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A Case Study on Factors Influencing Retention of Mental Health Clinicians in a New Hampshire Community Mental Health Center

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A CASE STUDY ON FACTORS INFLUENCING RETENTION OF MENTAL HEALTH
CLINICIANS IN A NEW HAMPSHIRE COMMUNITY MENTAL HEALTH CENTER

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by

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This dissertation, by William E. Keating, has
been approved by the committee members signed below
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ABSTRACT

A CASE STUDY ON FACTORS INFLUENCING RETENTION OF MENTAL HEALTH
CLINICIANS IN A NEW HAMPSHIRE COMMUNITY MENTAL HEALTH CENTER

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This study examined the perspectives of master-level clinical mental health providers and

members of leadership at a Community Mental Health Center (CMHC) in New Hampshire, to

understand clinician and leadership perspectives as to why master-level providers choose to

continue working at CMHCs. Most prior research on turnover in such organizations has focused

on why so many leave their positions, however this study instead focuses on factors related to the

decision to stay at a specific CMHC in an urban area of New Hampshire. A single case study

method was utilized to focus on masters-level mental health care providers with additional

interviews with leadership at the CMHC. Some of the findings that will be explored is what

draws providers to community mental health centers, the importance of connections with

colleagues and leadership, and aspects of why master-level providers stay. The study contributes

to the understanding of clinician retention in community mental health centers and provides

recommendations for master-level providers, CMHC leadership, and clinical mental health

educators. Some of the overarching themes that surface from the data were around why

clinicians remain in the CMHC, the reasons why providers do the work they do each day, the

draw to CMHC, and reasons why people master-level providers consider leaving a CMHC.

Connections with leadership and supervisor were very important in why clinicians want to stay at

the CMHC. Licensure contracts were also an area that was explored in this research. Clinicians

and members of leadership provided their perspective on licensure contracts and the

implementation of the contracts. This dissertation is available in open access at AURA

(https://aura.antioch.edu/) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: burnout, case study, community mental health, employee turnover, mental health

professionals, retention, leadership, work life balance

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To my grandmother, Catherine Snyder. This work is built from the support, love, and encouragement you have provided me since the day I was born. Never giving up on me and constantly telling me to aim for the stars! Completing this dissertation and doctoral journey was something that could not have been possible without you providing your love and support. I would also like to thank my husband, Drew Keating, for all his love and support throughout the doctoral journey. This doctoral journey has also been successfully completed due to all my friends and family that have believed in me and shown their support throughout this program. Pushing me to keep going and not giving up on me. I love you all!

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CHAPTER I: INTRODUCTION

This study addresses an increasingly critical shortage of mental health professionals in New Hampshire. In particular, the study has focused on understanding the perspectives of clinical mental health practitioners who decide to remain in Community Mental Health Centers (CMHC). The opening chapter begins by exploring current staffing problems in a single CMHC. Next, I specify the purpose of this research study and then describe my positionality as a mental health professional. An overview of community mental health in New Hampshire follows with the purpose of sharing with the reader a sense of the "actors," the policies and practices, and the context. This includes an overview of the geographic scope of the study and a preliminary sketch of community mental health centers (CMHCs), in NH, the primary institution within which the focus and conduct of this study are to unfold. I then describe staff within CMHCs including the nature of the positions and the expectations and regulations that govern practice. There follows a summary of the research design and a note about the ethical considerations that were anticipated in conducting the research. I conclude the chapter with an overview of the chapters within the dissertation and a brief chapter summary. It is important to note that the CMHCs in New Hampshire are not state run but do work closely with the department of health and human services.

The Current Problems of Staffing at Mental Health Centers in New Hampshire

Recruiting and retaining staff is a significant problem for CMHCs in New Hampshire. Jay Couture (2022), Executive Director at Seacoast Mental Health Center, stated that as of January 2016, there had been 147 position vacancies across the CMHC system. The numbers increased over the next six years and approached an all-time high of 400 in 2022 (Couture, 2022). Throughout the pandemic, the CMHC system has experienced a high level of employee

turnover and even with this turnover, the centers have not closed and have not discontinued providing services. Some have actually added services. Couture went on to report that positions at the CMHC need to be staffed with qualified professionals and enough professionals to ensure that caseload sizes are manageable. She stated that there needs to be more done to recruit and retain professionals for a stronger labor force in the CMHC system (Couture, 2022) and concluded, "We must find ways to implement meaningful and sustainable changes that resolve our workforce challenges. The treadmill is going faster. We must find solutions before we can no longer manage to hold on" (Couture, 2022, para. 9).

Couture (2022) also shared that during the pandemic, supports were put in place to help professionals; specifically, payroll protection loans, stipends for clinical staff, flexible leave for professionals exposed to COVID-19, adjustments to salary, and sign-on/retention bonuses. She discussed the need for sufficient, steady, and maintainable funding to ensure competitive salary ranges and benefits for CMHC employees. Another benefit that the state offers is the State Loan Repayment Program (SLRP), which provides that a portion of student loans will be repaid as long as the recipient signs a commitment letter to the CMHC after receiving the payment. One limitation to this program is only a few professionals can be approved at a time and it is only available to master's-level licensed professionals (Couture, 2022).

Most of the CMHCs experience high staff turnover, which affects the continuity of services for clients. Center leaders also find it difficult to recruit qualified candidates with appropriate credentials that also hold a level of experience. Often, clinical staff are hired by the CMHC, receive supervision for licensure, obtain licensure, receive excellent training and support, and then leave for higher paying positions. Some of the CMHCs are trying to address the problem by having clinicians sign a contract agreeing that if they receive two years of

licensure supervision, they agree to stay with the agency for two years after licensure is obtained. This is one way to address the problem, however it might be just prolonging the problem and not solving it. Even though clinicians stay for an additional two years, often they eventually leave the agency and move on. This study did not explore where clinicians go when they leave the CMHC and was not able to obtain exit interview data in the data collection for the study.

The design of the study includes an inquiry about the characteristics and qualities of a community mental health center that help retention rates of mental health providers. This will allow an expansion of knowledge and understanding around workplace cultural considerations that may or may not be impacting provider retention in community mental health in New Hampshire.

It is also important to look particularly at CMHCs that are in populated areas within the state where turnover is even more of a problem than less populated regions. This may be because providers have more employment options and thus may find it easier to leave the CMHC. This positions this CMHC as a meaningful setting for this study. Providers working in a center that is in a remote area in the state may not have the option to leave for another agency.

Purpose of Study

The purpose of this study is to understand the perspectives of master's-level mental health providers regarding what motivates them to remain employed with a CMHC and to explore related perspectives from CMHC leadership. The mental health field is continuously changing and due to the challenges and growing obligations, it is often difficult for the CMHCs to retain highly qualified professionals. CMHCs are often not properly staffed, which decreases their ability to provide services to the populations they are serving. This study is intended to provide the insight into successful employee retention and effective ways to boost retention.

