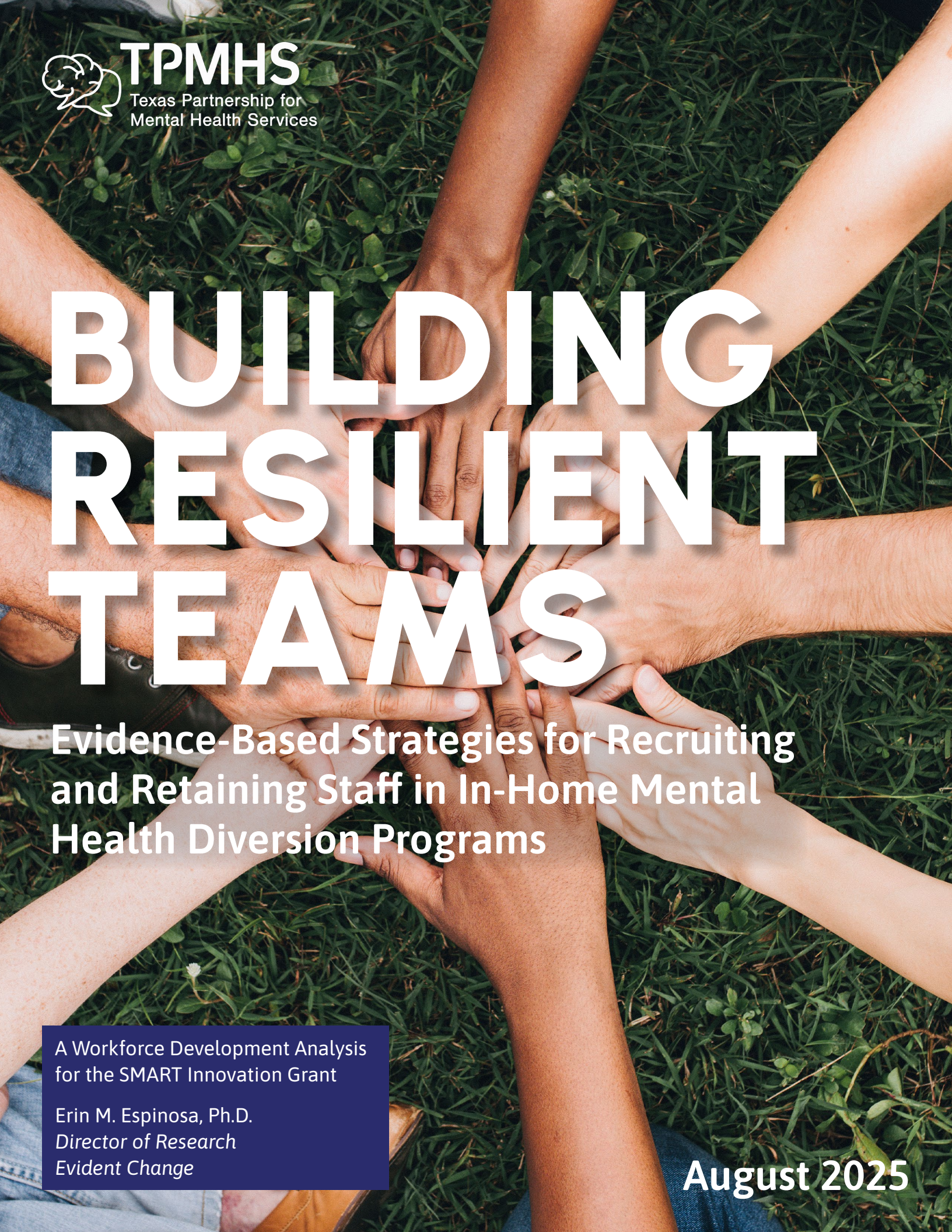

TPMHS
Texas Partnership for Mental Health Services

BUILDING RESILIENT TEAMS

Evidence-Based Strategies for Recruiting and Retaining Staff in In-Home Mental Health Diversion Programs

A Workforce Development Analysis for the SMART Innovation Grant

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August 2025

A Report For:

TEXAS CENTER FOR CHILD
AND FAMILY STUDIES

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EXECUTIVE SUMMARY

Key Findings and Recommendations

This report examines evidence-based practices for recruiting and retaining staff in in-home mental health diversion programs, with specific application to the Texas Center for Child and Family Studies' (TCCFS) Resilient Families initiative developed and implemented by CK Behavioral Health. The analysis reveals that workforce challenges in Texas are severe, with the state ranking last nationally in population-to-behavioral health provider ratios and facing turnover rates of 30-40% in community mental health settings.

Critical Workforce Context in Texas

Texas confronts a mental health workforce crisis characterized by:

Geographic disparities: 97% of counties are fully or partially designated as Mental Health Professional Shortage Areas, with rural areas particularly affected.

Demographic misalignment: Over 80% of providers identify as white while more than 40% of the state's population is Hispanic.

Aging workforce: 45% of clinicians are expected to be over age 65 within ten years.

Compensation gaps: Texas mental health worker salaries fall below national medians, with significant disparities between public and private settings.

Primary Drivers of Turnover

Research consistently identifies both financial and non-financial factors driving workforce instability:

Financial strain: Low wages relative to educational requirements, with entry-level positions sometimes paying less than fast-food jobs.

Organizational factors: High workloads, inadequate support, poor organizational climate, and excessive administrative burden.

Burnout and secondary trauma: Emotional exhaustion from high-stress work environments and exposure to client trauma.

Limited career advancement: Few opportunities for professional growth and development.

Evidence-Based Recruitment & Retention Strategies

The most effective workforce retention strategies target organizational-level interventions rather than individual solutions:

Organizational Culture and Climate

- Foster person-centered practice over productivity metrics
- Create psychologically safe environments that normalize discussions about stress and trauma
- Implement participatory decision-making processes that give staff ownership in organizational improvements

Leadership and Supervision

- Provide trauma-informed, supportive clinical supervision focused on reflective practice rather than punitive oversight
- Train supervisors in effective communication and support skills
- Ensure leadership demonstrates visible commitment to staff well-being

Professional Development and Support

- Offer ongoing training opportunities and clear career pathways
- Implement mentorship programs and peer support networks
- Provide competitive compensation packages including comprehensive benefits

Workload and Policy Management

- Maintain manageable caseloads and reduce unnecessary administrative burdens
- Offer flexible scheduling and work arrangements
- Establish clear role definitions and team-based support systems

Payment Model Alignment

- Fee-for-service systems create structural barriers to implementing evidence-based recruitment and retention strategies
- Case rate and value-based payment models provide the stable revenue foundation necessary for a sustainable workforce investment

Candidate Profiles for Success in In-Home Settings

Successful in-home mental health providers demonstrate

- Strong relationship-building skills and cultural competence
- Flexibility and adaptability to diverse family circumstances and changing needs
- Empathy and resilience to manage emotional demands and secondary trauma exposure
- Commitment to reflective practice and ongoing learning

Educational Requirements by Role

- **Master's level clinicians:** Required for evidence-based clinical models (MST, FFT, MDFT, PCIT) and supervisory positions
- **Bachelor's level staff:** Acceptable for support roles under supervision, with many states offering Qualified Mental Health Professional designations

- **Associate/certificate level:** Appropriate for paraprofessional and peer support roles with proper training and oversight

Motivational Factors for In-Home Work

- Staff are drawn to and retained in in-home family services by...
- Meaningful work that demonstrates clear, visible impact on family outcomes
- Positive relationships with both families supported and colleagues that create professional fulfillment
- Flexibility in scheduling and service delivery approaches that accommodate both client needs and personal circumstances
- Supportive organizational culture that provides adequate resources, values staff input, and prioritizes skills and competencies growth and worker well-being
- Alignment with personal values around supporting children and families
- Professional growth opportunities and recognition for contributions that acknowledge the challenging nature of the work

Lessons from Other Industries

Best practices from related fields emphasize:

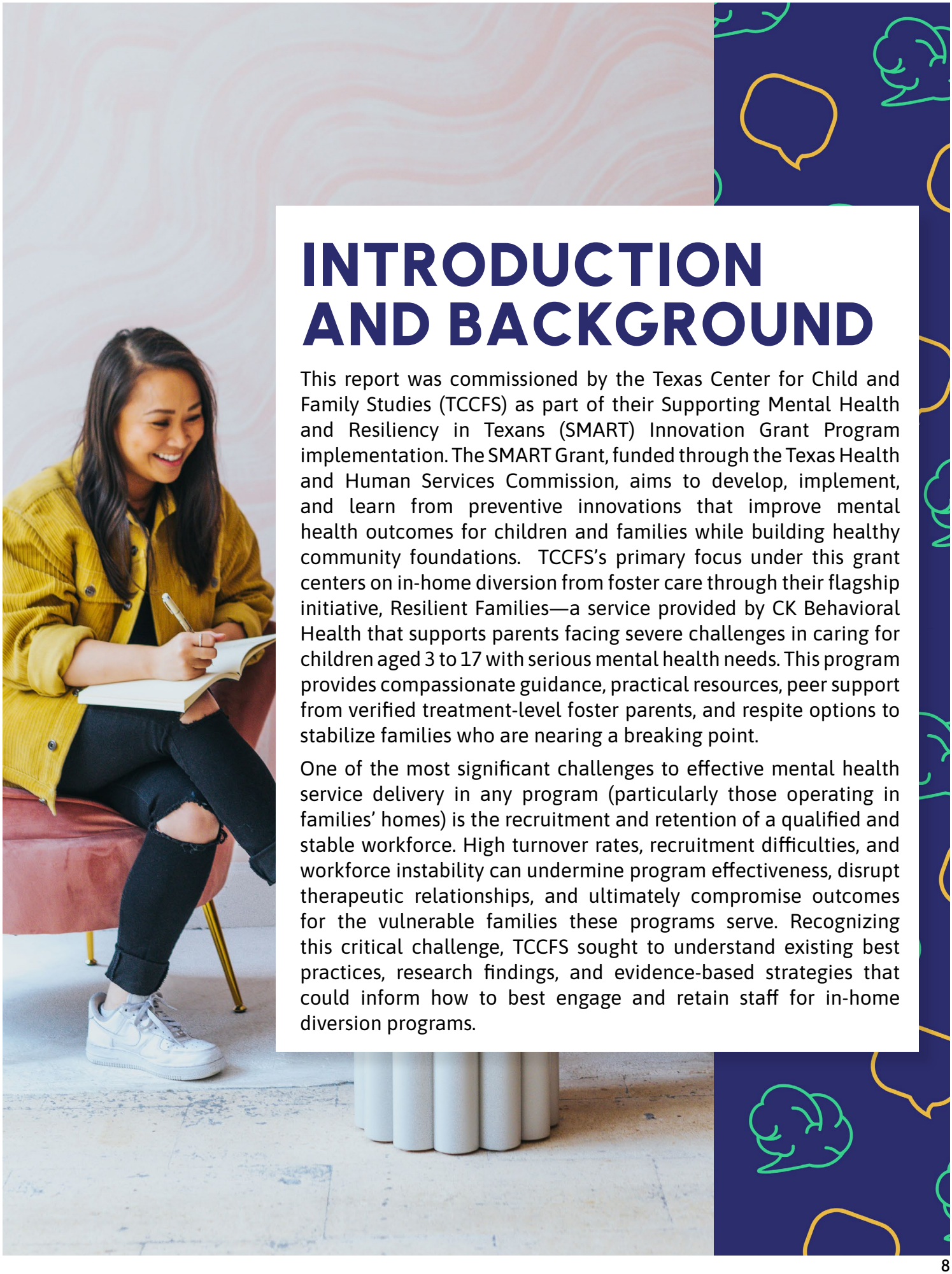
- Relationship-centered approaches that prioritize connection and trust-building as core competencies
- Cultural competence and workforce diversity reflecting served populations
- Comprehensive support systems including supervision, peer networks, and recognition programs
- Data-driven workforce planning using metrics to guide recruitment and retention strategies
- Innovation and flexibility in service delivery models and employment arrangements

Implementation Recommendations

To strengthen workforce recruitment and retention, TCCFS should prioritize:

- **Immediate Actions:** Conduct organizational climate assessments, enhance supervisor training in trauma-informed practices, and implement flexible work policies
- **Medium-term Strategies:** Support the development comprehensive professional development programs, establish peer support networks, and create clear career advancement pathways
- **Long-term Investments:** Advocate for improved compensation structures, build partnerships with educational institutions for workforce pipeline development, and implement data systems to track retention metrics
- **Program-Specific Adaptations:** Design recruitment materials that highlight meaningful impact, establish mentorship programs pairing new staff with experienced workers, and create family feedback mechanisms to demonstrate program effectiveness

The evidence strongly indicates that organizational-level interventions focusing on supportive culture, effective leadership, and comprehensive staff support systems are most effective for building a stable, high-quality workforce capable of delivering successful in-home diversion services.



INTRODUCTION AND BACKGROUND

This report was commissioned by the Texas Center for Child and Family Studies (TCCFS) as part of their Supporting Mental Health and Resiliency in Texans (SMART) Innovation Grant Program implementation. The SMART Grant, funded through the Texas Health and Human Services Commission, aims to develop, implement, and learn from preventive innovations that improve mental health outcomes for children and families while building healthy community foundations. TCCFS's primary focus under this grant centers on in-home diversion from foster care through their flagship initiative, Resilient Families—a service provided by CK Behavioral Health that supports parents facing severe challenges in caring for children aged 3 to 17 with serious mental health needs. This program provides compassionate guidance, practical resources, peer support from verified treatment-level foster parents, and respite options to stabilize families who are nearing a breaking point.

One of the most significant challenges to effective mental health service delivery in any program (particularly those operating in families' homes) is the recruitment and retention of a qualified and stable workforce. High turnover rates, recruitment difficulties, and workforce instability can undermine program effectiveness, disrupt therapeutic relationships, and ultimately compromise outcomes for the vulnerable families these programs serve. Recognizing this critical challenge, TCCFS sought to understand existing best practices, research findings, and evidence-based strategies that could inform how to best engage and retain staff for in-home diversion programs.

Research Objectives

This report addresses the following primary research question: What are the evidence-based or research-informed practices for engaging and retaining staff in in-home diversion programs?

To comprehensively answer this question, the project was guided by six targeted research questions:

- What resources and studies have examined recruitment and retention for the mental health workforce in Texas and other U.S. regions?
- What instructive lessons and promising practices emerge from existing literature?
- What motivators influence potential or current staff to enter or remain in in-home family service programs?
- What candidate profiles tend to succeed in tailored programs operating within families' homes?
- What lessons from other industries regarding motivation factors could apply to in-home diversion programs?
- How do payment models impact the ability to implement evidence-based workforce recruitment and retention strategies?

