CLAS)
- Serving LGBTQ+ and gender minority youth
- Serving youth with complex needs
- Supervisory skills
- Identification of behavioral health needs and effective prevention and early intervention strategies for the broader CYF-serving workforce
- Trauma-informed care and family engagement strategies for both the behavioral health and the CYF-serving workforce more broadly

STRATEGY IN PRACTICE

CONNECTICUT WORKFORCE COLLABORATIVE ON BEHAVIORAL HEALTH. The CWCBH conducted workforce planning, funding, and evaluation of behavioral health workforce initiatives in Connecticut for five years through federal funding before it was sunset. Initiatives successfully strengthened supervision and leadership, improved higher education curriculum, and supported workforce efforts within agencies.

While Connecticut has strong existing workforce training programs, gaps in training and access to training remain. In addition to identifying what trainings need to be enhanced and expanded, it is equally important that funding be added to address the more indirect costs of sending staff to trainings and implementing new practices (e.g., coverage for out-of-office staff, participation in learning collaboratives, additional data entry, maintaining lower caseloads for EBT implementation, etc.). These costs could potentially be included in new reimbursement rates or as part of alternative payment models.

Responses to both the survey associated with this strategic planning process, as well as those conducted specifically with outpatient and intermediate level of care providers, indicate that the workforce desires additional training opportunities and prefer flexible training modalities. Asynchronous training allows for staff to take trainings that work with their own schedules. Not all trainings are appropriate for this approach, as some topics benefit from interaction between trainer and trainees/among trainees. However, for those topics that lend themselves to this modality, it should be utilized.

IMPLEMENTATION PLAN

Action Steps:

1. Training opportunities within Connecticut for CYF-serving behavioral health providers should be assessed to identify any gaps and expand trainings as needed.
2. Estimate costs associated with developing and/or expanding training opportunities (costs for covering lost staff time, etc.) as well as costs for implementation.
3. DCF should expand funding to community-based providers to support organizations in the costs associated with training as well as with implementation of trainings.

Timeline:	*Cost:*
Identify gaps IN 2024 and begin rollout of additional trainings in FY2025.	No cost to identifying gaps; Costs associated with trainings to be developed as gaps are identified.

RECOMMENDATION 7: Remove administrative barriers to workforce entry and retention.

There are multiple conditions associated with entering and remaining in the behavioral health field, many of which are designed to ensure quality of care. These include education and licensing requirements, documentation of services, and ongoing supervision and training. Some requirements, however, may be excessive to the need for quality control or require significant out-of-pocket costs, and may hamper recruitment and retention efforts and ultimately decrease access to quality care. Removing unnecessary administrative mandates may help to grow and diversify the pipeline, decrease burnout and turnover, and increase access to care.

STRATEGY IN PRACTICE

CONSOLIDATED APPROPRIATIONS ACT. Medicaid has identified specific interventions of high need and high impact that benefit from reduced administrative requirements in order to increase their utilization. Among these are prescription medications to treat opioid use disorder. This change in requirements was passed by Congress in 2022.

Through Public Act No. 23-101 passed by the Connecticut General Assembly in 2023, the state addressed aspects of the licensing process that were burdensome. Changes included reduction in fees associated with applying for and maintaining licensure (which were among the highest in the country), and acceptance of out-of-state examination. Barriers associated with licensure may hinder diversity of the workforce. Entering the workforce should be no- to low-cost, and so continued efforts to reduce licensure costs or subsidize applicants through waivers or stipends bundled with tuition assistance for graduate programs. The state could reduce additional licensing barriers by removing the associate licenses; interim licenses for social workers, marriage and family therapists and others that add requirements and timelines but do not appear to improve quality. Providers report these as hinderances in the road to full licensure.

Disparities in pass rates on the Social Worker exams within Connecticut and nationally have raised significant concerns regarding the continued use of the national exams. Within the state, there are differences in pass rates by race and ethnicity, by primary language, and by age (Black: 39%; Hispanic/Latinx: 56%; Multiracial: 74%; White: 81%; English: 74%; Other Language: 47%; 18-39 years: 74-80%; 40 and over: 60-64%).[22,**] As providers seek to hire staff representative of the children they serve and with more experience, the exams are presenting a barrier and an undue burden on BIPOC and older graduates who must pay to take the exam multiple times, or may be discouraged from continuing on their path to licensure. Connecticut should partner with other states to identify an alternative to the national exam that will support quality and license portability but not promulgate continued structural inequities.