Positionality of Researcher

I have had a strong interest in employee retention in the mental health field for many years. Since entering the field of mental health and seeing and experiencing the employee retention problem, I have come to believe that the profession needs to take a comprehensive look at the issue. Most CMHCs in New Hampshire require masters-level staff who are looking for licensure supervision to sign a contract. The standard contract requires that they stay at the center for a specified amount of time after they receive their licensure. One of the concerns with that approach is that after most individuals get their licensure, they can and often do finish their contracts and leave soon after for private practice. From my perspective, this model is a temporary fix and does not address the overall deeper problem of retaining mental health providers. This approach only delays the inevitable, which is the employee leaving the center. It does not help the centers in addressing the areas that may be contributing to employee turnover.

I joined the mental health workforce in 2015, after graduating with my Clinical Mental Health Counseling Degree and I have been working in community mental health ever since. I have worked in four different CMHCs, one in Massachusetts and three in New Hampshire. As an intern, I worked with children, families, and adults and then transitioned into working with adults as a full-time therapist. After almost a year and a half, I moved into a leadership role. Coordinating the group therapy program and treatment was the start to my leadership journey and in 2017, I officially accepted a clinical supervisor role, leading two clinical teams. In 2017, I also took a part-time position as an emergency services clinician. This position provides emergency assessments for individuals and families experiencing mental health crises in the hospital emergency department.

Working in different CMHCs and having worked as a clinician and as a clinical supervisor, I have experienced different leadership styles, different perspectives on policy and regulations while providing clinical care to community, and different ways CMHCs address employee retention problems. When I was a clinician, I experienced turnover from a different perspective than I do now as a clinical supervisor. When someone leaves, their caseload needs to be shifted to other providers. Those providers already have a caseload and taking on more cases can lead to an overload. In my experience, when someone resigned from their position and I needed to take on part or most of their caseload there was often no pay increase or recognition for the additional work.

As a former emergency services clinician, I experienced turnover differently. Caseloads did not need to be shifted but the workload would increase nonetheless. For an emergency services clinician, when someone resigns the additional assistance is no longer there and a clinician or two will need to carry a day's worth of extra work. The level can shift from day to day but clinicians will need to address this. As a former clinical manager on multiple teams, working in a CMHC, I experienced turnover differently. Often, I needed to shift caseloads, let the team know, and try to find solutions around the loss of an employee. Another responsibility that a clinical supervisor often has when a provider resigns is finding a new provider and training them in policy, procedure, building clinical skills, and administrative responsibilities.

Changing gears to identity as an aspect of positionality, it is important for me to reflect on my identity and how it influenced me in shaping and conducting this study. As a White homosexual male living in New Hampshire—one of the least ethnically diverse populations in the United States (McCann, 2022), I live and work in a predominantly White context. According to McCann (2022), New Hampshire ranks 47th among states nationally in racial and ethnic

diversity. Thus, most people who were interviewed were White. Due to confidentiality, I will not be providing further demographic information. Even though I am not providing further demographic information on participants (discussed later), I was able to take into account my own privilege. Being a White homosexual male in the United States and New Hampshire, although being positioned with privilege, I have an unseen identity that provides some insight into being an outsider. I anticipated that if I interviewed any people of color, I might be seen as someone with privilege, and the participants of color will likely be weighing if it is safe to provide their racialized experiences to the interviewer. Each CMHC region had a different level of diversity. The CMHC regions where I have worked had very limited diversity.

Being a middle-class member of society and an individual with a master's-level education in clinical mental health counseling with a focus in substance use has allowed me to better understand myself and the impact I want to have on the mental health system. As I grew as a clinician and a leader, I realized that my impact was not going to be mainly as a clinician working with individual clients but as a leader working to strengthen leadership in the overall system.

When I was working as a mid-level manager at one CMHC, I had limited decision-making influence over how I lead my team and provide services to the clients. As one climbs the ladder and moves into higher positions, it is common that decision-making ability grows. When a professional's role and position grow, as the leader they then have greater influence over the system.

Insider and outsider status is important for research and the researcher to reflect on when performing research, specifically around experience, membership status with regarding groups, and roles within those groups. It is status in relation to the participants of the study. I was

considered to have insider status due to being a clinician, a clinical manager, and possessing experience in multiple CMHCs (Dwyer & Buckle, 2009). Being an insider allows the researcher to have an in-depth understanding about culture and a perspective on the situation being studied that an outsider researcher is unlikely to possess (Kerstetter, 2012). It is also important to note, that as a researcher I was marginally an outsider having never worked at the agency that is the focus of this study.

Overview of Community Mental Health in New Hampshire

It is important to recognize that the United States has a unique emphasis on allowing each state to govern its own mental health system. Since each state has its own department of mental health that governs the mental health services within that state. New Hampshire's mental health system is made up of 10 CMHCs, several private practices, and other facilities associated with education systems and general practice health systems like primary care physical health providers. As someone who has worked in the CMHC system in New Hampshire, it is important to mention that the clinical work is hard due to the mission of the CMHC system and it being around seeing anyone in the catchment area that the CMHC is designated to serve. The acuity level is typically quite high, which contributes to the work being more difficult.

The Legal-Regulatory Framework for New Hampshire's CMHCs[1]

The CMHCs provide mental health and substance use treatment to individuals and families. Each center is responsible to offer treatment to eligible clients, families, and children that live in the region. Each region comprises roughly 20 to 30 towns and is defined as a catchment area. Each CMHC provides individual therapy, group therapy, psychiatric services,

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[1] This section relies on the regulations in the administrative code for Community Mental Health in New Hampshire. These are contained in Chapter He-M 400 Community Mental Health, Part He-M 401 "Eligibility Determination and Individual Service Planning." Specific sections of this code are cited here as "NH Ch. He-M 400, Part He-M 401.*x*" where x is the specific subsection of the cited information within the code.

case management, functional support services, and supported employment assistance to their consumers. According to the State's enabling legislation for CMHCs in New Hampshire, they can provide treatment in homes, community, and at the CMHC (NH Ch. He-M 400, Part He-M 401).

Each CMHC is a non-profit that is governed by a board of directors. This board helps the CMHC make decisions in accomplishing their mission. Every CMHC in New Hampshire has multiple contracts with the state Department of Health and Human Services. An example of such an expectation across every CMHC is that every center needs to house and implement an Assertive Community Treatment Team, a form of treatment that is provided to individuals who are at risk of repeated hospitalizations, incarceration, homelessness, and unable to function in community with multiple supports from the treatment team (NH Ch. He-M 400, Part He-M 401.06(a)(6) c).