Report Structure and Methodology

This report synthesizes findings from peer-reviewed research (e.g. academic journals), grey literature (e.g. agency websites and publications), workforce studies, and industry best practice guides to provide evidence-based recommendations for workforce recruitment and retention in in-home mental health services. The analysis draws from multiple sources including academic research on mental health and child welfare workforce issues, implementation science frameworks, organizational psychology studies, and practical guidance from leading national organizations in behavioral health and child welfare.

The report is organized to present ***Key Findings by Research Question***, providing a systematic examination of each area of inquiry. Following the findings, the report concludes with practical recommendations and implementation strategies that TCCFS can apply to strengthen their workforce development efforts for the Resilient Families program and other in-home diversion initiatives.

The approach prioritized Texas-specific data and studies where available, while also incorporating national research and best practices from comparable programs and settings. Special attention was

given to identifying strategies that address the unique challenges of in-home service delivery, including the emotional demands of working in family homes, the need for cultural and contextual competence and flexibility, and the importance of organizational support systems to prevent burnout and secondary traumatic stress.

Through this comprehensive analysis, the report aims to provide TCCFS with actionable insights that can inform recruitment strategies, enhance retention efforts, and ultimately strengthen the workforce foundation necessary for successful in-home diversion programming.

Primary Research Question: What are the evidence-based or research informed practices for engaging and retaining staff in in-home diversion programs?

Focus Research Questions (RQ)

- What resources and studies have examined recruitment and retention for the mental health workforce in Texas and other U.S. regions?
- What instructive lessons and promising practices emerge from existing literature?
- What motivators influence potential or current staff to enter or remain in in-home family service programs?
- What candidate profiles tend to succeed in tailored programs operating within families' homes?
- What lessons from other industries regarding motivation factors could apply to in-home diversion programs?
- How do payment models impact the ability to implement evidence-based workforce recruitment and retention strategies?

KEY FINDINGS BY RESEARCH QUESTION

RQ 1: What resources and studies have examined recruitment and retention for the mental health workforce in Texas and other U.S. regions?

Recruitment & Staffing Patterns

Lack of Access

Texas faces critical shortages in the mental health workforce, particularly in rural areas and for specialized services like in-home programming (Hogg Foundation, 2023; HHSC, 2022). A 2023 report indicates further that while the workforce may be growing, it is not distributed proportionately around the state[1]. More specifically, as of 2021, over 240 Texas counties include a federally designated Mental Health Professional Shortage Area (MPHSA) with many areas reporting one or no licensed mental health professional in the area[2].

as of 2021, over 240 Texas counties include a federally designated Mental Health Professional Shortage Area

In 2023, the U.S. Health Resources and Services Administration (HRSA, 2023), issued a comprehensive federal report providing an overview and comparison of state-level data on shortages, supply, and demand for behavioral health professionals, including psychiatrists, psychologists, social workers, counselors, and marriage and family therapists[3]. Texas is highlighted as one of the states with the largest number of MHPSAs, with 97% of counties fully or partially designated as shortage areas. In fact, Texas ranks last among all 50 states in population-to-behavioral health provider ratios and Texas has the lowest rate of individuals with a diagnosis receiving care from a specialist (22%). Compounded by high uninsured rates (18%), this places Texas at the bottom for access to behavioral health care among all states.

Workforce Demographics

According to data collected by the 2023 Texas Behavioral Health Executive Council Workforce study, over 45% of Texas clinicians responding to the survey (n = 11,067) are expected to be over age 65 within ten years, indicating a looming retirement wave[4]. In addition, the workforce is not demographically representative of Texas' population; over 80% of providers report identifying as white[3], while more than 40%[5] of the state's population is Hispanic.

Mental Health Deserts

Multiple state reports, workforce studies, and news investigations confirm that rural Texas faces severe "mental health deserts" due to geographic disparities in provider distribution. These shortages complicate

1 Health Profession Fact Sheets: https://healthdata.dshs.texas.gov/dashboard/health-care-workforce/hprc/health-profession-fact-sheets#

2 Health Profession Supply: https://healthdata.dshs.texas.gov/dashboard/health-care-workforce/hprc/health-profession-supply

3 Health Resources & Services Administration – Health Workforce Research: https://bhw.hrsa.gov/data-research/review-health-workforce-research

4 2023 Texas Behavioral Health Executive Council Workforce Study Data: https://bhec.texas.gov/workforce-survey-and-data/

5 Hispanics officially make up the biggest share of the states' population, new census numbers show: https://www.texastribune.org/2023/06/21/census-texas-hispanic-population-demographics/

both access to care and the retention of mental health workers in programs serving remote families[6]. This lack of providers forces rural residents to rely on emergency rooms for mental health crises, illustrating the severe service gaps in these "deserts" [7 8].

Morales et al., (2020) published a review of details on how rural areas across the U.S (including Texas) face significant shortages of mental health professionals, leading to "mental health deserts." Barriers included professional isolation, limited resources, and recruitment/retention challenges, matching the rural Texas attributes described in state and news reports.

In 2022, the University of Michigan's Behavioral Health Workforce Research Center (Buche, et al., 2022) published a report that specifically identified that workforce shortages and challenges undermine the delivery of in-home services in rural areas. The study identified unique rural challenges such as professional isolation, limited access to supervision and ongoing education, fewer career advancement opportunities, and lower compensation compared to urban or private settings.

Retention

While the average turnover rate varies by organization and region, the annual turnover rates in Texas community mental health settings can be estimated to range from 30-40% [9 10]. For example, in 2022, the average turnover rate at behavioral health facilities across the U.S. was 31.3% with rates ranging from 17.37% for supervisors to 37.17% for mental health workers and psychiatric aids[5]. While the Texas State Auditor's Office indicates a turnover rate of 37.1% for psychiatric nursing assistants[6], while the Texas Council of Community Centers reports that rates are as high as 40% across various regions of the state [11] .

the average turnover rate at behavioral health facilities across the U.S. was 31.3%

Academic research and national workforce reports indicate that annual turnover rates in publicly funded mental health settings in large, diverse states (such as California, Florida, and New York) often range from 30% to 60%. These states face similar challenges as Texas, including provider burnout, high caseloads, and financial pressures [12]. While not all states publish detailed turnover rates for mental health professionals, available evidence suggests that states with large behavioral health systems and workforce shortages (e.g., Georgia, Arizona, and Oklahoma) report turnover rates for direct care and support staff that are consistently above 30%, mirroring Texas and national averages [5 8].

Why do people leave?

A 2019 study found that between 20% and 60% of therapists in community mental health agencies leave their organizations annually reporting financial strain and low wages were a significant contributor to them leaving (Adams et al., 2019). Financial strain was defined as the combination of cognitive, emotional, and behavioral responses to economic hardship. This indicates that it was not just about low income, but also

6 Challenges of Accessing Mental Health in Rural Texas: https://www.virtuerecoveryhouston.com/challenges-of-accessing-mental-health-care-in-rural-texas/

7 In rural Texas, ERs are facing a growing mental health crisis: https://www.texastribune.org/2024/05/07/texas-mental-health-hospitals-er/

8 In rural Texas, ERs are facing a growing mental health crisis: https://dallasweekly.com/2024/05/in-rural-texas-ers-are-facing-a-growing-mental-health-crisis/

9 2022 Turnover at Behavioral Health Facilities Averages more than 30%: https://openminds.com/market-intelligence/news/2022-turnover-at-behavioral-health-facilities-averages-more-than-30/

10 Classified Employee Turnover for Fiscal Year 2023: https://sao.texas.gov/reports/main/24-702.pdf

11 Workforce Challenges in Mental Health and Intellectual Disability Services: https://txcouncil.com/wp-content/uploads/2022/10/MH_IDD-Workforce-Challenges_8.23.22.pdf

12 Prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-led mental health system: https://pmc.ncbi.nlm.nih.gov/articles/PMC4715798/ ei

how workers think about, feel about, and respond to their financial situation.

Hallet et al. (2024) found that low wages (e.g. participants indicating they cannot make ends meet – despite high educational requirements with entry-level positions paying less than or as little as fast-food occupations), administrative burden (e.g. reporting and documentation requirements), lack of career development (limited opportunities for promotion and wage progression) and a stressful work environment (e.g. feeling like they are always putting out fires leading to emotional exhaustion) are interconnected and collectively drive turnover in the public mental health workforce.

Salary disparities between public and private settings contribute significantly to retention challenges, with Texas compensation for public mental health workers falling below the national median. For example, mental health providers may leave public or Medicaid-funded settings for private practice due to low reimbursement or payment rates resulting in low compensation. Medicaid reimbursement rates in Texas are significantly lower than what providers can make in private practice, making it difficult for public organizations to retain staff [13] [14]. More specifically, a workforce study by the University of Texas at Austin Steve Hicks School of Social Work (2024) found the average annual salary for mental health and substance use workers in Texas is lower than the national average for the same or similar roles – further highlighting the compensation gap and its impact on retention [15]. Nationally, low wages are cited as a key factor leading to high turnover and retention challenges among behavioral health providers, with financial concerns particularly apparent in public and community-based settings [16]. More specifically, Health Resources & Services Administration (HRSA) projects that by 2037, shortages will persist or worsen for many key mental health roles, with some professions (e.g., psychologists, school counselors) facing deficits exceeding 100,000 full-time equivalent positions [17].

But it isn't just about the money...

A 2014 meta – analysis reviewed 22 studies on why U.S. child welfare workers (who often overlap with the broader mental health workforce) intend to leave their jobs. There findings match those of other meta-analyses (e.g. Kim & Kao, 2014) examining both individual and organizational factors impacting burn out among service providers. They found that satisfaction with organizational environment strongly predicted commitment to the organization, while work-related burnout had a negative impact (Brown et al., 2019; Green et al, 2014). Related to trauma and mental health, Henderson et al's. (2024) meta-analysis found mental health professionals exhibit high rates of personal trauma history (19-81%) and secondary traumatic stress (19-70%), with 14 of 18 studies finding a significant positive relationship between these variables. This suggests that those with personal trauma histories are at heightened risk for developing secondary traumatic stress resulting in burnout. Table 1 below provides an overview of these studies by workforce, factor and key findings.

13 When it comes to upping mental health services, Texas has a Medicaid problem: https://www.texastribune.org/2023/04/28/texas-mental-health-medicaid

14 A look at the Texas mental health workforce shortage: https://www.texastribune.org/2024/07/17/texas-mental-health-workforce-explainer/

15 Texas Social Work Workforce Study: https://socialwork.utexas.edu/wp-content/uploads/2024/10/TX-SW-Workforce-Report24.pdf

16 State of the Behavioral Health Workforce, 2024: https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf

17 Health Workforce Projections: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand

Table 1: Key findings across workforce studies related to burnout and turnover.

Study & Citation	Type of Workforce	Individual Factors	Organizational Factors	Unique/Key Findings on Burnout Causes
Green, A., Albanese, B., Shapiro, N., & Aarons, G. (2014)	Community-based mental health service providers	Coping style, resilience	Workload, support, role conflict	Both personal and organizational factors matter; high workload and poor support are major contributors.
Kim, H., & Kao, D. (2014)	U.S. child welfare workers	Emotional exhaustion	Climate, support, autonomy, demands	Poor support, high demands, and low autonomy drive burnout and turnover intentions.
Brown, A., Walters, J., & Jones, A. (2019)	Social workers	Job satisfaction, commitment	Compensation, recognition, work-life	Burnout tied to low satisfaction and weak commitment; organizational improvements help retention.
Henderson, A., Jewell, T., Huang, X., & Simpson, A. (2024)	Mental health professionals	Personal trauma history, risk of secondary traumatic stress	(Not primary focus)	Personal trauma history is a strong predictor of secondary traumatic stress, which is closely linked to burnout symptoms.

While each study addresses a different human service workforce, they converge on the finding that *burnout is primarily driven by organizational factors such as high workload, lack of support, and insufficient recognition*. Individual factors like coping style and job satisfaction also play important roles, however organizational interventions are consistently highlighted as the most effective means to address burnout and improve retention.

The following list provides a summary of the key findings across each study, enhanced with additional grey literature as noted, and organized by individual and organizational factors.

Individual Factors

- **Attitudes and Perceptions:** The strongest predictors of turnover intention were organizational commitment and job satisfaction. Workers who felt less committed to their organization or less satisfied with their jobs were much more likely to consider leaving [18] [19].

- **Stress and Burnout:** High levels of stress and emotional exhaustion were among the most powerful drivers of turnover intention. Burnout (especially emotional exhaustion) increased the likelihood that workers would want to leave[14] [15].

18 Turnover intention predictors: https://ncwwi.org/files/Retention/Kim__Kao_2015.pdf

19 Why do social workers leave?: https://pmc.ncbi.nlm.nih.gov/articles/PMC9819938/

Organizational

- **Climate and Culture:** Perceptions of fairness, organizational support, and a positive organizational climate were all linked to lower turnover intention. When workers felt their workplace was fair, supportive, and well-managed, they were more likely to stay.
- **Job Demands and Resources:** High job demands (e.g. emotional labor, shiftwork, and work-home interference) increased exhaustion and turnover intention, while job resources (such as rewards, recognition, job control, feedback, and participation) reduced burnout and made staff more likely to stay.
- **Professionalism and Commitment:** Feeling devoted to the profession—driven by altruism and a belief in public service—helped retain staff, even when pay and advancement were limited.

Implications for Burnout Causes

A meta-analysis of 35 years of intervention research (1980 – 2015) examining studies with 1,894 in home workers found that person-directed interventions were more effective than organization-directed interventions at reducing emotional exhaustion while targeted on-the-job skills development (Dreison et al., 2018). The moderate effectiveness of person-directed interventions suggests individual factors (coping skills, personal resilience) are modifiable contributors to burnout. The effectiveness of job training and education among organizational interventions indicates skill development and professional competence are key organizational factors in preventing burnout. This indicates that addressing root causes of burnout requires comprehensive approaches targeting both individual and organizational factors.

Similar findings are reported in mental health programs generally. Lack of support, low job satisfaction, and high emotional demands have been consistently linked to higher turnover intention. While organizational support (e.g. skill development opportunities, access to appropriate resources, etc.), recognition, and opportunities for feedback and participation have been consistently found to serve as protective factors against burnout and turnover (Blankerts & Robinson,1997; Olaniyan et al., 2020; Scanlan & Still, 2019).