While it appears that reimbursement rates are the predominant reason that private practice providers do not accept insurance, the administrative requirements associated with accepting insurance (which vary across insurance panels) are complex and require both time and technology (many private practice providers still practice without use of an electronic health record program)[23], contributing to the large number of private practices only accepting clients who are able to pay out-of-pocket, reducing access to care. The state should explore opportunities to simplify the process, provide technology and/or technical assistance that supports more providers to accept insurance.

** Note that the listed rates apply to the Licensed Clinical Social Work Exam. Similar disparities exist for the licensed master's in social work exam across race and ethnicity and primary language, but not age.

IMPLEMENTATION PLAN

Action Steps:

1. Stakeholders, including social workers, employers, DPH and professional organizations, should partner with other states to identify an alternative to the current licensing exam.
2. DPH should propose to the state legislature the removal of associates licenses.
3. DCF, DSS, and other state agencies as relevant, should work with providers to identify unnecessary requirements to remove from state contracts, such as paperwork, data collection or other administrative requirements that do not add value to the quality of care for children and families.

Timeline:	*Cost:*
Approximately one year to identify exam alternative and reductions in administrative requirements.	Up to $75,000 for staff or consultant support.

RECOMMENDATION 8: Expand the youth and family peer support workforce.

Peer support specialists have demonstrated effectiveness in supporting some behavioral health needs and taking on limited roles to complement the masters-level (licensed/license-eligible) workforce, which can alleviate workforce shortages.[24] Peer supports are used regularly (and are Medicaid-reimbursed) for adult services. Their use in children's services has been more limited (and typically not Medicaid-reimbursable), however use of family peer supports in children's services has demonstrated effectiveness in improving family hopefulness, increasing family engagement, and reducing disparities[25]. "Family peers" refer to family members with lived experience as a caregiver for a child (or other dependent) with a mental health and/or substance use condition.[26] "Youth peers" are older teens or are transitional age youth with lived behavioral health experiences who work as peers directly with youth. The current workforce crisis is an optimal time to expand peer and family services, which can both complement treatment by masters-level clinical staff and in some cases even provide low intensity services, enabling clinical staff to use their time for youth with more significant needs. Certifying family peers is a much faster process than increasing the pipeline of masters-level clinical staff and can provide a reasonably large and rapid increase in the overall workforce.

STRATEGY IN PRACTICE

KENTUCKY SYSTEM OF CARE. Kentucky has a certification process for both family and youth peer support specialists. Once certified, the peers work in various settings supporting children's behavioral health in the state and are integral to the state's system of care. Medicaid reimbursement of services is available contingent on certification and ongoing continuing education.

While Connecticut currently has minimal numbers of paid family or youth peers working within children's behavioral health services, the state has a strong infrastructure to build upon, including an existing peer support training program by FAVOR that conforms to SAMHSA's National Model Standards[27] for training. Connecticut also recently added reimbursement for some peer support services within its Medicaid State Plan Amendment. Additional work is needed to expand training and certification programs, define paid peer roles, develop an infrastructure for recruitment and retention, develop career pathways, and expand services that are reimbursable by Medicaid and other insurers. The state should also use the opportunity to recruit families with lived experience who are currently underrepresented in the workforce and/or underserved within the children's behavioral health system.

IMPLEMENTATION PLAN

Action Steps:

1. DCF should convene a Connecticut Peer Support Workforce Workgroup. The membership should include youth peer mentors, family advocates, providers, and a representative of DCF. Youth and family should comprise at least 51% of the membership. The Workgroup should:
    a. Conduct a review of the status of youth and family peer support in Connecticut, as well as national best practices, and identify options for expansion and improvement.
    b. Develop recommendations related to roles, integration with the existing workforce structure, training, certification, diversity, career pathways, and budget implications.
    c. Report recommendations to the CCBHPIAB.
2. CCBHPIAB include recommendations in their annual report to the state legislature as relevant.
3. Fund expansion of training, certification and employment of family and youth peer supports.

Timeline:	*Cost:*
Complete report in advance of the 2025-2027 state budget setting process	Up to $50,000 for staff or consultant to convene stakeholders and write plan; Cost of plan activities to be determined during planning phase

RECOMMENDATION 9: Increase prevention and early intervention provided by community-based organizations.