Approval and Operation of Community Mental Health Center

The Community Mental Health Centers plan, establish, and sustain programs and services for consumers in their region of the state. CMHCs are able to access limited funding provided by New Hampshire Department of Health and Human Services to launch and maintain new program initiatives that can help clients in their recovery. Federal funding, private sources of funding, and third parties are also utilized for funding the work of the CMHC (NH Ch. He-M 400, Part He-M 401.05[c]).

It is expected that the CMHC treatment programs build on patient strengths and decrease the negative effects of mental illness. It is also expected that the treatment program will increase the patient's capacity to manage their symptoms and help promote and increase supports (NH Ch. He-M 400, Part He-M 401.05[d][3]). The CMHC treatment programs provide an intake

assessment, which assists in determining level of care, treatment modalities, risk factors, and consumer eligibility. Once eligibility is determined, plans for the patient's specific needs are formalized. This might include case management, individual counseling services, individual employment services, emergency services, and individualized collaborative service formation and monitoring (NH Ch. He-M 400, Part He-M 401.04[2]).

Approval of CMHC certification comes with requirement for a site visit after an application is submitted to the Bureau of Mental Health. The application requires demonstration of the CMHC's ability to provide services, while also documenting the need for services to potential consumers. The application also includes a line-item budget. Approval of CMHC is for a five-year term, unless certification is suspended or retracted. Re-approval consists of a self-evaluation of the CMHC current abilities to carry out its programs and also of its performance in carrying out those programs. Re-approval also requires a record of unmet service needs in the catchment area. A copy of the mission statement is also required and should guarantee compliance with federal and state laws (NH Ch. He-M 400, Part He-M 401.04[11]).

Consumer Eligibility

Individuals and families who seek treatment at a CMHC in New Hampshire need to go through an intake process and meet eligibility requirements. Adult eligibility is determined by assessing functional impairments due to mental illness such as activities of daily living, interpersonal functioning, adaptation to change, and concentration and task performance. Eligibility is also determined using a specific mental illness diagnosis such as schizophrenia and other psychotic disorders, mood disorders, borderline personality disorders, posttraumatic stress disorder, obsessive-compulsive disorder, panic disorder, and eating disorders. It can also be determined with a diagnosis of dementia wherein the person is seen as impaired because of

psychiatric symptoms, and is also anxious, depressed, delusional, hallucinating or paranoid (NH Ch. He-M 400, Part He-M 401.[04]).

Eligibility criteria for children include being under the age of 18 and diagnosed with a serious emotional disturbance, substance use, or thought disorder. The child needs to be experiencing serious problem with school or work and facing concerns with behavior toward others or themselves at home or in the community (NH Ch. He-M 400, Part He-M 401.[08]).

Staffing at the Community Mental Health Center

Each CMHC is required to generate job descriptions, staffing formations, employment conditions, employee performance evaluations, and employee development plans. Each is staffed with an executive level of leadership, specifically a chief executive officer and possibly other executive level positions. The CMHCs have boards of directors to oversee the mission and direction of the center. Working down the organizational hierarchy from the Board, next is the director level, staffed by professionals who lead departments of the CMHC such as finance, clinical services, administrative duties, quality assurance and improvement, and information technology. Supervisors are the next level down in the organization, leading clinical teams and responsible for quality assurance, finance, and other areas in the center.

The level before supervisors and leadership in the CMHC organization are the direct clinical staff, including functional support workers, case managers, employment specialists, and health mentor workers. Another clinical position in CMHCs are master's-level therapists. These therapists can possess different educational backgrounds, specialty of practice, and licensure. Finally, among clinical staff are those that prescribe medications such as psychiatrists and nurse practitioners. Other professionals that work in the CMHC include administrative support staff,

such as quality assurance workers, front desk workers, administrative assistance, and other professionals who support the clinical staff in providing care to the consumers.

Expectations and Regulations of Clinical Staff in Community Mental Health Setting

This section is an overview of contextual factors related to CMHCs in New Hampshire. It reviews current state regulations related to CMHC. Unfortunately, the community mental health center policies were not available for review. Each center has its own policies and expectations that are contextual to their experiences, which vary from center to center. These experiences continuously shape the mental health providers and the mental health centers, while also shaping state regulations (NH Ch. He-M 400, Part He-M 401.07).

Each CMHC clinical provider is expected to see and treat a specified number of people in a week. This is formally called *productivity within* and all therapists, medical providers, case managers, and functional supports face that expectation. Productivity expectations tend to vary from position to position and can also vary from center to center. Paperwork expectations are standard across all 10 CMHCs in New Hampshire. Intakes are performed and documented by the master's-level clinician. The intake is initiated by an individual or family seeking services and completing an application for services. Once eligibility is determined and services are prescribed, providers will be connected to the individual or family, specifically for psychiatric services, individual therapy, group therapy, functional support services or case management. From the intake, an individualized service plan is completed and signed off by a prescriber (NH Ch. He-M 400, Part He-M 401.10). This plan prescribes what treatment an individual or family will receive and the frequency and duration of service that will be provided. Every three months after the intake, an "Adult Needs and Strengths Assessment" or, for minors, a "Child Adolescents Needs and Strengths Assessment" is prepared. This helps to determine progress in treatment and to

make sure that the goals and objectives on the treatment plan are still relevant. Annually, the client receiving services needs to have a redetermination of eligibility completed if they are to continue receiving services at the CMHC (NH Ch. He-M 400, Part He-M 401.04[d]).

Providers are also required to complete session notes after all services that are being provided. When a provider takes further action outside a session such as making phone contact, holding meetings about the patient, or any other tasks or contacts that may be completed outside a session, records are to be kept (NH Ch. He-M 400, Part He-M 408). Other forms of paperwork that are required are annual releases of information for primary care physician, emergency contact or anyone else the individual may want their provider to contact. Additional forms that are required are covered by a confidentiality agreement and client rights, and responsibilities are forms that need to be addressed annually (NH Ch. He-M 400, Part He-M 408).

Research Design

The case study is an empirical method used to examine a phenomenon in depth, looking at the varying perspectives of that phenomenon. This methodology is used when researchers want to understand or better understand real-world situations in detail (Yin, 2018).

The single case study method was selected for this study due to its ability to focus on situations that affect individuals, groups or organizations (Yin, 2018). This research design includes interviewing clinical staff and leadership at one CMHC in New Hampshire. Case studies also help to focus on current events (Yin, 2018), in this case, specifically employee retention. In this single-case study design, interviews were conducted to understand cultural considerations and other factors that motivate master-level clinicians to stay employed at the CMHC.