RQ 1 Conclusion

Research consistently demonstrates that Texas faces a mental health workforce crisis of exceptional severity, ranking last nationally in provider ratios while confronting a demographic cliff with nearly half of current clinicians approaching retirement within the next decade. This crisis is compounded by geographic and demographic disparities, with 97% of Texas counties designated as health care shortage areas and rural regions experiencing “mental health deserts” that force residents to rely on emergency rooms and hospitals for care.

While turnover rates of 30-40% mirror national averages, the underlying drivers of turnover reveal a complex interplay of structural and cultural factors: financial strain from wages that fail to compete with private sector compensation, administrative burdens that detract from direct care, and organizational climates characterized by high stress and limited professional development opportunities. Critically, the research reveals that while individual factors like personal trauma history and coping skills contribute to burnout, organizational interventions targeting workplace culture and climate, support systems, and professional development opportunities offer the most promising pathways for sustainable workforce retention.

As Texas grapples with the growing demand for mental health services amid an aging workforce and persistent geographic disparities, addressing these systemic organizational challenges becomes not just a workforce issue, but a fundamental public health imperative that will determine the state’s capacity to serve its most vulnerable populations. Critically, this workforce crisis is exacerbated by fee-for-service payment models that create productivity pressures, revenue instability, and administrative burdens—structural barriers that prevent organizations from implementing the very retention strategies that research identifies as most effective.

RQ2. What instructive lessons and promising practices emerge from existing literature?

The National Council on Mental Wellbeing (NCMW; 2023) conducted an applied mixed methods study that included a nationwide survey, interviews and focus groups with national stakeholders, and case study analysis applying implementation frameworks to identify practitioner driven best practices for workforce retention in behavioral health. Practices identified included the implementation of retention bonuses, expanding loan repayment programs, integrating telehealth, creating clear career pathways, and fostering trauma-informed supervision. Preliminary research indicates that these best practice recommendations are being implemented through the Certified Community Behavioral Health Clinic (CCBHC) model[20] [21]. As of 2024, there are nearly 500 CCBHCs operating in 46 states, Washington, D.C., and Puerto Rico, serving an estimated 3 million people and employing thousands of new staff in both urban and rural areas.

The NCMW regularly publishes CCBHC Impact Reports, which include survey data from hundreds of clinics demonstrating the success of these retention strategies. For example, 98% of CCBHCs reported an increase in staff positions since adopting the model, with a median of 22 new positions per clinic among Medicaid supported CCBHCs 21. Some CCBHCs report preliminary improvements on both retention and staff well-being[22]. A few publicly available policy papers indicate investments such as those recommended by the NCMW are linked to better recruitment and retention outcomes in the mental health workforce [23] [24]. However, to date no systematic study of these recommendations on staff retention and youth outcomes has been conducted.

A recent study (Aarons et al., 2021) examined the relationships between leadership, organizational climate, staff turnover intentions, and actual voluntary turnover during a large-scale statewide (New Mexico) behavioral system reform. The results offer several instructive lessons and promising practices relevant to addressing mental health workforce shortages and retention issues, particularly during periods of system transformation such as the implementation of new service delivery models. Some of those practices, along with those identified by the NCMW are included in the Key Considerations for Retention section below.

Key Considerations for Retention

Leadership as a Buffer Against Turnover

Strong, positive leadership is crucial. Effective leaders help create an empowering organizational climate, which is associated with lower staff turnover intentions and actual turnover. This is especially important in high-stress environments, where good leadership can directly reduce the negative, demoralizing aspects of workplace climate that drive staff to consider leaving.

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20 2024 CCBHC Impact Report: https://www.thenationalcouncil.org/wp-content/uploads/2025/04/24.06.3_2024-CCBHC-Impact-Report_FINAL.pdf

21 CCBHC Workforce Innovations: https://www.thenationalcouncil.org/wp-content/uploads/2025/02/CCBHC-Workforce-Innovations.pdf

22 Overview: CCBHCs and Workforce: https://www.thenationalcouncil.org/wp-content/uploads/2023/05/Session-6-Employee-Wellness-and-Resilience.pdf

23 Addressing the behavioral health workforce crisis: Understanding the drivers of turnover & strategies for retention: https://nwi.pdx.edu/pdf/addressing-the-behavioral-health-workforce-crisis.pdf

24 The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect: https://pmc.ncbi.nlm.nih.gov/articles/PMC2742697/

Organizational Climate Matters

Research highlights an empowering climate (characterized by support, autonomy, and shared mission) reduces turnover intentions, while a demoralizing climate increases them. Interventions that improve the organizational climate, such as fostering open communication, recognition, and staff involvement in decision-making, can help retain staff.

Targeted Interventions During Change

During system reforms, targeted organizational interventions may be needed to reduce demoralization, enhance staff commitment, and support the adoption of new practices. This could include leadership training, team-building activities, and structured support for staff adapting to new workflows.

In addition, Morse et al.'s (2021) literature review synthesized research on interventions for addressing burnout and turnover among public mental health professionals, emphasizing that organizational-level changes to workplace climate [25] [26], policies, and support systems are more likely to yield sustainable improvements in retention than individual-level solutions. This finding aligns with a growing body of research identifying key organizational climate factors for workforce retention, including prioritizing person-centered supervision models over productivity-focused management systems, implementing skills and practice-based approaches, and creating opportunities for professional growth and well-being (Aarons et al., 2006; Green et al., 2014; Morse et al., 2012; Rollins et al., 2022). Studies examining client perspectives reveal that both staff and parents/clients are motivated by the shared value of supporting healthy child development, and when this alignment exists, staff engagement increases as employees feel capable of making a meaningful difference (Hubel et al., 2017). The following section provides a summary of all the practices and lessons reviewed related to workforce retention for in-home service providers.

25 Research Snapshot: Organizational conditions that influence work engagement and burnout: https://kmb.camh.ca/eenet/resources/research-snapshot-organizational-conditions-that-influence-work-engagement-and-burnout

26 Addressing burnout in the behavioral health workforce through organizational strategies: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://library.samhsa.gov/sites/default/files/pep22-06-02-005.pdf

Promising Practices for Workforce Retention[27] [28]

- **Address Organizational Context Alongside System Change:** Policymakers and administrators should consider the organizational environment when implementing new service models, ensuring that reforms do not inadvertently worsen workplace stress or demoralization.
- **Improving Organizational Culture and Climate:** Programs should focus on building a positive, supportive workplace culture, which can help offset some of the challenges posed by lower pay or high job demands, both of which are common in mental health settings. Fostering a workplace culture that prioritizes person-centered practice over productivity metrics and creating a healthy work environment while promoting psychological safety.
- **Enhancing Supervision and Leadership:** Leadership support, including visible commitment to staff well-being and involving wellness representatives in decision-making. Training and supporting leaders (at all levels) to foster an empowering climate can be a strategic investment for organizations facing workforce shortages and high turnover. This should include both training and providing coaching support to supervisors in effective communication and support skills.
- **Workflow and Policy Improvements:** Modifying workflow to reduce unnecessary administrative burdens and non-value-added tasks. This could include implementing institutional policy changes such as flexible scheduling, improved leave policies, and support for childcare and family needs.
- **Team-Based, Participatory Interventions:** Using team-based approaches to identify and address organizational barriers, resulting in increased morale, job satisfaction, and organizational commitment, and decreased role conflict and rigidity. In addition, participatory decision-making fosters a sense of ownership and engagement among staff, which is associated with better retention outcomes.
- **Opportunities for Professional Development:** Providing ongoing opportunities for professional development and self-growth supports engagement and organizational buy while enhancing staff retention.
- **Recognition and Reward Systems:** Ensuring that staff feel valued through recognition programs and transparent communication decreases the odds of quitting or reducing work hours.

Other implications of organizational climate and worker retention

Williams and Glisson (2014) conducted a large-scale national study examining how organizational culture and climate within U.S. child welfare systems affect youth outcomes. The study found organizational culture and climate explained 70% of the variance in youth outcomes. Other studies have found that agencies with a more proficient workforce (knowledgeable, responsive, client-focused), anchored in evidence-based supervision [29] and support (Aarons et al., 2010), and less resistant (open to change and innovation) climates had a more engaged, functional, and more satisfied workforce. These positive climates, in turn, have been found to be directly linked to better youth outcomes (Radey & Wilke, 2021; Schoenwald, et al., 2009), including improved outcomes [30] such as psychosocial functioning (Williams & Glisson, 2014).

27 Organizational conditions that influence work engagement and burnout: https://colab.ws/articles/10.1037%2Fprj0000472

28 Does organizational support help reduce health care worker burnout? https://www.pulmonologyadvisor.com/features/health-care-worker-burnout

29 What are preliminary building blocks to strengthen quality supervision? https://www.casey.org/what-are-preliminary-building-blocks-to-strengthen-quality-supervision/

30 The impact of turnover on families involved in child welfare: https://ncwwi.org/wp-content/uploads/2023/02/The-Impact-of-Turnover-on-Families-Involved-in-Child-Welfare.pdf

Why do worker retention and supervision strategies matter?

Impact on Organizational Culture and Climate

High turnover rates create a destructive cycle that undermines the very foundations needed for effective youth services. It disrupts the development of proficient organizational cultures while fracturing the stable relationships that are essential for positive outcomes. This workforce instability is particularly damaging because worker retention and organizational climate and culture operate in a symbiotic relationship: agencies that cultivate supportive, functional environments with manageable stress levels successfully retain staff, which in turn reinforces and strengthens the organizational culture, creating an upward spiral toward better youth outcomes. When experienced workers remain, they become the institutional memory that preserves critical organizational knowledge, ensures continuity of care relationships that youth and families depend on for healing and growth, and serves as the backbone for implementing evidence-based practices that ultimately benefit the children and families served.

Importance of Effective Supervision: [31] [32]

Effective supervision serves as the cornerstone of healthy organizational culture and climate, functioning as both a retention strategy and a catalyst for quality service delivery. Research demonstrates that evidence-based supervision and supportive consultation (including practices like fidelity monitoring) improve staff retention, but only when implemented through a supportive lens rather than a punitive compliance framework. Quality supervisors must serve multiple critical roles such as providing emotional support that buffers against burnout, offering guidance that builds professional competence, and creating development opportunities that foster career growth and engagement. This multifaceted supervisory approach creates a ripple effect throughout the organization. It not only directly improves worker efficacy, job satisfaction, and retention, but also generates better outcomes for the children and families supported by the organization. Perhaps most importantly, supervisors function as cultural ambassadors who model the very qualities of engagement, support, and responsiveness that they expect frontline workers to demonstrate with families. This creates a consistent culture of care that permeates every level of the organization and reinforces the agency's mission in practice.

R2 Conclusion

Addressing mental health workforce retention requires a multifaceted organizational approach that prioritizes systemic change over individual-level interventions. The evidence consistently demonstrates strong leadership, empowering organizational climates, and supportive supervision practices serve as critical foundations for workforce stability, with organizational culture and climate explaining up to 70% of variance in youth and family outcomes. Successful retention strategies must integrate structural supports such as flexible scheduling and reduced administrative burdens with cultural elements like participatory decision-making, professional development opportunities, and recognition systems that help staff feel valued and engaged in meaningful work. As demonstrated through the CCBHC model's early success (with 98% of participating clinics reporting increased staff positions) targeted investments in these evidence-based organizational practices not only improve workforce retention but create a positive cycle where stable, experienced teams deliver better outcomes for the children and families they serve. Moving forward, policymakers and organizational leaders must recognize that sustainable workforce solutions require comprehensive attention to the organizational context, ensuring that system reforms strengthen rather than undermine the supportive environments essential for both worker well-being and client success.

the CCBHC model's early success shows 98% of participating clinics report an increase in staff positions

31 Supervision: Child Welfare Information Gateway: https://www.childwelfare.gov/topics/workforce/supervision/?top=224

32 Organizational Culture, Supervision and Retention of Public Child Welfare Workers: https://jssw.thebrpi.org/journals/jssw/Vol_6_No_2_December_2018/1.pdf

RQ 3. What motivators influence potential or current staff to enter or remain in in-home family service programs?

Research suggests the motivation to remain in an organization and join into in-home service programs is influenced by a combination of fair compensation, opportunities for professional development, organizational stability (Glebbeek & Bax; 2022), and a supportive, mission-driven work culture (Bride, et al., 2021). Individuals drawn to in-home services occupations tend to be motivated to enter and remain in those roles because they find meaning and purpose in helping families in crisis, even when exposed to trauma. The intrinsic reward of making a difference in the lives of vulnerable families is a powerful motivator that helps sustain workers despite the emotional toll of the job.

For example, Boyas, Wind, and Kang (2012) demonstrate the most influential motivators for staff to enter and remain in in-home family service programs are rooted in the quality of workplace relationships and organizational support. High employment-based social capital, a supportive and fair organizational climate, and strong peer and supervisory relationships all serve as key motivators for retention and recruitment. Conversely, high job stress and burnout are demotivators, emphasizing the need for targeted interventions (especially for younger staff) to build supportive environments that encourage long-term commitment to the field.

In addition, studies examining client perspectives related to staff motivation and retention indicate that a sense of community and relationship building are critical connectors that help reduce parental isolation and serve as an intrinsic motivator for staff to remain in their roles. Furthermore, both parents and staff are motivated by shared values – particularly the desire to support children's healthy development and family well-being (Hubel, et al.; 2017). More recently, Kleinman, et al., (2023) found that staff are motivated to enter and stay in in-home family service programs when they experience meaningful work, strong relationships, flexibility, organizational support, cultural alignment, and opportunities for growth. These same factors are highly relevant for retaining a mental health workforce, suggesting that investment in supportive, flexible, and mission-driven work environments is critical for long-term staff retention [33].

The following section provides a summary of the key motivators identified in this systematic review while Table 2 below provides an overview by motivator and the evidence supporting it.

Key Motivators

Relevant Program Content and Perceived Benefit

Staff are more likely to be motivated when they see that program content is meaningful, meets families' needs, and is perceived as beneficial by both families and themselves. More specifically, in-home providers are motivated by the opportunity to deliver services that address real needs, such as parenting support, child development, maternal health, and mental health resources.

Positive, Trusting Relationships

A strong, supportive, and stable relationship between in-home providers and families is a key motivator. Staff who can build trust and rapport with families report higher job satisfaction and are more likely to remain in their roles. The ability to form these relationships is often cited as a primary reason for entering and staying in the field.

33 Understanding family engagement in home visiting: Literature syntheses: https://acf.gov/sites/default/files/documents/opre/hv_reach_literature_synthesis_dec2022.pdf

Flexibility

Flexibility in scheduling, visit frequency, and meeting locations is critical. Staff value the autonomy to tailor their work to fit families' schedules and needs, which not only supports family engagement but also contributes to staff retention by reducing work-related stress and burnout.