As trusted partners to families, others within the community, including primary care practices, faith-based organizations, schools, after-school programs, and others can play a critical role in prevention and early intervention for CYF behavioral health needs. Youth who have strong healthy connections within their family and community are approximately half as likely to have mental health challenges later in life.[28] Through introductory education for community-based organizations on mental health, trauma, and substance use, these organizations' staff can promote healthy relationships with trusted adults, educate children on positive mental health strategies and the harm of alcohol and drug use, reduce stigma associated with receiving care, screen for substance use, mental health, trauma and other needs, and make referrals. These low-cost prevention and early intervention strategies can (1) identify symptoms early and connect families to behavioral health providers; and (2) prevent the need for treatment by a behavioral health provider for those children whose needs can be prevented or addressed through non-clinical interventions. Examples of these interventions include "Friendship Benches" at primary care sites where paraprofessional staff can offer a safe space for youth to discuss challenges and experiences, and offer low intensity interventions and referrals as needed; "Faith-Based Navigators" to support positive conversations and reduce mental health stigma; as well as the prevention strategies regularly offered to families by staff working directly with CYF (staff at WIC sites, home visitors, community health workers, early childhood providers, faith-based organizations, and others).

STRATEGY IN PRACTICE

BROTHER, YOU'RE ON MY MIND. Intended to address the disparity in mental health care access and utilization among African American men, and the rising rate of suicide among 15–24-year-old African Americans, *Brother, You're On My Mind* is a collaboration between the Omega Psi Phi Fraternity and the National Institute on Minority Health and Health Disparities. The Omega chapters identify local behavioral health resources, provide education to their members, and promote awareness in their local communities.

While these strategies cannot replace treatment provided by behavioral health clinical staff for those children who need clinical intervention, they can reduce the need for treatment, reduce stigma, and/or identify needs earlier to prevent the need for higher levels of care, and in the long-term reduce clinical caseloads and costs.

IMPLEMENTATION PLAN

Action Steps:

1. DCF should convene a Connecticut stakeholder group with expertise in CYF behavioral health prevention and early intervention. The group should be charged to develop a statewide plan for expanding the role of community-based organizations in prevention and early intervention and identify promising practices that improve mental health and reduce drug and alcohol use among youth. The group will:
    a. Conduct a review of statewide community-based prevention and early intervention resources.
    b. Identify any disparities across populations and their access to culturally responsive resources.
    c. Identify effective programs within the state and any gaps that may be addressed by out-of-state promising practices that are culturally responsive.
    d. Develop a plan and accompanying 5-year budget for review by the CCBHPIAB.
2. CCBHPIAB include recommendations in their annual report to the state legislature as relevant.
3. Fund additions and expansions of community-based prevention and early interventions that address CYF behavioral health needs in children and youth.

Timeline:
Complete report in advance of the 2025-2027 state budget setting process

Cost:
Up to $50,000 for staff or consultant to convene stakeholders and write plan; Cost of strategies to be developed during planning phase (these are generally low-cost strategies)

Attachment A: The Annapolis Framework for Workforce Planning in Behavioral Health[††]

Broadening the Concept of "Workforce"

Goal 1: Expand the role of families and young adults with lived experience to actively participate in and influence their own care, provide care and supports to others, and educate the workforce.

Goal 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

Goal 3: Expand the role and capacity of all health and social service providers, through interprofessional collaboration, to meet the needs of children, youth, and families with mental and substance use conditions.

Strengthening the Workforce

Goal 4: Expand the pipeline of individuals into the field, ensuring broad diversity, successful completion of initial education and training, and entry into the workforce.

Goal 5: Implement systematic recruitment and retention strategies at the federal, state, and local levels to find and retain a diverse workforce.

Goal 6: Increase the relevance, effectiveness, and accessibility of training and education.

Goal 7: Foster the development of supervisors and leaders among all segments of the workforce.

Creating Structures to Support the Workforce

Goal 8: Establish financing systems that enable competitive employee compensation commensurate with required education and levels of responsibility.

Goal 9: Implement systems to track key workforce measures and evaluate workforce development practices.

Goal 10: Build a technical assistance infrastructure that promotes adoption of workforce best practices.

[††] *The Annapolis Framework for Workforce Planning in Behavioral Health* was developed by the Annapolis Coalition to guide behavioral health workforce development efforts. It identifies 10 key goals clustered in three major areas. This slightly modified form addresses the focus on the CYF-serving workforce in order to use it as the framework for developing Connecticut's Behavioral Health Workforce Plan for Children, Youth, and Families.

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