Case study methodology also fosters a deeper understanding of the culture that is associated with retention of staff in CMHCs in the state of New Hampshire. I reviewed publicly available information on the CMHCs but was unable to retain metrics of retention.

This study focused on retention of clinical staff at one of the CMHCs in New Hampshire. The participants in this study were master's-level clinicians who are working full-time or part-time at the CMHC. The study also looked at leaders at the CMHC and their perspective on retention of staff. Data was collected through individual interviews, both in person and over Zoom, a video conferencing platform. The data was analyzed using a thematic analysis approach (Clarke et al., 2015). Each interview was transcribed and then each transcript was coded. This allowed me to identify key words, beliefs, or perceptions from the data and to explore emergent themes.

Geographic Scope and Setting of the Study

This research is about staffing features and challenges at CMHCs in New Hampshire. It focused on one CMHC in the state. New Hampshire has 10 regions; I decided to focus on a more populated region due to the ability for providers to have more employment options to choose from if they decide to leave the agency. I also chose this particular region because I had no employment history with that agency. As I will discuss in Chapter III, I decided to focus on the retention of master's-level professionals and their experiences. From my professional perspective, the experiences of bachelor level and doctoral level practitioners are different and should be addressed in separate studies that focus on those populations.

Interviews were conducted with this CMHC's master's-level mental health providers, senior members of leadership, human resources manager, clinical directors, and clinical supervisors to help understand the culture around what helps providers at CMHC in New

Hampshire remain working in the agency. The interviews were recorded and transcribed followed by researcher coding. An expanded discussion of the research methods will be presented in Chapter III.

Ethical Issues in the Proposed Research

The most important anticipated ethical consideration arises because I have worked in the mental health field in New Hampshire for eight years. I have worked at three CMHCs in that time. Since I have worked at multiple centers, it is ethically appropriate to ensure that the performed study did not take place in any of the centers that I have worked previously. Currently, there are 10 mental health centers in New Hampshire and I purposely chose one in which I had not been employed. A full discussion of the ethical issues and the steps I took to meet these in a way that protects both the participants and their patients will be presented in Chapter III.

<div align="center">

Chapter Summary and Outline of Chapter II

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In this chapter, I began by introducing current problems of staffing at CMHCs in New Hampshire, focusing on issue of turnover in and its impacts on the system. Subsequent sections introduced the study's purpose and my positionality as researcher, followed by quite detailed account of the nature and regulation of community health in New Hampshire. The latter section comprised the legal-regulatory framework generally, how approvals and operations proceed at CMHCs, consumer eligibility, staffing overview, and expectations and regulations of clinical staff in the New Hampshire community mental health setting. The discussion then moved to the research design including the geographic scope of the proposed research.

The literature review in Chapter II, is organized under three main themes. The first section explores interventions that can be applied when addressing employee turnover. The

second section reviews factors that are often connected with employee turnover. The last section considers positive culture in the workplace environment. To better understand retention of staff, it is important to understand employee turnover and the conditions of turnover. Understanding the turnover and interventions can help to understand increasing retention. The literature review chapter will explore and define turnover interventions, characteristics of turnover, and qualities of a positive workplace.

In Chapter II, I also explore how New Hampshire defines community mental health, current staffing patterns and the populations they serve in the state. Later in Chapter II, the literature review will describe the themes that surfaced from that review. "The Great Resignation"[2] (Cohen, 2021; Fox, 2022) is an important dimension of turnover and the current situation that is occurring in the workforce. Chapter II also discusses the gaps in the current research and how the dissertation contributes to addressing those gaps in the research. Chapter III presents in detail the methods I have chosen for the proposed research, centered on the single case study approach using interviews and thematic analysis of these interview data. Ethical considerations will be thoroughly addressed in Chapter III.

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[2] The originator of this phrase was a Texas A & M management professor, Anthony Klotz, who introduced it in an interview with *Bloomberg Businessweek* (Cohen, 2021).

CHAPTER II: LITERATURE REVIEW

In this chapter, I explore definition of terms, explain my literature search approach, provide the results of the literature review, and discuss how the public health crisis influenced and continues to influence mental health providers. This chapter also includes an overview of the specific problems surrounding "the Great Resignation" during the 2020 pandemic. Gaps in the research are identified with a summary of possible interventions that may be utilized to address employee retention in community mental health centers.

Literature Search Approach

The goal of the search process was to identify areas of the literature that can be built upon while also identifying gaps in the literature. In conducting this literature review around turnover, I determined that there was significant research on turnover but very little on why professionals stay. So I share this research on turnover as a foundation for the emergent research question that framed this research study regarding why master-level providers choose to stay employed at CMHC. The literature search for this dissertation was performed using the PsycINFO database at Antioch University. The search began with a broad scan of articles about the following:

- Employee turnover, turnover, employee retention, labor turnover, burnout.
- Mental health institutions and their challenges.
- Studies of organizations, including community mental health centers, mental health organizations, and clinics.

The search was extended from the articles that were discovered in the original search based on a rationale of including articles on turnover broadly, how burnout can potentially impact staff turnover perspective, and on interventions to reduce turnover and burnout.

The articles eventually chosen for this literature review were selected from approximately 100 articles that were originally reviewed from the search. After reviewing a range of articles with different methodologies, my focus was to find articles that provided solutions to the employee turnover problem in mental health systems. I found that qualitative articles appeared to present more details around the problem of turnover and were able to conceptualize possible solutions. I did not exclude any articles based on methodology, but the focus was on increasing retention and possible solutions for increasing retention.

Literature Flow and the Organization of This Chapter

The remainder of the chapter is organized according to the flow of the subjects that eventually emerged in the literature search. This is summarized in Figure 2.1. It should be cautioned that often a publication about the mental health care turnover addresses several of the other dimensions portrayed in Figure 2.1; for example, it may explain why turnover is happening, what the effects are, and what steps may mitigate turnover, all in one paper. However, it is helpful for organizing ideas about the proposed research and preparing to structure questions to eventual participants to use the breakdown of causes, consequences, and remedies to discuss each separately here.

I begin—as was more briefly done in Chapter I—looking at literature that examines the significant challenges of turnover and retention in mental health care generally, including in the United States. This section will conclude that the understandable priority for global research on mental health sector turnover has been in rural/remote and less-developed areas. However, this focus leaves a gap of research about the same issue which is also faced in more urban and developed settings. That gap is what my study addresses.

Next in this chapter, literature about the factors or influencers that cause and exacerbate turnover is reviewed. A central theme that emerges is around *burnout*, why it happens, and what its consequences are, especially in mental health organizations. Literature that more broadly surveys other factors contributing to staff turnover is also reviewed and it will be seen that almost any such other factors can make burnout worse and result in more turnover. There is special attention to what has recently been called "the Great Resignation" that arose in connection with the COVID-19 pandemic (Cohen, 2021; Fox, 2022).