Supportive Organizational Climate

A program culture that values staff input, provides adequate resources, and fosters peer support is a significant motivator. When organizations offer professional development, supervision, and opportunities for collaboration, staff feel more supported and are more likely to stay.

Table 2. Motivator by implication as described in the research.

Motivator	Evidence/Implication from Sources
Sense of purpose/meaningful work	Sustains workers despite trauma; intrinsic motivator; seeing positive family outcomes
Relevant program content/impact	Staff motivated by meaningful, helpful work; families enroll/ stay when programs meet needs
Employment-based social capital	Reduces stress, burnout, and intent to leave; positive workplace relationships
Supportive organizational climate/ culture	Increases retention and job satisfaction; enhances resilience; fosters collaboration
Peer and supervisory support	Buffers against job stress; reduces burnout; increases retention
Fairness, trust, and open communication	Lowers turnover intentions; foundation for engagement and satisfaction
Quality of relationships/working alliance	Foundation for engagement and satisfaction; trusting, supportive relationships
Flexibility (scheduling, location, content)	Reduces burnout, supports retention, and accommodates needs
Secondary trauma supports	Reduces burnout, increases retention
Professional skills and support	Increases competence, job satisfaction, and retention
Perceived impact/seeing positive outcomes	Intrinsic motivator; seeing benefits for families
Program alignment and fit	Enhances self-efficacy and commitment; alignment with values
Opportunities for professional growth	Motivates staff to remain; training and advancement
Age-appropriate supports	Tailored interventions for younger staff
Social connections with other families	Promotes retention; opportunities for family-to-family support

RQ 3 Conclusion

The evidence on motivators for staff retention in in-home family service programs provides compelling validation of the broader workforce retention findings identified in RQ2. The motivators that sustain workers in these challenging positions directly reinforces the organizational climate factors and retention strategies previously examined. While RQ2 established the foundational research on evidence-based retention practices (including supportive supervision, empowering organizational climates, and mission-driven cultures) the specific examination of motivators in in-home services reveals how these broader principles manifest in practice. Rather than re-presenting the extensive organizational research detailed in RQ2, this analysis focuses specifically on what keeps staff engaged in their positions: the intrinsic reward of meaningful work aligned with personal values, the ability to build trusting relationships with families, and the experience of seeing tangible positive outcomes for vulnerable children.

The motivators identified here (employment-based social capital, flexible service delivery, and shared commitment to healthy child development) demonstrate how the evidence-based practices from RQ2 translate into day-to-day staff experiences that promote retention. This convergence is particularly significant because in-home services often represent some of the most trauma-exposed and challenging positions within the mental health continuum, yet staff remain motivated when organizations implement the supportive, person-centered approaches identified in the broader retention literature. The finding that both staff and families are motivated by shared values around supporting children reinforces the critical connection between workforce stability and positive outcomes, providing concrete evidence that when organizations create environments where staff feel supported, empowered, and mission-aligned, they achieve the dual benefit of retaining workers while enhancing service quality for the families served.

RQ4: What candidate profiles tend to succeed in tailored programs operating within families' homes?

The unique challenges of providing mental health services in clients' homes demand a fundamentally different approach to staff selection than traditional services and approaches. Unlike traditional clinical settings, in-home environments are unpredictable, deeply personal spaces where providers must navigate complex family dynamics while establishing therapeutic relationships within minutes of arrival. When hiring decisions focus on research-backed competencies, in-home mental health programs become more responsive to client needs, culturally sensitive to diverse communities, and operationally sustainable for long-term success. This strategic approach benefits everyone involved where clients receive higher-quality care, families experience better engagement, and organizations build stronger, more stable teams.

This section examines the research-backed criteria for successful candidate selection, organized into **five critical domains:** (1) the interpersonal and cultural competencies that enable professionals to build trust within family systems; (2) the adaptive qualities of flexibility, patience, and empathy that allow for responsive care delivery; (3) the reflective practices and collaborative decision-making approaches that sustain both quality outcomes and workforce retention; (4) the educational credential requirements that vary by program model and state regulations; and (5) the essential skill demonstrations that distinguish effective practitioners from their peers. Together, these elements form a comprehensive framework for identifying candidates who can navigate the unique demands of providing mental health services in the intimate, unpredictable environment of clients' homes.

Key Candidate Considerations

Relationship – Building and Cultural/Contextual Alignment [34] [35]

Candidates who can establish trusting, close connections with families are consistently identified as more successful in home-based settings. Organizations should specifically seek out staff who can relate to families, sometimes prioritizing those who share similar backgrounds or life experiences with the populations served.

Flexibility, Patience, and Empathy

Staff must be persistent while adapting to the varied and evolving needs of families. This includes being able to support families with a wide range of challenges, from daily living crisis intervention, and adjusting approach family circumstances change [36]. More specifically, staff should be able to apply empathy in navigating the myriad of information and distractions (Goodson, et al., 2013) that occur while building with relationships with families and engage in a continual process of improving their skills to do so [37]. Successful candidates should demonstrate a belief that recovery can happen and in the capacity of individuals and families to thrive, even when facing significant challenges (Moyers, et al., 2016; Steinbrenner, et al., 2020).

34 Promoting infant-early childhood and parent mental health in home visiting programs: https://www.nccp.org/wp-content/uploads/2023/09/NCCP-HV-Report_FINAL.pdf#:~:text=recruit%20home%20visitors%20who%20can%20forge%20close%20connections

35 Evidence-based practices KIT Training – Permanent supportive housing: https://library.samhsa.gov/sites/default/files/trainingfrontlinestaff-psh.pdf

36 Behavioral health homes for people with mental health and substance use disorders: https://www.ccsme.org/wp-content/uploads/2017/08/CIHS_Health_Homes_Core_Clinical_Features.pdf

37 Professional competence and integrity: https://ftm.aamft.org/professional-competence-and-integrity/

Reflective Practice and Shared Decision Making

Reflective practice [38] involves mental health professionals systematically examining their own thoughts, feelings, and interventions to identify what worked, what didn't, and how they can improve their therapeutic approach with each family. Shared decision-making (Slade, 2017; Haugom, 2020) empowers clients and families to actively participate in treatment planning and goal setting, ensuring that interventions align with their values, preferences, and cultural context rather than being imposed by professionals. Both have been identified as correlated with improved client outcomes and higher rates of staff retention. High quality candidates should both be open to reflective practice and ongoing learning to better adapt to the complex needs of families.

Educational Requirements

Successful candidates typically have a background in social work, psychology, counseling, or a closely related field, with experience working with children and families, especially in intensive in-home crisis intervention contexts or settings [39] (Schoenwald, et al; 2013; Novins et al., 2013). Research reveals that typical education requirements function within a tiered system for in home-based family programs. The following section provides an overview of the typical tiered system.

1

Tier One - Master's Level Required for Credentialed Evidence-Based Models [40]

Credentialed evidence-based clinical models typically require or strongly prefer master's level education for staff delivering direct services and providing clinical supervision. These include Functional Family Therapy (FFT), Multidimensional Family Therapy (Henderson, et al., MDFT)[41] [42], Multisystemic Therapy (Henggeler, et al., 2009; MST) [43], Parent-Child Interaction Therapy (Steinbrenner, et al., 2020; PCIT), and Homebuilders/Intensive Family Preservation Services (Lippens, et al., 2024; IFPS) programs. The master's degree requirement (or strong preference) reflects the intensive, complex nature of these interventions and the need for advanced clinical training to maintain treatment fidelity and

38 Reflecting on 'Reflective Practice': https://oro.open.ac.uk/68945/1/Finlay-%282008%29-Reflecting-on-reflective-practice-PBPL-paper-52.pdf

39 The California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/program/homebuilders/detailed

40 California Evidence – Based Clearinghouse for Child Welfare (CEBC): https://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/detailed

41 How effective is Functional Family Therapy...: https://www.eurekalert.org/news-releases/995723

42 Functional Family Therapy (FFT) Toolkit technical report: https://youthendowmentfund.org.uk/wp-content/uploads/2023/12/YEF-Functional-Family-Therapy-Technical-Report_December-2023-1.pdf

43 Multisystemic Therapy for social, emotional, and behavioural problems...: https://onlinelibrary.wiley.com/doi/full/10.1002/cl2.1158

achieve desired outcomes. Implementation teams for these models are led by master's or doctoral level professionals who possess the clinical expertise necessary to oversee evidence-based practice standards. The educational requirement or preference is typically tied to the credentialing and certification processes that ensure practitioners can deliver these specialized interventions with adherence to specific protocols and treatment manuals. This standard helps maintain the integrity of the evidence base that supports these models' effectiveness with high-risk families requiring intensive intervention. Table 3 below provides an overview of the requirements and recommendations of these models.

Table 3. Model by degree requirement.

Model/Program	Master's Degree Required?	Notes
Multisystemic Therapy (MST)	Yes	Required for all therapists, licensure also typically required
Homebuilders/IFPS	Preferred/Required (supervisors)	Master's required for managers/ supervisors; sometimes bachelor's with experience for direct service
Functional Family Therapy (FFT)	Preferred/Required	Master's required or strongly preferred for clinical and supervisory roles
Multidimensional Family Therapy (MDFT)	Preferred/Required	Master's required or strongly preferred for clinical and supervisory roles
Parent-Child Interaction Therapy (PCIT)	Preferred/Required	Master's required or strongly preferred for clinical and supervisory roles

2

Tier Two - Bachelor's Level Acceptable

Many states [44] allow individuals with a bachelor's degree to work in mental health roles, but the scope of practice is typically limited, and supervision by a higher-credentialed professional (usually a master's-level clinician) is required. These positions are often titled "Qualified Mental Health Professional" [45] (QMHP[46]) or similar, and are most common in roles such as case management, psychosocial rehabilitation, and community mental health services rather than in independent counseling or therapy.

States with QMHP or Equivalent Designations for bachelor's degree Holders

At least 20 states, including Texas, Virginia, North Carolina, Oregon, Michigan, Kansas, and others, allow individuals with a bachelor's degree to serve in certain mental health professional roles, provided they work under the supervision of a higher-credentialed clinician. The exact title, scope of practice, and supervision requirements vary by state and by the specific mental health service provided.

The following states specifically recognize bachelor's-degreed individuals as mental health professionals under titles such as QMHP or similar, with the requirement of supervision and/or additional experience:

- **Texas:** Uses the QMHP-CS (Qualified Mental Health Professional-Community Services) designation. Bachelor's degree holders can provide mental health services but must be supervised by a master's-level clinician (LPHA) or another QMHP-CS, depending on the duties [47].

44 Mental health licensure & career overview: https://www.publichealthonline.org/mental-health/

45 How to become a Qualified Mental Health Professional...: https://www.bridgewater.edu/academics/divisions/psychology/how-to-become-a-qualified-mental-health-professional-and-what-to-look-for-in-a-program/

46 What is a QMHP?: https://www.bridgewater.edu/academics/divisions/psychology/career-options-in-mental-health-and-psychology/

47 26 Tex. Admin. Code...: https://www.law.cornell.edu/regulations/texas/26-Tex-Admin-Code-SS-301-363

- **Virginia:** Has a formal QMHP designation. Bachelor's degree in human services plus 1,500 hours of experience, or a non-human services bachelor's plus 3,000 hours, qualifies for the QMHP title. Clinical supervision is required 45.
- **North Carolina, Oregon, Michigan, Kansas:** These states have adopted the QMHP or similar designations, allowing bachelor's-level professionals to work in mental health, typically in case management or support roles, under supervision 45.
- **Idaho, Minnesota, Maine, Louisiana, Iowa, Oklahoma, Pennsylvania, New York, Georgia, Florida, Hawaii, Illinois, Maryland, New Jersey, Virginia:** Recognize bachelor's-level staff for certain mental health roles, often linked to the Certified Psychiatric Rehabilitation Practitioner (CPRP) or Certified Family Recovery Practitioner (CFRP) credentials, or as part of Medicaid-funded psychosocial rehabilitation services. Clinical supervision and/or additional training is required [48].

Tier Three - Associate/Certificate Level

Home visiting programs, paraprofessional support roles, and peer support models often accept associate degrees or specialized certifications, particularly when the role involves support rather than clinical intervention. Several states permit individuals with associate degrees or certificate-level education to serve as in-home service providers, including in mental health roles [49]. These providers often work as behavioral health paraprofessionals, behavioral health technicians, or aides, delivering supportive, non-licensed services under supervision. The education requirements typically range from a high school diploma plus state-approved training to an associate degree or a one-year certificate program.

The following list provides an overview of different state approaches using this tier of education. Table 4 below provides a summary of the overview.

Key States and Their Approaches

- **Colorado:** Has launched a behavioral health P-TECH program that allows high school students to earn a free associate degree to become behavioral health specialists, preparing them for roles including in-home and community behavioral health services [50].
- **Minnesota:** Defines Mental Health Behavioral Aides (MBHAs) as two levels. Level I requires a high school diploma and two years' experience (no certification), and Level II requires an associate degree plus formal certification after state training [51].
- **Arizona:** Defines Behavioral Health Paraprofessionals who require a high school diploma and skills verified by a clinical director, and Behavioral Health Technicians who require a high school diploma plus four years of experience or higher education such as an associate degree. These roles provide services in healthcare institutions and community settings under supervision [52].
- **Oregon:** Offers Qualified Mental Health Associate (QMHA) roles with various pathways including certificate or associate degree options. Certification is required to serve in state-certified mental health programs. QMHAs provide case management, screenings, and client education, often including in-home services [48].

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48 State recognition of the CPRP and CFRP: https://www.psychrehabassociation.org/cprp-certification/state-recognition-cprp-and-cfrp

49 Trends in State strategies to improve the behavioral workforce: https://nashp.org/trends-in-state-strategies-to-improve-the-behavioral-health-workforce/

50 Colorado launches new program to build out a pipeline of behavioral health ...: https://www.denver7.com/lifestyle/health/colorado-launches-new-program-to-build-out-a-pipeline-of-behavioral-health-specialists

51 The emerging field of behavioral health paraprofessionals: https://www.nga.org/publications/the-emerging-field-of-behavioral-health-paraprofessionals/

52 The emerging field of behavioral health paraprofessionals: https://www.nga.org/wp-content/uploads/2024/04/State-Approaches-for-Regulation-of-Paraprofessionals_April2024.pdf

- **Maine:** Has Mental Health and Rehabilitation Technicians with state guidelines for training and certification, who provide community support services to adults with serious mental illness, including in-home services [48].
- **Georgia:** Employs paraprofessionals with state-delivered training and certification to provide community-based services, which can include in-home mental health support[48].
- Other states with certification programs or formal training pathways for paraprofessionals/technicians offering in-home or community mental health services include **Alaska, Michigan, Pennsylvania, Utah, Virginia, Florida, and New York**. These states often have Medicaid reimbursement mechanisms supporting these roles [48 49].

Table 4. Education or certification requirement by state.

State	Role Title(s)	Education - Certificate Requirement	Supervision - Certification	Includes In-Home Services?
Colorado	Behavioral Health Specialist	Associate degree via P-TECH program	Yes, work-based learning & supervision	Yes
Minnesota	Mental Health Behavioral Aide	Level I: HS diploma + 2 years' experience; Level II: Associate + certification	Yes, state training & certification	Yes
Arizona	Behavioral Health Paraprofessional / Technician	HS diploma + skills verification / HS + 4 years exp or associate degree	Yes, clinical oversight	Yes
Oregon	Qualified Mental Health Associate (QMHA)	Certificate or associate degree pathways	Yes, certification required	Yes
Maine	Mental Health & Rehab Technician	State-developed training and certification	Yes	Yes
Georgia	Paraprofessional	State training via learning management system	Yes	Yes
Others (AK, MI, PA, UT, VA, FL, NY)	Various paraprofessional/ technician roles	Certificate or associate degrees common	Yes	Yes

Experience as Substitute

Multiple programs allow experience to substitute for education, with formulas like "bachelor's + 2 year's experience" vs "master's degree" being common. Research consistently shows that program intensity, clinical complexity, and population risk level are the primary determinants of educational requirements, rather than the home-based setting itself. Programs serving higher-risk families or providing intensive clinical interventions require higher educational credentials, while supportive and educational programs can effectively utilize staff with lower formal educational requirements combined with appropriate training and supervision.

Supervisors

Recent peer-reviewed research and authoritative sources underscore the value and often the requirement for supervisors in mental health agencies to hold at least a master's degree, due to the complexity of clinical work, the need for advanced skills, and the importance of effective supervision in evidence-based practice. For example, while Homebuilders (now often called Intensive Family Preservation Services; IFPS) sometimes allows for bachelor's level staff with significant experience, master's level clinicians are strongly preferred and often required for supervisory and lead clinical roles. Program manuals and recent RFAs (e.g., North Carolina DHHS 2024) specify that managers and supervisors must have a master's degree or equivalent experience, with exceptions requiring a waiver.

A 2021 systematic review published in BMC Psychiatry highlights the critical role of clinical supervision in mental health service delivery, noting that effective supervision is essential for maintaining provider competence and fidelity to evidence-based practices. While the review discusses the importance of supervision generally, it references broader literature and standards that reinforce the need for supervisors to have advanced training—typically at the master's level or higher—to ensure that they can provide formative and restorative support to frontline staff. The review also notes that clinical supervision is recognized as a key factor in developing provider competencies, which are most effectively nurtured by supervisors with advanced clinical education and experience (Bradley & Becker, 2021).

Additionally, national standards and certification bodies, such as those referenced by the National Board for Certified Counselors (NBCC) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP), require that counseling supervisors have at least a master's degree in an allied mental health field and often several years of post-master's clinical experience [53]. While the most recent edition of these standards is not itself peer-reviewed research, it is widely cited in the literature and informs current practice.

53 Requirements related to the practice of counseling: https://www.ncbi.nlm.nih.gov/books/NBK259170/

Recent peer-reviewed literature in counselor education also emphasizes the importance of post-master's experience for effective supervision and leadership in mental health agencies, further supporting the view that advanced education (master's or higher) is foundational for supervisory roles [54]. While these studies focus on counselor education and supervision, the findings are directly applicable to mental health agency settings, where supervisors are responsible for supporting staff, ensuring treatment fidelity, and promoting positive client outcomes.

Relevant Training and Skills

Studies have shown that an organization can have a highly educated and trained clinical staff, and yet, see a decrease in positive outcomes. For example, the COMBINE (Combined Pharmacotherapies and Behavioral Interventions) study was a large, multisite randomized controlled trial examining the effectiveness of combing medications and behavioral interventions for alcohol dependence. It implemented rigorous procedures for therapist selection, training, certification, supervision, and session monitoring to ensure treatment fidelity.

However, the study found that therapist empathy was independently associated with better client outcomes. Approximately 11% of the variance in client drinking outcomes was attributable to which therapist a client saw, even within a highly structured, manualized, and supervised intervention (Moyers, et al.; 2016). This underscores that therapists are not interchangeable, their interpersonal skills, particularly empathy, matter. More specifically, skills-building and therapist empathy contributed independently to individuals getting better from the specialized treatment and treatment as usual groups.

Essential Skill Demonstration

- **Empathy:** Demonstrate cognitive (e.g. understanding client's perspective), emotional (e.g. can foster a sense of solidarity and understanding), and compassionate (e.g. shared feeling of genuine desire to help) empathy [55] because it builds trust, validates client experiences, enhances communication, and is empirically linked to better therapeutic outcomes [56]. Empathy is not just a therapeutic tool, it is the cornerstone of effective, human-centered mental health care[57].

- **Adaptability and Resilience:** Ability to adapt approaches and interventions to unique family needs and changing circumstances [58] [59]. An ideal candidate should demonstrate active problem solving by systematically addressing challenges and using structured methods and collaborative engagement [60]. They should be able to adapt their approach to each unique situation, integrating new strategies, and continuously updating their skills [61]. These competencies are essential for effective, responsive care in real-world, home-based settings.

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54 An exploration of the perceived impact of post-Master's experience...: https://tpcjournal.nbcc.org/an-exploration-of-the-perceived-impact-of-post-masters-experience-on-doctoral-study-in-counselor-education-and-supervision/

55 The role of empathy in supporting mental health: https://www.grandrisingbehavioralhealth.com/blog/the-role-of-empathy-in-supporting-mental-health

56 Understanding the importance of empathy in therapy: https://www.achievingstarstherapy.com/blog/understanding-the-importance-of-empathy-in-therapy

57 The role of empathy in health and social care professionals: https://pmc.ncbi.nlm.nih.gov/articles/PMC7151200/

58 10 Essential skills every home health aide should have: https://www.7dayhomecare.com/10-essential-skills-every-home-health-aide-should-have

59 Families and mental health workers: the need for partnership: https://pmc.ncbi.nlm.nih.gov/articles/PMC1489835/

60 Six principles to enhance health workforce flexibility: https://pmc.ncbi.nlm.nih.gov/articles/PMC4532254/

61 Organizational social context measure: https://cbhr.utk.edu/osc/

- **Self-Management and Stress Tolerance:** Candidates should demonstrate skills in time management, the ability to be comfortable in high-stress environments, manage the emotional demands of in-home crises, and to balance multiple family cases efficiently (Glisson, 2015). They should be able to quickly assess situations and identify immediate risks or concerns and adapt to the unique contexts of the families [62]. They should demonstrate the capacity to proactively seek guidance from supervisors or colleagues when faced with challenges and use consultation to gain perspective and improve or enhance their skills [63].

- **Lifelong Learning Mindset:** Research has consistently shown that access to (and taking advantage of that access) ongoing professional development, activities is associated with lower turnover intentions and greater workforce stability [64]. Commitment to staying current with research, best practices, and emerging issues can be demonstrated through actively seeking out new knowledge, embracing feedback, adapting to change, and sharing learning with others in a self-directing manner [65].

RQ4 Conclusion

The literature underscores that successful in-home mental health providers are those who combine strong clinical skills, adaptability, and a commitment to evidence-based models with personal resilience and alignment to organizational culture. Selection processes should rigorously assess these attributes through structured interviews, competency-based training and coaching, and ongoing supervision to ensure both effectiveness and retention (Bradley & Becker, 2021). Candidates most likely to succeed in home-based, family-focused mental health programs are those who combine strong interpersonal skills (especially relationship-building and cultural sensitivity) with flexibility, teamwork, and a commitment to ongoing learning and reflective practice. While clinical expertise is necessary, the ability to connect with families and adapt to their unique needs should be non-negotiable.

62 Supporting families in crisis: Skills for family social workers: https://www.tripodpartners.com/career-advice/social-work/supporting-families-in-crisis-skills-for-family-social-workers/

63 Implementation strategies for mental health professionals: https://www.gtbhc.org/implementing-self-care-strategies-for-mental-health-professionals.html

64 The importance of continuing education for mental health professionals: https://allia.health/blog/the-importance-of-continuing-education-for-mental-health-professionals

65 10 helpful habits to develop a life long learning mindset: https://www.phoenix.edu/blog/develop-lifelong-learning-mindset.html

RQ5: What lessons from other industries regarding motivation factors could apply to in-home diversion programs?

Summary of the literature

Several industries that share similar challenges with in-home diversion programs (including high-stress environments, vulnerable populations, and demanding fieldwork) offer insights into effective motivation strategies. Healthcare, particularly home healthcare and community mental health services, demonstrates that worker retention improves significantly when organizations emphasize the meaningful impact of the work through regular outcome sharing and client success stories. These sectors have found that making the connection between daily tasks and larger mission outcomes explicit helps sustain workers through difficult periods.

The nonprofit sector, especially organizations serving at-risk populations, has successfully implemented peer support networks and mentorship programs that create horizontal support systems beyond traditional supervision. These models could be adapted for in-home programs by establishing formal peer consultation groups where workers can share challenges and solutions with colleagues facing similar situations.

From social work and case management fields, research shows that autonomy in decision-making (even within structured protocols) serves as a powerful motivator. Workers who feel trusted to exercise professional judgment within clear boundaries report higher job satisfaction and longer tenure. This suggests that in-home diversion programs should build flexibility into their service delivery models while maintaining accountability structures.

From the child welfare sector, research has demonstrated that professional development opportunities focused on skill-building rather than compliance training significantly improve both job satisfaction and effectiveness. Similarly, emergency services have shown that debriefing processes and trauma-informed organizational practices help workers process difficult cases and scenarios while maintaining their sense of professional competence and personal resilience.

The following list provides a broad summary of some of those motivation factors in in-home mental health, while Table 5 below provides a cross walk of the motivator by evidence and application to the mental health work force:

- **Emphasize Relationship-Building:** Just as in home visiting, mental health professionals are more likely to stay when they can form meaningful, trusting relationships with clients.
- **Prioritize Flexibility:** Allowing flexibility in scheduling and service delivery can help prevent burnout and accommodate both staff and client needs.
- **Create a Supportive Work Environment:** Organizational support, including supervision, peer networks, and recognition, is crucial for retention in both fields.
- **Focus on Relevant, Impactful Work:** Staff are motivated by seeing the positive impact of their work. Ensuring that services are tailored to client needs and that staff can witness outcomes supports retention.
- **Cultural Competence and Representation:** Recruiting and supporting staff who reflect the cultural and linguistic backgrounds of clients can enhance both staff satisfaction and client engagement.
- **Invest in Professional Development:** Ongoing training, opportunities for advancement, and skill-building are essential for keeping staff engaged and committed.

Table 5. Motivator by evidence in other disciplines and application to mental health.

Motivator/Factor	Evidence from In-Home Industry Programs	Application to Mental Health Workforce
Relevant program content/impact	Staff motivated by meaningful, helpful work	Highlight impact and relevance of services
Trusting relationships	Central to engagement and retention	Foster strong client-provider relationships
Flexibility	Reduces burnout, supports retention	Offer flexible schedules and service options
Supportive organizational climate	Increases satisfaction and retention	Build supportive, collaborative environments
Cultural/linguistic alignment	Enhances engagement, satisfaction	Recruit diverse, culturally competent staff
Professional growth opportunities	Motivates staff to remain	Provide training and advancement pathways

Workforce Development in Guides and Frameworks in Related Fields

A systematic search and summary of workforce development guides and frameworks from related industries and fields provides an overview of evidence-based, field-tested strategies that have been refined through practical implementation rather than theoretical speculation. Unlike academic research (that may focus on isolated variables) workforce development frameworks represent comprehensive approaches that organizations have actively implemented to address retention challenges in real-world settings.

Industries such as healthcare, social services, emergency response, and education have faced similar workforce pressures (including high turnover, emotional demands, fieldwork requirements, and service to vulnerable populations), and have developed specific frameworks and best practices through trial and adaptation. Examining these established guides, allows for the identification proven motivational strategies that have demonstrated success across multiple contexts and organizational types.

This approach is particularly valuable because workforce development frameworks typically integrate multiple retention factors into cohesive systems, showing how different motivational elements work

together in practice. Furthermore, these guides often include implementation guidance, metrics for success, and lessons learned from failures, providing a more complete understanding of how cross-industry insights can be practically adapted for in-home diversion programs rather than simply identifying what might work in theory.

The following section provides an overview of some select applicable guides and frameworks.

National Council for Mental Wellbeing's "Building an Effective Behavioral Health Workforce: Recruitment, Retention and Innovation" (2023) provides a comprehensive, evidence-based framework highly relevant to recruiting and retaining a high-quality mental health workforce for in-home service providers.

Key Applicability to In-Home Mental Health Service Providers:

- **Centering Staff and Client Experience:** The guide underscores the need to focus on both staff and client experiences, recognizing that staff well-being directly impacts client outcomes and organizational effectiveness. For in-home providers, this means creating a workplace where staff feel valued, connected, and supported, which in turn enhances service quality and retention.

- **Workplace Strategies:** The guide identifies five key strategies for in-home providers that centers on creating sustainable support systems that address both the operational and individual demands of the work. Organizations should maximize staff capacity through ongoing training, manageable caseloads, and support systems that enable quality service while preventing burnout. Beyond competitive pay, successful programs offer flexible scheduling, career development opportunities, and collaborate with other agencies to strengthen the talent pipeline. Responsive policies require regular review to meet staff needs, particularly by reducing administrative burdens and implementing flexible work arrangements. Table 6 below provides an overview of those workplace strategies.

Table 6. Workplace strategies and their application.

Strategy	Application to In-Home Providers
Maximize Staff Capacity to Support Client Recovery	Invest in ongoing training, manageable caseloads, and support systems to help staff deliver high-quality care and avoid burnout.
Incentivize the Workforce Pipeline	Go beyond salary: offer flexible schedules, career development, and collaborate with other agencies to build a robust workforce pipeline.
Establish Responsive Policies and Practices	Regularly review and adapt policies to meet staff needs, including documentation burden reduction and flexible work arrangements.
Promote Role Clarity and Team Efficacy	Clearly define roles, provide effective team-based support, and ensure staff understand how their work fits into the larger mission.
Prepare Supportive Managers	Train supervisors in trauma-informed, supportive leadership to foster psychological safety and address secondary trauma.