The following section reviews the *consequences* for mental health care organizations of turnover. Then, the chapter turns to interventions that can mitigate and reduce employee turnover issues. I conclude with a survey of works related to the broader context of organizational cultures and climates that impact turnover whether reducing or exacerbating it. They show, unsurprisingly, that a positive climate can help reduce turnover while a negative one makes turnover worse.

Figure 2.1

Flow of Literature Review
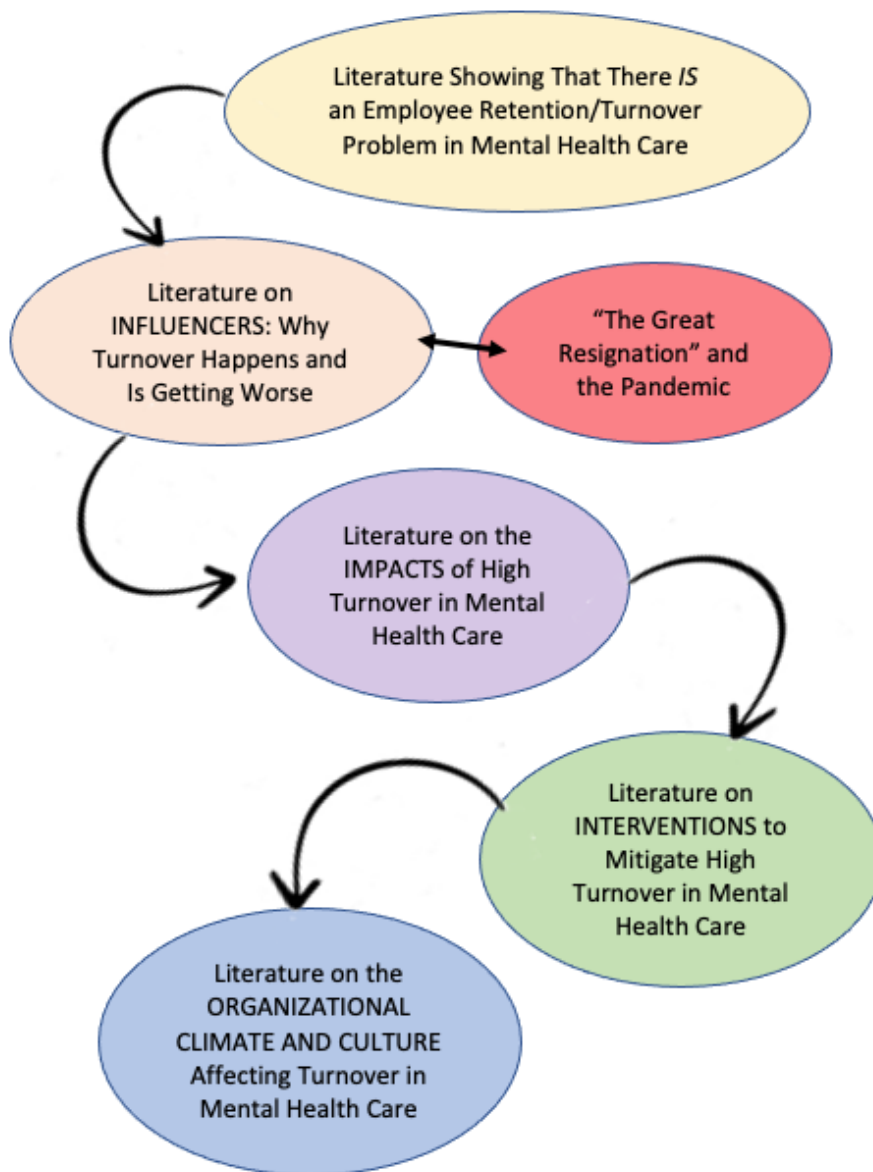
Note. Copyright by author.

Is There a Problem? Employee Retention and Turnover in Mental Health Care

The existence of a deepening crisis, specifically within mental health care organizations in New Hampshire, was highlighted in Chapter I with the observations made by Jay Couture (2022). She warned that workforce maintenance problems were like a treadmill moving ever

faster: "We must find solutions before we can no longer manage to hold on" (Couture, 2022, para. 9).

My literature review made it apparent that what is faced in New Hampshire is not only a national (Hoge et al., 2013; U. S. Department of Health, 2017) but a potential worldwide crisis (Saraceno et al., 2007; World Health Organization, 2007). Hoge et al. (2013) cited the alarming figure that "only 39 percent of those with mental health conditions obtained care" (p. 2005). From all corners of the globe, mental health care institutions are encountering staff turnover and, in many cases, unfilled needs, that put the mental health of many populations in jeopardy. This is probably most acute in many developing countries (Desjarlais et al., 1995; Saraceno et al., 2007) and in remote areas worldwide. For reasons beyond the scope of this review, many workers, especially professionals, prefer to move to the cities and similarly leave from developing countries, in the "brain-drain" to the West which affects mental health care no less than many other sectors (Oladeji & Gureje, 2016). Cosgrave et al. (2015a, 2015b) have thoroughly assessed the problem in rural Australia, studies that I will come back to below.

After an extensive literature review and looking at the publication dates, it appears that the subject of turnover and retention became a major focus in the late 1990s and early 2000s. Losing skilled employees for whatever reason has always been a concern of organizations whether in the private or public sectors. Several papers that explicitly deal with employee turnover can be found in the early decades of the 20th century (e.g., Diemer, 1917; Eberle, 1919). But as the century unfolded, it appears that across all sectors of society, employees were choosing to leave the safety of lifelong employment and to move both within and between employment sectors. Studying hospitals and employee retention but with a conclusion that seems

to apply much more broadly, McGuinness (1998) concluded, "The old employment contract is null and void" (p. 45).

Cultural Perspectives on Turnover

Employee turnover is defined in Australia and New Zealand as the voluntary or involuntary departure of their employment. Turnover is viewed as being harmful to agencies in many ways, one way is the workload shifts to other employees and adds to their current workload. Turnover can also lower team morale and an employee's sense of fulfillment in their work, which can then lead to burnout (Bukach et al., 2017). Mental health providers, who work in rural regions in Australia and New Zealand typically, gain a larger range of clinical and managerial skills due to caseload demands and the severity of cases (Bukach et al., 2017).

In Australia and New Zealand, addressing employee turnover is done by exercising flexibility with work schedules, which can help assist employees with work life balance. Organizations should focus on the significance of work-life balances and how it can positively impact employee turnover. Employees today are voicing their need for work-life balance and needing to balance their home life, work, physical and mental health, along with their other obligations. Professionals also want to ensure they have time for socializing and engaging in activities of relaxation (Timms et al., 2015).