- **Emphasizing Meaning, Purpose, and Psychological Safety:** The guide highlights that staff are motivated by meaning and purpose (knowing their work makes a difference is a top factor for recruitment and retention). Psychological safety is crucial: staff must feel empowered to speak up, share concerns, and innovate without fear of reprisal. In-home providers can foster this by encouraging open communication, recognizing staff contributions, and building a culture of respect.

- **Belonging and Team Connectedness:** Social connection and team cohesion are vital to protect against burnout and compassion fatigue, especially in multidisciplinary teams working in the field. Agencies should prioritize regular team meetings, peer support, and opportunities for staff to connect and collaborate.

- **Data-Informed and Innovative Approaches:** The guide encourages the use of data to inform workforce strategies, monitor progress, and adapt interventions. Innovation (such as telehealth, flexible employment options, and new care models) can help attract and retain talent, particularly in hard-to-staff areas.

Table 7 below provides an overview of all the key strategies included in the guide and their application for in-home providers.

Table 7. Guiding principle by application to in-home providers.

Guide Principle/Strategy	Application for In-Home Providers
Center staff/client experience	Build supportive, responsive workplace culture
Maximize staff capacity	Manageable caseloads, ongoing training, burnout prevention
Incentivize pipeline	Flexible work options, career development, collaboration
Responsive policies	Reduce documentation burden, adapt to staff needs
Role clarity/team efficacy	Define roles, foster team-based support, mission alignment
Supportive management	Trauma-informed, psychologically safe supervision
Data-informed innovation	Use data, embrace new models (telehealth, flexible scheduling)
Policy/advocacy	Engage in advocacy for systemic workforce improvements

Source: https://www.thirdsectorcap.org/wp-content/uploads/2023/09/Third-Sector_Behavioral-Health-Workforce_September-2023-Final.pdf

National Child Welfare Workforce Institute's "Workforce Development Framework" provides a comprehensive, systems-level approach to building and sustaining a high-quality workforce. Although designed for child welfare, its core strategies are highly applicable to recruiting and retaining a high-quality mental health workforce for in-home service providers.

Key Applicability to In-Home Mental Health Service Providers:

- **Holistic, Systemic Workforce Planning:** The framework emphasizes the need for system-wide planning rather than isolated interventions. In-home mental health agencies can use this approach to align recruitment, retention, supervision, and professional development with organizational mission and service goals.
- **Data-Driven Decision Making:** The framework highlights the importance of using data to assess workforce needs, monitor progress, and guide improvements. In-home providers can collect and analyze data on staff turnover, satisfaction, and training needs to inform targeted strategies for recruitment and retention.
- **Focus on Organizational Culture and Climate:** A positive, supportive organizational culture is central to workforce stability. By fostering a culture of respect, inclusion, and support, in-home mental health providers can attract and retain staff who are committed to high-quality care.
- **Comprehensive Recruitment and Selection:** The framework encourages strategic recruitment and selection practices that ensure the right fit for both the role and organizational values. In-home providers can develop clear job descriptions, realistic job previews, and structured interview processes to identify candidates most likely to thrive.
- **Professional Development and Support:** Ongoing training, coaching, and career development are essential for workforce retention. In-home mental health agencies can implement regular training, mentorship, and advancement opportunities to support staff growth and satisfaction.

- **Leadership and Supervision:** Effective leadership and supportive supervision are highlighted as key retention factors. Agencies can invest in training supervisors to provide reflective, trauma-informed, and strengths-based support to frontline staff.

Table 8 below provides an overview of each key element and their application to in-home providers.

Table 8. Key framework element by application to in-home providers.

Framework Element	Application to In-Home Providers
System-wide workforce planning	Align HR, supervision, and development with service mission
Data-driven strategies	Use staff and service data to guide recruitment and retention
Organizational culture focus	Build inclusive, supportive workplace environments
Strategic recruitment/selection	Use clear, mission-aligned hiring practices
Ongoing professional development	Provide training, mentorship, and advancement opportunities
Strong leadership/supervision	Train supervisors in supportive, trauma-informed practices

Source: https://ncwwi.org/the-workforce-development-framework/

Planning for emotional labor and secondary traumatic stress in child welfare organizations (Caringi, Lawson, & Devlin, 2012) focuses on the importance of planning for emotional labor and secondary traumatic stress (STS) in child welfare organizations. While the context is child welfare, the guide's principles are highly relevant and applicable to recruiting and retaining a high-quality mental health workforce for in-home service providers.

Key Applicability to In-Home Mental Health Service Providers:

- **Recognizing Emotional Labor and STS as Core Workforce Issues:** In-home mental health providers, like child welfare workers, frequently encounter emotionally intense situations and are at high risk for secondary traumatic stress. The article emphasizes that organizations must acknowledge these stressors as fundamental components of the job, not as individual weaknesses or failures.
- **Proactive Organizational Planning:** The guide advocates for organizational-level planning to address emotional labor and STS, rather than leaving staff to cope individually. For in-home providers, this means integrating support systems into recruitment materials and onboarding processes, signaling to potential hires that their well-being is a priority.
- **Recruitment Implications:** By openly addressing emotional labor and STS in recruitment, organizations can attract candidates who are both aware of these challenges and value supportive work environments. Transparent communication about available supports (e.g., supervision, peer support, training) can be a strong recruitment tool for high-quality candidates seeking sustainable careers.
- **Retention Strategies:** The guide highlights the need for ongoing training, supervision, and peer support to mitigate the effects of emotional labor and STS. For in-home service providers, implementing regular reflective supervision, access to counseling, and fostering a culture of openness about stress can improve retention by reducing burnout and turnover.
- **Creating a Supportive Culture:** The guide recommends building a workplace culture that normalizes discussions about emotional challenges and encourages help-seeking. In-home mental health agencies can adopt these practices to foster resilience, loyalty, and long-term commitment among staff.

Table 9 below provides an overview of each key principle identified in the article and their application to in-home providers.

Table 9. Key principle by application to in-home providers.

Article Principle	Application to In-Home Providers
Plan for emotional labor & STS	Integrate into recruitment, onboarding, and ongoing training
Organizational responsibility	Build systemic supports, not just individual coping
Supportive supervision & training	Offer reflective supervision, peer groups, and wellness resources
Transparent recruitment messaging	Attract candidates valuing support and resilience
Normalize emotional challenges	Create open, stigma-free culture around stress and trauma

Source: https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1139&context=jfs

Substance Abuse and Mental Health Services Administration's "Trauma-Informed Care in Behavioral Health Services." *Treatment Improvement Protocol (TIP) Series, No. 57* (2014) provides a comprehensive guide for implementing trauma-informed care (TIC) in behavioral health settings. Its workforce development recommendations are highly applicable to recruiting and retaining a high-quality mental health workforce for in-home service providers.

Key Applicability to In-Home Mental Health Service Providers:

- **Trauma-Informed Recruitment and Hiring:** The guide emphasizes actively recruiting staff with trauma-informed training or lived experience in trauma and recovery. In-home service providers should prioritize candidates who demonstrate empathy, understanding of trauma, and relationship-building skills, using behavioral interviewing to assess these attributes. Outreach to diverse communities and peer support networks can help build a workforce that reflects and understands the populations served.
- **Comprehensive, Ongoing Training:** Trauma informed care requires early and ongoing training and coaching for all staff, not just initial onboarding. Training and coaching should cover trauma theory, trauma-informed principles, practical implementation strategies, and self-care techniques to mitigate secondary traumatic stress. Regular training updates help staff stay current with best practices and maintain resilience.
- **Supportive Organizational Culture:** The guide stresses the need for an organizational culture that values staff well-being and safety. In-home providers should create policies and practices that normalize the challenges of secondary trauma, offer peer support, and encourage open discussion of workplace stress. Leadership should model trauma-informed values and provide opportunities for staff input into policy and practice decisions.
- **Retention Through Well-Being and Support:** Retention strategies include offering competitive wages, manageable caseloads, adequate benefits (including mental health support), and opportunities for professional advancement. Providing regular, trauma-informed clinical supervision and recognizing the impact of secondary trauma as a systemic, not personal, issue is essential. Organizations should implement self-care supports and flexible policies to promote staff wellness and prevent burnout.
- **Equity and Workforce Diversity:** The guide and related research highlight the importance of equity-centered workforce initiatives, such as leadership development for marginalized groups and recruitment from the communities served. Culturally responsive training and policies help ensure the workforce is prepared to meet the needs of diverse clients.

Table 10 below provides an overview of each key TIC principle and their application to in-home providers.

Table 10. Key TIC principle by application to in-home providers.

TIC Workforce Principle	Application to In-Home Providers
Trauma-informed recruitment	Hire for trauma knowledge, empathy, and lived experience
Ongoing, comprehensive training	Provide regular TIC and self-care training for all staff
Supportive organizational culture	Normalize secondary trauma, offer peer support and open dialogue
Retention through well-being	Competitive pay, benefits, manageable caseloads, clinical supervision
Equity and diversity focus	Recruit from served communities, support marginalized staff

Source: https://library.samhsa.gov/product/tip-57-trauma-informed-care-behavioral-health-services/sma14-4816

Implementation Science Perspectives

A systematic search and summary of implementation science frameworks is crucial for because these frameworks provide structured methodologies for successfully translating cross-industry motivational strategies into practice within in-home diversion programs. Implementation science research specifically addresses the gap between knowing what works and making it work in real organizational contexts, offering evidence-based approaches for adapting proven strategies from other industries to fit the unique operational constraints, cultural dynamics, and resource limitations of in-home diversion settings. These frameworks identify critical factors that determine whether borrowed strategies will succeed or fail when transferred across industries, including organizational readiness, stakeholder engagement, and adaptation processes.

By examining implementation science, organizations can understand not just which motivational factors from other industries might be theoretically applicable, but also how to systematically assess organizational capacity for change, identify potential barriers to adoption, and develop structured implementation plans that increase the likelihood of successful integration. This approach is essential because motivation strategies that work in healthcare, education, or social services may require significant modification to function effectively in the specific context of in-home diversion programs, and implementation science provides the roadmap for making these adaptations successfully.

The following section provides an overview of the review of three frameworks considerations related to implementation science.

Expert Recommendations for Implementing Change (ERIC) Project: The ERIC[66] compilation provides a robust, validated toolkit for systematically selecting and implementing strategies to recruit and retain a high-quality mental health workforce for in-home service providers (Powell, et al.; 2015). By leveraging its ratings and thematic clusters, organizations can prioritize interventions that are both important and feasible, adapt to local context, and build a resilient, satisfied, and effective workforce.

Key Applicability to In-Home Mental Health Service Providers:

- **Tailored, Evidence-Based Approach to Workforce Initiatives:** The ERIC framework offers a menu of strategies—such as audit and feedback, educational outreach, and developing stakeholder interrelationships—that organizations can select and tailor to their specific context, rather than relying on a one-size-fits-all checklist. For in-home providers, this means one can systematically choose and combine strategies best suited to your workforce challenges, such as high turnover, burnout, or onboarding needs.

66 Results from the Expert Recommendations for Implementing Change (ERIC) project: https://implementationscience.biomedcentral.com/articles/10.1186/s13012-015-0209-1

- **Prioritizing Strategies by Importance and Feasibility for Recruitment and Retention:** Highly rated strategies include assessing readiness and identifying barriers/facilitators to ensure that workforce initiatives are context-specific and address real organizational challenges. Organizations should also develop educational materials and provide ongoing training to support staff development and satisfaction. Supervisors should routinely audit and feedback by regularly monitoring staff experiences and outcomes to inform continuous improvement. Also, organizations should build stakeholder relationships by engaging staff, supervisors, and community partners in workforce planning and support.

- **Structured Implementation and Change Management:** The ERIC strategies help organizations move from planning to action, supporting the implementation of new recruitment, onboarding, supervision, and retention practices in a structured, evidence-informed way. For in-home mental health agencies, this can mean using strategies like: Conducting ongoing training and supervision to address secondary trauma and emotional labor, providing reminders and support for clinicians to reinforce best practices and reduce isolation, or forming implementation teams to guide and monitor workforce initiatives

- **Flexibility and Adaptation:** The framework emphasizes the need to adapt strategies to local context and workforce realities, recognizing that what works in one setting may not work in another. In-home providers can use the ERIC compilation to pilot new approaches, gather feedback, and refine interventions for maximum impact.

Exploration, Preparation, Implementation, Sustainment (EPIS) Framework: A 2019 systematic review of EPIS (Moullin, et al., 2019) indicates that it provides robust, evidence-based strategies that in-home mental health service providers can adopt to enhance recruitment and retention. By focusing on onboarding, social support, staffing, professional development, positive culture, flexibility, and innovation, agencies can build a resilient, satisfied, and high-quality workforce

Key Applicability to In-Home Mental Health Service Providers:

- **Onboarding and Transition Programs:** The review highlights the effectiveness of structured onboarding and transition programs in improving early retention and reducing turnover, especially for new hires or those moving between units. For in-home providers, comprehensive onboarding—including mentorship, orientation to home-based care, and peer introductions—can help staff acclimate, build confidence, and feel supported from the outset.

- **Stress Coping and Social Support:** Interventions that address stress management and provide social support (such as peer groups, supervision, and access to mental health resources) are linked to higher retention. In-home mental health agencies should build in regular opportunities for staff to debrief, access counseling, and participate in peer support networks to combat isolation and burnout.

- **Extra Staffing and Workload Management:** Adequate staffing levels and manageable caseloads are essential for retention. Overwork and high job demands are major push factors for leaving. Agencies should monitor workloads and adjust staffing to prevent burnout, ensuring clinicians have the resources needed to provide quality care.

- **Professional Development and Career Growth:** Development opportunities and department resources—including ongoing training, career advancement pathways, and skills development—are strong retention factors. In-home providers should offer clear career ladders, tuition reimbursement, and support for continuing education to attract and keep high-quality staff.

- **Positive Work Environment and Organizational Culture:** The review underscores the importance of a supportive, respectful, and inclusive organizational culture. Leadership should foster psychological safety, recognize employee contributions, and maintain open communication channels. Staff should feel valued, heard, and part of a collaborative team.

- **Flexible Work Organization and Scheduling:** Flexible scheduling and attention to work-life balance are critical, especially for in-home roles that may involve variable hours. Agencies can improve retention by offering flexible shifts, autonomy over schedules, and policies that support work-life integration.
- **Recruitment Approaches and Technological Innovations:** Innovative recruitment strategies (e.g., sign-on bonuses, lifestyle benefits) and the use of technology (for communication, training, and scheduling) can enhance both recruitment and retention. In-home providers should leverage digital tools for training, supervision, and team connection, making work more accessible and less isolating.

Job Demands-Resources (JD-R) model is used to conceptualize how job demands (e.g. workload, emotional strain) and job resources (e.g., support, development opportunities, positive work environment) interact to influence job satisfaction, burnout, and ultimately, retention or turnover. Devries, et al. (2023) used the JD-R framework to organize and interpret the determinants and interventions affecting healthcare worker retention. This systematic review offers valuable insights applicable to recruiting and retaining a high-quality mental health workforce for in-home service providers.

Key Applicability to In-Home Mental Health Service Providers:

- **Structured Onboarding and Transition Support:** The review highlights that comprehensive onboarding and transition programs significantly improve early retention by helping new staff acclimate to their roles and organizational culture. For in-home mental health providers, this suggests implementing structured orientation, mentorship, and peer support during the critical early employment phase to reduce turnover.
- **Stress Management and Social Support:** Interventions offering stress coping mechanisms and social support—such as peer support groups, clinical supervision, and access to mental health resources—are linked to better retention outcomes. Given the emotionally demanding nature of in-home mental health work, agencies should prioritize regular debriefings, trauma-informed supervision, and mental health supports to mitigate burnout and secondary traumatic stress.
- **Adequate Staffing and Workload Balance:** The review identifies that manageable caseloads and sufficient staffing are crucial to prevent burnout and job dissatisfaction. In-home providers must monitor workloads carefully, ensuring clinicians are not overwhelmed, which supports sustained engagement and quality care delivery.
- **Professional Development and Career Advancement:** Opportunities for ongoing training, skill development, and clear career pathways are strong motivators for retention. Agencies should offer continuing education, tuition reimbursement, and defined advancement tracks to attract and retain skilled mental health professionals.
- **Positive Organizational Culture and Leadership:** A supportive, respectful, and inclusive workplace culture fosters employee retention. Leadership practices that promote psychological safety, recognize employee contributions, and maintain open communication channels are essential for sustaining workforce morale and commitment.
- **Flexible Work Arrangements:** Flexibility in scheduling and work organization supports work-life balance, which is particularly important for in-home providers who may face variable hours, and travel demands. Offering flexible shifts, autonomy over schedules, and family-friendly policies can enhance job satisfaction and retention.
- **Recruitment Innovations and Technology Use:** The review notes that innovative recruitment incentives (e.g., sign-on bonuses) and leveraging technology for training, supervision, and communication can improve both recruitment and retention. In-home mental health agencies can adopt digital platforms for remote supervision, telehealth, and team collaboration to reduce isolation and improve workforce engagement.

RQ6: How do payment models impact the ability to implement evidence-based workforce recruitment and retention strategies?

Payment Model-Workforce Connection

Payment models are not neutral when it comes to staff recruitment and retention for in-home behavioral health services and supports. Simply put, they either support or undermine workforce retention. Fee-for-service (FFS) systems create structural barriers to implementing the organizational supports, manageable caseloads, and relationship-centered practice that research identifies as essential for retaining high-quality staff (Morse et al., 2021; Aarons et al., 2021). Conversely, case rate and value-based payment models remove these barriers and provide the stable revenue foundation necessary for sustainable workforce development.

Fee-for-Service Barriers to Workforce Retention

Current FFS payment structures create multiple obstacles to implementing evidence-based workforce retention strategies:

Productivity Pressure vs. Relationship-Building

- Traditional FFS models incentivize organizational structures designed to support high service volume, creating pressure to maximize billable encounters.
- Research indicates that in-home behavioral health work requires time for relationship-building, family engagement, and crisis response—activities that may not generate immediate billable services.
- Travel time between homes, care coordination, and team consultation are typically non-billable, creating financial pressure on both organizations and workers.
- Staff report feeling caught between quality care and productivity demands, leading to moral distress and burnout (Hallet et al., 2024).

Caseload Management Challenges

- FFS pressure to maintain high caseloads to generate adequate revenue conflicts with research showing that manageable caseloads are essential for retention (De Vries et al., 2023).
- Organizations cannot easily implement evidence-based caseload standards when revenue depends on high service volume.
- Staff burnout from excessive caseloads leads to turnover, creating a destructive cycle of understaffing and overwork.

Revenue Instability Prevents Workforce Investment

- FFS revenue streams fluctuate based on service utilization, staff retention, and community needs, making it difficult to project budget resources for competitive salaries, benefits, and professional development.
- Organizations cannot reliably invest in workforce retention strategies like enhanced supervision, support programs, or flexible scheduling when revenue is unpredictable.
- Temporary funding gaps during client transitions or program ramp-up periods force organizations to make short-term decisions that undermine retention efforts.

Administrative Burden and Documentation Requirements

- FFS models require extensive service-by-service documentation to justify billing, with complex requirements that create compliance stress and reduce job satisfaction.
- Documentation requirements often prioritize billing compliance over clinical quality or relationship outcomes.
- Staff spend significant time on administrative tasks rather than direct service or professional development (Hallet et al., 2024).

Case Rate Models Enable Workforce Retention

Case rate and value-based payment models remove systemic barriers and create conditions that support evidence-based workforce retention strategies:

Stable Revenue Foundation for Workforce Investment

- Predictable monthly payments allow organizations to budget for competitive salaries, comprehensive benefits, and professional development programs.
- Revenue stability enables long-term workforce planning and investment in retention strategies.
- Organizations can hire adequate staff to maintain reasonable caseloads without financial pressure to overload workers.
- Stable funding supports enhanced supervision models, peer support programs, and organizational climate improvements (National Council for Mental Wellbeing, 2023).

Quality Over Quantity Incentives

- Case rates reward successful family outcomes rather than service volume, aligning payment with the relationship-centered practice that staff find meaningful (Kleinman et al., 2023).
- Providers can spend adequate time with families without productivity pressure, reducing staff stress and improving job satisfaction.
- Focus on outcomes rather than encounters allows for flexible service delivery that accommodates both family needs and staff well-being.
- Quality metrics tied to payments create organizational culture and climates that are focused on excellence rather than quantity.

Flexible Service Delivery Models

- Case rates allow for innovative service approaches that support both family engagement and staff retention.
- Providers can implement team-based models, flexible scheduling, and culturally responsive services without billing constraints.
- Organizations can invest in staff support services like mental health benefits, trauma-informed supervision, and peer consultation.
- Flexibility in service delivery reduces staff burnout and increases professional autonomy (Boyas, Wind, & Kang, 2012).

Reduced Administrative Burden

- Simplified billing processes reduce documentation requirements and administrative stress.
- Staff can focus on direct service, professional development, and team collaboration rather than billing compliance.
- Reduced administrative burden improves job satisfaction and allows for investment in clinical supervision and support (Morse et al., 2021).
- Technology investments can focus on clinical support rather than billing systems.

Research Evidence Supporting Payment Model Impact on Workforce

National Evidence

Certified Community Behavioral Health Clinic (CCBHC) Model Success

- CCBHCs operating under prospective payment systems report improved staff retention and job satisfaction.
- 98% of CCBHCs reported staff position increases since adopting the model, with a median of 22 new positions per clinic (National Council for Mental Wellbeing, 2024).
- Enhanced staff roles, interdisciplinary teamwork, and improved morale result from clearer goals and stable funding.
- Preliminary data shows improvements in both retention and staff well-being under value-based payment structures.

Cross-Industry Evidence

- Healthcare organizations operating under capitated models consistently show lower turnover rates and higher staff satisfaction (De Vries et al., 2023).
- Value-based payment models enable investment in the organizational supports identified as most effective for workforce retention.
- States using tiered case rates for children's behavioral health have reported improved care coordination and expanded access to services at lower per-capita costs.

Texas-Specific Opportunities

Community-Based Care (CBC) Success

- Texas's implementation of Community-Based Care (CBC) through Single Source Continuum Contractors demonstrates the state's commitment to moving beyond fee-for-service models for complex family services.
- CBC expansion statewide (completion expected by 2029) creates precedent for alternative payment models in family services.

Directed Payment Program for Behavioral Health Services (DPP BHS)

- Texas's value-based payment program for Community Mental Health Centers (CMHCs) and Local Behavioral Health Authorities (LBHAs) provides prospective monthly payments tied to quality outcomes.
- All participants must be Certified Community Behavioral Health Clinics (CCBHCs), creating infrastructure for value-based payments.
- Performance incentives tie payments to outcomes rather than volume, supporting the organizational conditions necessary for workforce retention.

MCO Value-Based Requirements

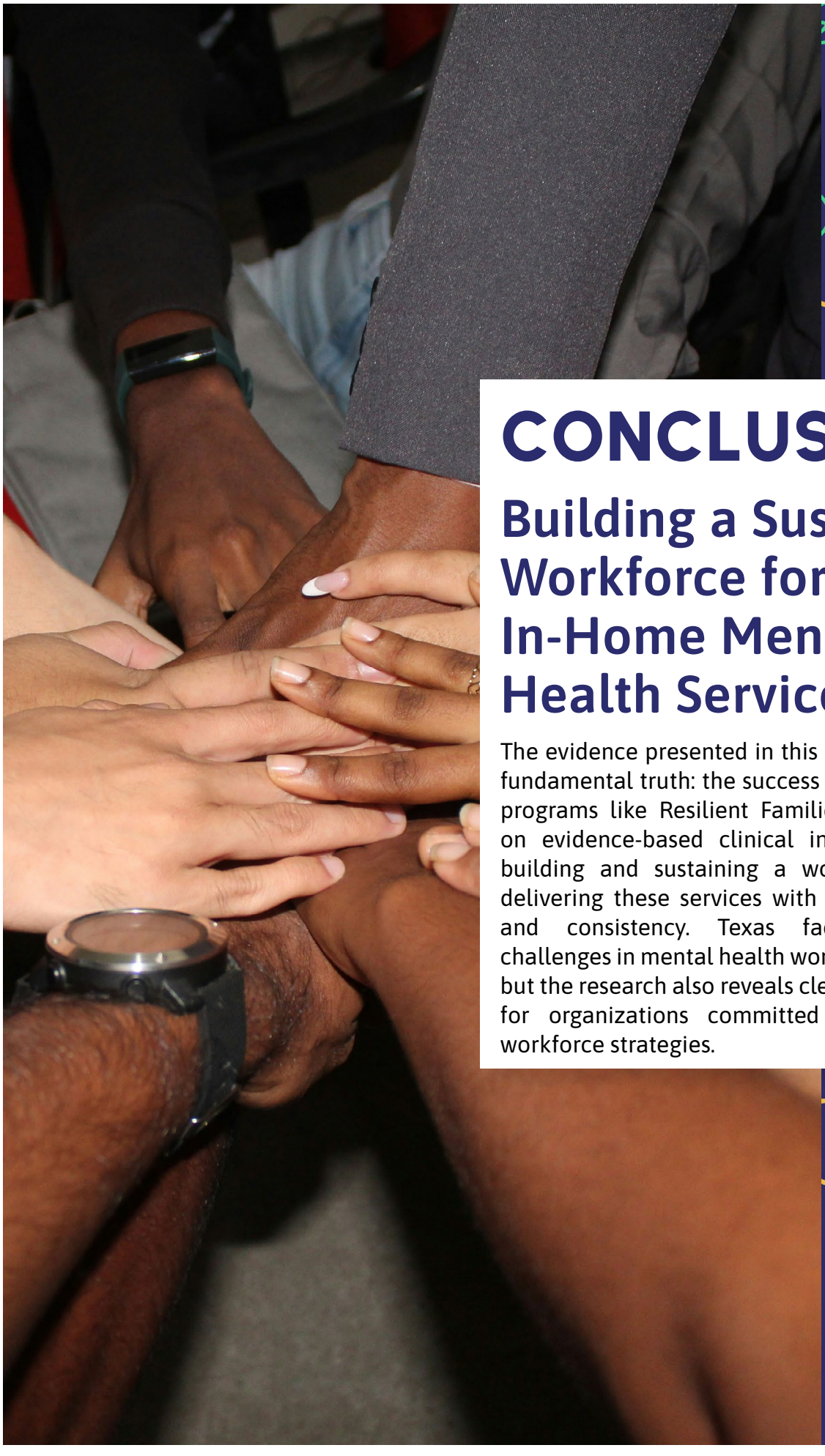
- Texas has transitioned all LBHAs to CCBHCs operating under prospective payment systems.
- MCO capitation rates tied to outcomes create value-based reimbursement systems.
- Texas requires that 50% of MCO services be value-based, creating system-wide momentum toward payment models that support quality over quantity.

RQ6 Conclusion

The evidence demonstrates that payment models function as foundational workforce retention strategies rather than neutral financing mechanisms. Fee-for-service systems create structural barriers that prevent organizations from implementing the evidence-based retention strategies identified in this report—supportive supervision, manageable caseloads, professional development opportunities, and empowering organizational climates. Case rate and value-based payment models remove these barriers by providing revenue stability, aligning incentives with quality outcomes, enabling flexible service delivery, and reducing administrative burdens.

For TCCFS and the Resilient Families program, Texas's expanding infrastructure of CBC, CCBHC implementation, and MCO value-based payment requirements creates unprecedented opportunities to pioneer payment models that support both workforce retention and family outcomes. The convergence of these initiatives positions Texas as a leader in demonstrating how payment model reform can address the workforce crisis while improving services for families.

This finding has implications for sustainable workforce development. Organizations cannot successfully implement evidence-based retention strategies within payment systems that structurally undermine those strategies. Moving forward, workforce development efforts should include payment model advocacy as a core component, recognizing that stable, high-quality teams require aligned financial incentives that reward relationship-centered practice, reasonable caseloads, and organizational investment in staff well-being.



CONCLUSION

Building a Sustainable Workforce for In-Home Mental Health Services

The evidence presented in this report underscores a fundamental truth: the success of in-home diversion programs like Resilient Families depends not just on evidence-based clinical interventions, but on building and sustaining a workforce capable of delivering these services with fidelity, compassion, and consistency. Texas faces unprecedented challenges in mental health workforce development, but the research also reveals clear pathways forward for organizations committed to evidence-based workforce strategies.

Key Insights for TCCFS and the Field

The Organizational Imperative

Perhaps the most compelling finding across all research questions is that workforce retention is fundamentally an organizational responsibility, not an individual challenge. While personal factors like coping skills and job satisfaction matter, the evidence consistently points to organizational climate, leadership quality, and systemic supports as the primary determinants of workforce stability. This finding shifts the focus from asking "How can we help individual workers cope better?" to "How can we create organizational conditions that support thriving, long-term careers?"