Another method for addressing employee turnover in Australia and New Zealand is to build and strengthen strong working relationships. Building these kinds of associations can help promote individual growth, collective knowledge, and overcoming potential barriers that may be experienced by providers. Maintaining a supportive working environment, employees often feel a sense of satisfaction and a decrease in distress. When employees experience job fulfillment, it

can at times prove to be an indicator for employee retention, however this should not be the only tool used to predict employee retention (Timms et al., 2015).

Many organizations in Australia and New Zealand want to improve work-life balance and often focus on a few different areas. First, organizations can provide, daycare, dry-cleaning, or a gym or fitness room (Brough & O'Driscoll, 2010). A potential benefit that can help combat employee turnover is looking at different benefits that can be utilized by the individual employee and the employee's family. Another focus could be time-off, another could be flexible hours that allow the clinical provider to practice work-life balance (Brough & O'Driscoll, 2010).

A second major theme is organizations who promote autonomy in the jobs that are being performed. It is also important to understand that the work/life conflict that some experience, is a struggle that can occur internally. At times, it can feel like a poor fit between employer and employee. This can arise in a number of different ways, one being that partaking in one responsibility is more difficult or needing to pick a role that are equally important (De Cieri et al., 2005). Another conflict that could provide insight into feeling that the role or employer fit is not suitable to what the individual is needing can be not feeling supported when needing to take care of a loved one or raising your child or any other difficult life occurrence that may take place (De Cieri et al., 2005). It is important for organizations to "take the temperature of the room" on a routine basis, specifically to gain awareness around the ever-shifting needs of the employees. When an organization looks at how to increase their employees' drive, commitment, job gratification, and stress levels, it can improve retention and recruitment (De Cieri et al., 2005). By implementing flexibility through telecommunication, part-time work, sharing job responsibilities, potential leave options can help create and sustain work-life balances for employees and help improve retention.

In the United Kingdom, employee turnover has very negative effects on patient treatment, often interrupting services and frequently negatively influencing the therapeutic relationship with future providers (Blankertz & Robinson, 1997). Blankertz and Robinson (1997) reported that provider turnover is often associated with low levels of flexibility in a job and experiencing a bad fit with the immediate supervisor, which usually was experienced as a lack of support. Recruiting and retaining mental health providers is a concern in the United Kingdom. Turnover rates in social work, community mental health, and child welfare can range from 30% to 60% from year to year. Provider turnover can negatively impact stability of treatment and influence uncertainty on an organization. One way to impact organizational instability is the financial safety of the organization (Blankertz & Robinson, 1997). Providers generate revenue for an organization, if there is continuous turnover in the organization that can influence the revenue stream. It is believed that burnout is a consistent factor to provider turnover in the United Kingdom.

One strategy suggested by Paris and Hoge (2010) to help address employee turnover is to ensure competitive salaries, incentives around benefits and non-monetary incentives, opportunities for professional growth and advancement, funding for increasing staffing to address needs, ability to practice self-care, work-life balance, clinical supervision, flexible work schedules, informal and formal support networks, and ability to speak directly with leaders (Paris & Hoge, 2010). It is believed that organization leaders need to understand what motivates their providers, knowing what draws them to enter the field of community mental health and what motivates them to remain in the field of community mental health. These areas can help with recruitment and retainment of providers (Blankertz & Robinson, 1997). Once senior leadership can distinguish what motivates their employees, they need to integrate interventions that can increase enthusiasm and fulfillment in the employees' work. Incentives can be observed as

competitive wages and benefits, stimulating work, well-defined job descriptions, opportunity for professional growth and training, and job security (Blankertz & Robinson, 1997).

Making sure strategies are assembled into the organization and policies can assist in reducing provider burnout. Integrating mentoring opportunities can also help to increase support in the agency and employee retention. (Blankertz & Robinson, 1997) An important intervention that could help decrease employee turnover is implementing a system where the employee gets feedback on a routine basis and the employer receives feedback on a routine basis. This can help to ensure that open communication is part of the culture and system at the CMHC (Martin & Schinke, 1998).

Factors Contributing to Why Turnover Happens

Voluntary departure from a mental health care position, as in any professional work, can be because of a more positive opportunity elsewhere (inside or outside mental health care) or because of negative factors in the current position (Aarons & Sawitzky, 2006). There is little that a mental health center can do about the lure of other employers except to make their own institution a more attractive workplace. I will come to such possibilities below in reviewing the climate and culture of organizations. In this section, I focus more on specific negative forces that contribute to turnover. The concept of "burnout" is important because it brings together several related shortcomings that can make quitting the most attractive option.

Employee Burnout

In scholarly research,[3] the metaphor of employee "burnout" was first applied to working situations by Freudenberger (1974) almost half a century ago to describe the mental hardships

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[3] According to O'Connor et al. (2018), the first ever use of the metaphor of "burning out" in relation to one's work was by novelist Graham Greene in the story of an architect "who could no longer find meaning in art or pleasure in life" (p. 74). Greene wrote *A Burnt-Out Case* in 1961.

most any kind of job can involve. Though he first named the phenomenon while studying what he called an "alternative health care agency" (by which he meant one not primarily run by government), Freudenberger admitted that he had himself gone through such strains and loss of enthusiasm. The concept has quickly moved from its inception to becoming an almost universally recognized phenomenon in every conceivable profession and as widely used in everyday settings as by scholars. Thus, there are both lengthy academic reviews and metanalyses (Alarcon, 2011; Maslach et al., 2001) and countless mass market books that talk about burnout to a general audience (e.g., Nagoski & Nagoski, 2020; Parker et al., 2021).

It is important to recognize that burnout is a term for an aggregate of symptoms and issues that can diminish employee's capacity and their willingness to continue in their position. Maslach and Jackson (1981), for example, proposed three dimensions of burnout—emotional exhaustion, depersonalization, and personal accomplishment. Lizano (2015) described Maslach and Jackson's dimensions as follows:

> Emotional exhaustion is the central dimension of burnout, marked by feelings of being depleted because of chronic exposure to job stress. Feelings of emotional exhaustion then lead to the worker distancing himself or herself from clients, becoming cynical and detached. The third dimension, personal accomplishment, refers to feelings of ineffectiveness in the workplace regardless of the effort exerted. (p. 168)

Morse et al. (2012) reviewed the problem of burnout in the context of the mental health field, noting the irony that "the mental health field has paid relatively little attention to the health and well-being of its own workers" (p. 348). They suggested several important directions for researchers to take to develop a better understanding of burnout in the field. They especially emphasized the need for "organization-level interventions" (Morse et al., 2012, p. 349) which I will come back to in the concluding topic of this literature review which is on organizational climate and culture. O'Connor et al. (2018) conducted a thorough review and meta-analysis of 62 studies on burnout of mental health professionals, concluding, "Work-related factors such as

workload and relationships at work, are key determinants for burnout, while role clarity, a sense of professional autonomy, a sense of being fairly treated, and access to regular clinical supervision appear to be protective" (p. 74).