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For TCCFS, this means that investments in organizational climate and culture, supervisor training and support, and systemic feedback loops and support structures will yield greater returns than individual-focused interventions alone. The organizations that successfully retain staff are those that have fundamentally reimagined their approach to workforce support as a core operational strategy rather than a peripheral human resources function.

The Power of Relationship-Centered Practice

The research reveals that successful in-home mental health work is inherently relational—both in terms of staff-family relationships and workplace relationships among colleagues. Staff who can build meaningful connections with families and who experience supportive relationships with supervisors and peers are significantly more likely to remain in their roles despite the emotional demands and systemic challenges they face.

This relationship-centered approach extends beyond individual interactions to encompass organizational culture. Programs that foster collaboration, open communication, and shared decision-making create environments where staff feel valued and connected to both their work and their workplace community. For Resilient Families, this suggests that relationship-building skills should be prioritized not only in direct service training but also in supervisor development and organizational policy design.

The Intersection of Individual and Organizational Factors – Successful Candidates

While organizational factors dominate the retention literature, successful workforce strategies must also attend to individual characteristics and motivations. The most effective candidates for in-home work combine clinical competence with personal qualities like empathy, flexibility, and cultural humility. However, even the most well-suited individuals will leave if organizational conditions do not support their success and well-being.

This intersection suggests that TCCFS should implement or support comprehensive approaches that begin with thoughtful recruitment and selection processes designed to identify candidates whose values and skills align with in-home work, followed by robust organizational supports that enable these individuals to thrive in their roles over time.

Strategic Implications for Implementation

Building From Strengths

TCCFS enters this workforce development effort with significant advantages. The organization's commitment to evidence-based practice, family-centered values, and innovative service delivery provides a strong foundation for implementing research-informed workforce strategies. The SMART Grant funding offers the resources and flexibility needed to pilot new approaches and measure their effectiveness.

The existing partnership with CK Behavioral Health and the established Resilient Families program provide real-world laboratories for testing workforce innovations. Rather than implementing all strategies simultaneously, TCCFS can strategically sequence interventions, learning from early implementations to refine approaches before broader adoption.

Addressing Systemic Challenges

While TCCFS cannot single-handedly resolve Texas's broader mental health workforce crisis, the organization can contribute to systemic solutions through its advocacy efforts, partnership development, and demonstration of effective practices. Success with workforce retention in the Resilient Families program can serve as a model for other organizations and potentially influence policy discussions about workforce development investments.

The research on educational pathways and professional development suggests opportunities for TCCFS to partner with universities and training programs to create workforce pipelines specifically designed for in-home services. Such partnerships could address both immediate staffing needs and longer-term workforce development goals.

TCCFS should advocate for payment model reforms that align financial incentives with workforce retention goals, supporting the transition from fee-for-service to case rate models that enable sustainable investment in evidence-based retention strategies.

Measuring Success and Continuous Improvement

The implementation science literature emphasizes the importance of data-driven workforce strategies. TCCFS should establish baseline metrics for retention, job satisfaction, organizational climate, and program outcomes, then track these indicators over time as workforce interventions are implemented. This approach will enable the organization to identify which strategies are most effective in their specific context and adjust based on real-world evidence.

Regular staff surveys, exit interviews, and organizational climate assessments can provide ongoing feedback about the effectiveness of workforce initiatives. Additionally, tracking client outcomes alongside workforce metrics will help demonstrate the connection between staff stability and program effectiveness—a powerful argument for continued investment in workforce development.

Looking Forward: A Vision for Sustainable In-Home Services

The goal of these workforce development efforts extends beyond solving immediate staffing challenges. The vision is to create a sustainable model for in-home mental health services that attracts and retains

high-quality professionals who can deliver effective interventions while maintaining their own well-being and professional satisfaction.

Success in this endeavor has implications far beyond individual organizations. Families across Texas need access to high-quality in-home services that can prevent foster care placement, reduce reliance on institutional care, and support children and families in their natural environments. Achieving this vision requires organizations like TCCFS to demonstrate that it is possible to build stable, effective workforces for this challenging but essential work.

Final Recommendations

As TCCFS moves forward with workforce development initiatives, several principles should guide implementation:

Start with Culture: Prioritize organizational climate and culture development as the foundation for all other workforce strategies. Investments in supportive supervision, participatory decision-making, and trauma-informed organizational practices will create conditions for other interventions to succeed.

Think Systemically: Recognize that workforce challenges are interconnected with program design, funding structures, and community context. Address these challenges comprehensively rather than through isolated interventions.

Payment Model Advocacy: Advocate for case rate and value-based payment models that remove structural barriers to workforce retention and enable sustainable investment in evidence-based organizational supports.

Measure and Learn: Implement data systems that enable continuous learning and improvement. Use both quantitative metrics and qualitative feedback to understand what is working and what needs adjustment.

Build Partnerships: Engage with other organizations, educational institutions, and policy makers to address workforce challenges collaboratively. Share successes and lessons learned to benefit the broader field.

Invest for the Long Term: Recognize that building sustainable workforce capacity requires sustained investment and commitment. Quick fixes are unlikely to address the depth of current challenges.

The research presented in this report provides a roadmap for building the kind of workforce that Texas families deserve—professionals who are skilled, supported, and committed to helping families stay together and children thrive. By implementing evidence-based workforce strategies, TCCFS can contribute to transforming the landscape of in-home mental health services, creating a model that other organizations can follow and adapt to their own contexts.

The challenge is significant, but the opportunity to make a lasting impact on children, families, and communities makes this work not just necessary, but essential. With thoughtful planning, sustained commitment, and evidence-based implementation, TCCFS is well-positioned to demonstrate that high-quality, stable workforces for in-home mental health services are not just possible, but achievable.

REFERENCES

Aarons G. A., Sawitzky, A.C. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. Administration and Policy in Mental Health and Mental Health Services Research. 33(3), 289–301. doi: 10.1007/s10488-006-0039-1.

Aarons, G. A., Sommerfeld, D. H., Hecht, D. B., Silovsky, J. F., & Chaffin, M. J. (2009). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: evidence for a protective effect. Journal of consulting and clinical psychology, 77(2), 270–280. https://doi.org/10.1037/a0013223

Aarons G.A., Sommerfeld D.H. (2012). Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. Journal of the American Academy Child and Adolescent Psychiatry. 51(4):423–431. doi: 10.1016/j.jaac.2012.01.018.

Adams D.R., Williams N.J., Becker-Haimes E.M., Skriner L., Shaffer L., DeWitt K., Neimark G., Jones D.T., & Beidas R.S. (2019). Therapist Financial Strain and Turnover: Interactions with System-Level Implementation of Evidence-Based Practices. Administration and Policy in Mental Health ,46(6), 713-723. https://doi: 10.1007/s10488-019-00949-8.

Blankertz, L. E., & Robinson, S. E. (1997). Turnover intentions of community mental health workers in psychosocial rehabilitation services. Community mental health journal, 33(6), 517–529. https://doi.org/10.1023/a:1025000703487

Boyas, J. F., Wind, L. H., & Kang, S. (2012). Exploring the relationship between employment-based social capital, job stress, burnout, and intent to leave among child protection workers: An age-based path analysis model. Children and Youth Services Review, 34, 50 - 62.

Bradley, W. J., & Becker, K. D. (2021). Clinical supervision of mental health services: a systematic review of supervision characteristics and practices associated with formative and restorative outcomes. The Clinical Supervisor, 40(1), 88–111. https://doi.org/10.1080/07325223.2021.1904312

Bride, B. E., Smith Hatcher, S., & Humble, M. N. (2021). Trauma, secondary traumatic stress, and burnout in mental health providers working with families in crisis. Journal of Clinical Psychology, 65(10), 1085-1097.

De Vries N, Lavreysen O, Boone A, Bouman J, Szemik S, Baranski K, Godderis L, De Winter P. (2023). Retaining Healthcare Workers: A Systematic Review of Strategies for Sustaining Power in the Workplace. Healthcare (Basel). 11(13):1887. doi: 10.3390/healthcare11131887.

Glebbeek, A. C., & Bax, E. H. (2022). “Is high employee turnover really harmful? An empirical test using company records.” Academy of Management Journal, 47(2), 277-286.

Glisson, C. (2015). The Role of Organizational Culture and Climate in Innovation and Effectiveness. Human Service Organizations: Management, Leadership & Governance, 39(4), 245–250. https://doi.org/10.1080/23303131.2015.1087770

Gooson, B., Mackrin, M., Perry, D., O’Brien, K., & Gwaltney, M. (2013). Enhancing home visiting with mental health consultation. Pediatrics, 132 (2). S180 – S190.

Green, A., Albanese, B., Shapiro, N., & Aarons, G. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. Psychological Services, 11(1), 41-49.

Hallett, E., Simeon, E., Amba, V., Howington, D., McConnell, K. J., & Zhu, J. M. (2024). Factors Influencing Turnover and Attrition in the Public Behavioral Health System Workforce: Qualitative Study. Psychiatric services (Washington, D.C.), 75(1), 55–63. https://doi.org/10.1176/appi.ps.20220516

Haugom, E.W., Stensrud, B., Beston, G., Ruud, T., & Landheim, A. (2020). Mental health professionals' experiences with shared decision-making for patients with psychotic disorders: A qualitative study. BMC Health Services Research (20), 1093. https://doi.org/10.1186/s12913-020-05949-1

Henderson, C. E., Dakof, G. A., Greenbaum, P. E., & Liddle, H. A. (2010). Effectiveness of multidimensional family therapy with higher severity substance-abusing adolescents: Report from two randomized controlled trials. Journal of Consulting and Clinical Psychology, 78(6), 885–897. https://doi.org/10.1037/a0020620

Henggeler, S. W., Sheidow, A. J., & Lee, T. (2009). Multisystemic therapy (MST). In J. H. Bray & M. Stanton (Eds.), The Wiley-Blackwell handbook of family psychology (pp. 370–387). Wiley Blackwell. https://doi.org/10.1002/9781444310238.ch25

Hubel, G., Schreir, A., Wilcox, B., Flood, M.; & Hansen, D. (2017). Increasing participation and improving engagement in home visitation: A qualitative study of early head start parent perspectives. Infants & Young Children, 30 (1), 94 -107.

Kim, H., & Kao, D. (2014). A meta-analysis of turnover intention predictors among U.S. child welfare workers. Children and Youth Services Review, Elsevier, 47(P3), 214-23.

Kleinman, R., Ayoub, A., Del Grosso, P., Harding, K/. Hsu, R., McMillan, G., Mondi-Rago, C., Kalb, M., O'Brien, J., Roberts, J., Rosen, E., & Rosengarten, M. (2023). Understanding Family Engagement in Home Visiting: Literature Synthesis. OPRE Report #2023-004. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Lippens, L., De Clercq, L., Vandevelde, S., De Pauw, S., & Stams, G. J. (2025). Evaluating the effectiveness of intensive family preservation services: A multi-level meta-analysis. Child abuse & neglect, 160, 107198. https://doi.org/10.1016/j.chiabu.2024.107198

Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. Journal of clinical and translational science, 4(5), 463–467. https://doi.org/10.1017/cts

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2021). "Burnout in mental health services: A review of the problem and its remediation." Administration and Policy in Mental Health and Mental Health Services Research, 48(5), 443-457.

Moullin, J. C., Dickson, K. S., & Stadnick, N. A., Borsika, R., & Aaronsm G. (2019). Systematic review of the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. Implementation Science, 14(1), 1-16. Retrieved https://implementationscience.biomedcentral.com/articles/10.1186/s13012-018-0842-6

Moyers, T. B., Houck, J., Rice, S. L., Longabaugh, R., & Miller, W. R. (2016). Therapist empathy, combined behavioral intervention, and alcohol outcomes in the COMBINE research project. Journal of consulting and clinical psychology, 84(3), 221–229. https://doi.org/10.1037/ccp0000074

North Carolina Department of Health and Human Services (DHHS), 2024-2025 Homebuilders RFA, 2024

Novins, D., Green, A., Legha, R., & Aarons, G. (2013). Dissemination and implementation of evidence-

based practices for child and adolescent mental health: A systematic review. Journal of the American Academy of Child & Adolescent Psychiatry, 52(10), 1009 -1025.

Olaniyan, O., Hetland, H., Hystand, S., Iversen, A., & Ortiz-Barreda, G., (2020). Lean on Me: A Scoping Review of the Essence of Workplace Support Among Child Welfare Workers. Frontiers in Psychology. 11, 287. https//:doi.10.3389/fpsyg.2020.00287

Powell, B. J., Waltz, T. J., & Chinman, M. J., Damschroder, L., Smith, J., Matthieu, M., Proctor, E., & Kirchner, J. (2015). A refined compilation of implementation strategies: Results from the Expert Recommendations for Implementing Change (ERIC) project. Implementation Science, 10(1), 21

Radey, M., & Wilke, D. J. (2023). The Importance of Job Demands and Supports: Promoting Retention Among Child Welfare Workers. Child & adolescent social work journal : C & A, 40(1), 57–69. https://doi.org/10.1007/s10560-021-00762-z

Rollins, A. L., Eliacin, J., Russ-Jara, A. L., Monroe-Devita, M., Wasmuth, S., Flanagan, M. E., Morse, G. A., Leiter, M., & Salyers, M. P. (2021). Organizational conditions that influence work engagement and burnout: A qualitative study of mental health workers. Psychiatric rehabilitation journal, 44(3), 229–237. https://doi.org/10.1037/prj0000472

Slade, M. (2017). Implementing shared decision making in routine mental health care. World Psychiatry, 16(2), 146-153.

Scanlan, J.N., Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. BMC Health Serv Res. 19 (62). https://doi.org/10.1186/s12913-018-3841-z

Schoenwald, S. K., Mehta, T. G., Frazier, S. L., & Shernoff, E. S. (2013). Clinical supervision in effectiveness and implementation research. Clinical Psychology: Science and Practice, 20(1), 44–59. https://doi.org/10.1111/cpsp.12022

Steinbrenner J. R., Hume K., Odom S. L., Morin K. L., Nowell S. W., Tomaszewski B., Szendrey S., McIntyre N. S., Yucesoy-Ozkan S., Savage M. N. (2020). Evidence-based practices for children, youth, and young adults with autism. The University of North Carolina at Chapel Hill, Frank Porter Graham Child Development Institute, National Clearinghouse on Autism Evidence and Practice Review Team.

Williams, N. J., & Glisson, C. (2014). “Testing a theory of organizational culture, climate and youth outcomes in child welfare systems: A United States national study.” Child Abuse & Neglect,38(4), 757-767.