Other Causes of Turnover

To design the semi-structured interview questions I plan to use, it is important to go into this work with some foreknowledge of the other reasons mental health workers may have for leaving. But it is essential to recognize that any of the specific factors that may be given as reasons for turnover can exacerbate burnout. The factors can be separated for discussion purposes; however, the mental health care worker can experience a number of these factors together and that can make them want to work elsewhere.

Compassion Fatigue. The concept of "compassion fatigue" is especially hard to isolate from burnout (Newell & MacNeil, 2010). At the core of this concept—and related ones variously called "secondary traumatic stress disorder," "vicarious trauma," and "secondary victimization" (Figley, 1995, p. 1)—is the tendency for those who give care to others to end up with the emotional burdens that their patients were suffering (Herman, 1992). Any good mental health care worker needs to possess empathy to understand and/or feel to some degree what their patients are experiencing. However, the line can easily be crossed where so much trauma is taken on that the worker is too affected to be able to really help anymore. Bride et al. (2007) have explained this dilemma powerfully:

> Effective trauma treatment often involves assisting the individual to work through the traumatic experience, a process in which the client repeatedly recalls memories of the event in order to bring closure to the experience. Through this process, the clinician is often repeatedly exposed to traumatic events through vivid imagery. It is now widely recognized that the indirect exposure to trauma involves an inherent risk of significant emotional, cognitive, and behavioral changes in the clinician. (p. 155)

Rossi et al. (2012) described compassion fatigue as a state of feeling overly stressed, anger, moodiness, and possibly feeling emotionless towards aspects at work. In my proposed work, I will be especially interested but also expect to find it challenging to find ways to broach this influencer through interviews. This also is one of the reasons (as will be more directly discussed in Chapter III) for choosing a qualitative approach; learning about compassion fatigue through objective surveys is not likely to probe this very thoroughly.

Inadequate Remuneration and Benefits. It almost goes without saying that employees are affected in terms of their willingness to stay or leave by their level of earnings and other financial related benefits of the position. As mentioned, overly demanding caseloads may cause burnout but even when that syndrome is not reached, mental health care workers may simply look at what is being asked of them as needing fairer compensation. The risks they face and the expertise they must develop are high; not getting paid well for bearing such a burden eventually will mean looking at more remunerative work especially as workers get older and have to think how impossible it may have become to care for patients and want out.

Sokolová et al. (2016) looked at labor turnover across several occupations in the Czech Republic and found that perceived inadequate salary and benefits were the leading cause of turnover. Holmberg et al.'s (2016) Swedish research likewise determined that job satisfaction and dissatisfaction among mental health staff were very closely related to salary levels. Studies have been done in the United States that also show a correlation between perceived low wages and turnover although these have focused on entry level workers (Bukach et al., 2017) or on home care workers (Howes, 2008), for whom pay is notoriously low. What the role of wage levels will be for turnover among professionals whose remuneration is higher than such workers is one of the issues that my proposed study may shed some light on.

Case (Over)Load. Another significant cause of turnover in the mental health sector—one that I have personally seen unfold over and over in organizations I have worked with—is overworking by assigning an almost impossible workload to employees. The question of optimal and feasible caseloads blurs into discussions of burnout and emotional exhaustion. Even when the employee does not reach that stage, they may feel simply too swamped to provide the quality care their patients need and that they, as helpers feel driven to provide.

In my literature search, I encountered few studies that separated the issue of excessive caseloads from broader assessments of burnout and emotional exhaustion as causes of turnover. Happell et al. (2012), who reviewed the literature on community mental health nurses concluded, "Although heavy caseloads seem to be common among case managers, the research in this area is quite weak" (p. 131). Some attempts have been made to study the correlation between care providers' sense of personal efficacy and the feasibility of their caseloads which means, basically, providing sufficient time to do the work each patient requires (King et al., 2000). King et al. (2000) found that higher caseloads correlate with a lower sense of personal efficacy for mental health case managers, which they interpreted as meaning that overload led caregivers to feel they could not meet patient needs in time available. This strain on personal self-efficacy undoubtedly leads many mental health workers to consider leaving their current positions.

Lack of Opportunity for Career Advancement. Finally, turnover rates can rise because many institutions may knowingly or unknowingly fail to provide prospects for advancement. Feeling stuck in one's current position without prospects for new and more demanding case work is a recipe for what has been popularly labelled "bullshit jobs" (Graeber, 2018, book title). Watanabe-Galloway et al. (2015), who conducted surveys among mental health care workers in

Nebraska on "barriers and promoters of retention," found that career advancement opportunity was among the most important factors affecting commitment to stay in one's position.

The Ongoing 2020 Pandemic, "The Great Resignation" and Related Effects on Turnover

For anyone working in mental health care, the 2020 (and beyond) COVID-19 pandemic greatly heightened the problems of turnover and overload. On one hand, the incidence of mental health issues skyrocketed which meant that mental health organizations were even more strained with the demand for services than they had been previously. Panchai et al. (2021) reported that as the pandemic took hold, about "4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder . . . up from 1 in 10" (para. 1). And they predicted, based on the mental health impacts of other disasters, that these effects could remain throughout the 2020s. An ever-increasing literature is now assessing implications specifically to mental health care capacity. Moreno et al. (2020) called attention to the "unpredictability and uncertainty of the COVID-19 pandemic; the associated lockdowns, physical distancing, and other containment strategies; and the resulting economic breakdown could increase the risk of mental health problems and exacerbate health inequalities" (p. 813). These authors laid out a multi-pronged overall strategy for trying to cope with the added demand.

The pandemic has greatly influenced the disparities in the social and economic areas within society, which could be potentially contributing to a higher need for behavioral health services in people who already suffer from severe and persistent mental illness. The need for behavioral health services continues to grow as the pandemic lingers on (Morse & Dell, 2021). One of Morse and Dell's (2021) recommendations was to identify the challenges and successes that mental healthcare workers face during the ongoing public health crisis. Some challenges were identified by behavioral health workers during the public health crisis as feeling distressed

and overwhelmed due to interruptions in day-to-day schedules, feeling concern for their health and their loved ones' health.

Morse and Dell (2021) further outlined how mental health providers are experiencing obstacles to working remotely, specifically practicing balancing work and life obligations and maintaining the borders between work and home. Another area that was challenging for behavioral health workers during the public health crisis is the deficiencies of resources, both internally and externally. Technology was a barrier for a lot of providers, as well as IT support, PPE supply limitations, and sufficient office supplies for home and the office.

Screening patients and providers has been an additional burden, as well as needing to assess how to provide services and still effectively address the patients' needs. Providers and leadership needed to learn how to adjust plans and schedules, practicing being flexible, and finding solutions for problems that have not been experienced in history (Sklar et al., 2021). Some solutions to help providers through the public health crisis when helping patients, an increase in salary as well as understanding and compassion from colleagues and leadership is also something that was suggested in addressing distress and burnout of mental health providers. Another area for addressing the public health crisis and how it relates to mental health providers is ensuring that communication is succinct and consistent (Morse & Dell, 2021)

All of these have heightened the demand for mental health care while, concurrently, the "supply" side of mental health care has also been negatively affected: Especially given the added workplace stress, the sector has also been impacted by what organizational psychologist, Anthony Klotz, has called "the Great Resignation" (as cited in Fox, 2022). Cohen (2021) spoke of the "great post-pandemic resignation boom" (The Great Resignation has changed the workplace for good. 'We're not going back,' says the expert who coined the term) and Maurer

(2021) as the "turnover tsunami" (Turnover 'Tsunami' Expected Once Pandemic Ends). Record numbers of employees in all sectors have been resigning from health sector jobs in what Hyman (2021) referred to as "burnout: the other pandemic" (p. 673). According to Klotz (as cited in Fox, 2022), during the pandemic, many working professionals took a hard look at what was important to them and what they really valued in life. and decided to make a change, which was often to resign from their positions or even leave their field altogether. In August of 2021, 4.3 million Americans resigned from their jobs or left their designated professions all together, while resignation rates increased to 2.9% (Fox, 2022). Significantly—as will be addressed below in discussing interventions to decrease turnover— individuals are now looking for a work-life balance and how that can fit into their life. The pandemic has increased awareness around the importance of mental health, work-life balance, and family. In my proposed study and specifically in the interview structure, I plan to address the conundrum of COVID-19 increasing the need for mental health care organizations yet the concurrent strain on the organization and career change plans among its personnel.

Impacts of Turnover

The effects of high and ever-increasing rates of turnover in mental health care institutions is nothing less than an erosion of the ability of such places individually and collectively to help those who need it most. The financial costs alone are troubling because turnover means that the institution's funds must be diverted to new recruitment and on-the-job training. Gitter (2009) estimated that in some mental health care facilities, such financial costs can demand up to 20% of the overall operating budget. Gitter found that the costs of replacing a case manager in an Ohio mental health facility was close to $4,000 annually per employee, while a study in Iowa put the turnover cost as equivalent to one-fourth of overall salary costs (Iowa Department of Public

Health, 2011). Overall, the Iowa analysis concluded that, in 2016, the costs of staff turnover to the system ran to $234 million.

The impact of high rates of turnover in mental health care go well beyond what can be measured in dollars, however. The priority concern must be the quality of the services to patients as well as implications for morale among teams of mental health care workers. Merrifield (2015) called attention to the *UK Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (2015) which demonstrated a strong link between staff turnover and mortal risks to patients. Its lead author stated, "High staff turnover could compromise safety in that frequent changes of staff are likely to disrupt the continuity of care of vulnerable patients" (as cited in Merrifield, 2015, para. 9).

Just as poor morale exacerbates staff departures (Ben-Dror, 1994), a vicious circle is completed by lowered morale making an unstable work force. The worse the erosion of camaraderie on teams who must function well together, the less attractive it is for any individual who are still working on the team. Add to this the tangible stresses and strains on staff that is already working to cover the responsibilities of departing employees and a dismal, simple fact emerges. Turnover causes more turnover (Ben-Dror, 1994).

Another major consequence of high turnover among mental health care workers can be labelled "knowledge loss" (Hana & Lucie, 2011). Specifically, individual cases and the relationships that particular staff who leave have of clients' needs and unique situation. The impact is also about losing overall organizational knowledge, ways of managing both cases and other aspects of how the organization works. It is increasingly recognized that the collective knowledge within any institution is a valuable resource, and that "organizational learning"

depends on continuity, on people staying long enough to develop effective know-how and pass that on to new recruits (Beazley et al., 2002).

Interventions to Mitigate Turnover

The steps that can be taken to reduce turnover generally mirror that problem discussed above that lead employees to voluntarily leave mental health work. In this section I will consider the major specific strategies that have been identified, leaving until the final section of the chapter, a review of research on turnover at the full organizational level.

Improving Remuneration

Improving wages and benefit packages, while also providing career advancement opportunities were a few interventions listed in combatting turnover of providers (Bukach et al., 2017). Financial incentives were another intervention utilized for increasing retention of providers in the mental health field. One-way agencies are also working to address turnover through flexible work schedules, which can help assist employees with work-life balance. Organizations that pay attention to the importance of work-life balances can help combat employee turnover. Employees need to balance family, work, exercise, physical and mental health, and other responsibilities. This does not include activities of enjoyment, like socializing with friends or engaging in hobbies. When an employee is struggling with work-life balance and feeling that internal distress, it can lead to needing to make a difficult decision like leaving an agency (Timms et al., 2015).

Improving Opportunities to Advance in One's Career and in the Organization

This intervention approach follows from the point made earlier about how failure of the organization to make room for career advancement can lead to turnover. Thus, conversely, when organizations really take seriously the almost universal staff hope and expectation to move

upwards in their career, individuals' long-term commitment to the employer is much improved

(Watanabe-Galloway et al., 2015).

Improving Working Relations and Teamwork

An important way to address employee turnover is by building, strengthening, and

maintaining strong working relationships. According to Heavey et al. (2013), working within a

team is also a way to combat employee turnover, especially if leaving the agency means to work

independently and that support is significantly decreased. These relationships are built on

collaboration and working together to overcome barriers to the organization goals. When

organizations provide a supportive environment, employees feel a sense of gratification and

possibly a decrease in distress levels. Job gratification can even sometimes be a good forecaster

for employee turnover but cannot be the only tool utilized to predict possible intention of

turnover (Timms et al., 2015). Yanchus et al. (2017) linked turnover to civility in the

workplace. Their recommendation was that mental health establishments must strive for a

change in their organizational culture overall to improve civility within their workforces (a

subject I will return to in the final section of this chapter). Multidisciplinary teams allow the

provider to work with other professionals and not feel that they are working in a vacuum (Evans

& Huxley, 2006).

Improving Work-Life (or Work-Family) Balance

Another intervention that can be effective is to ensure that leaders acknowledge the

influence work requirements and obligations have on professionals outside of work. Brough and

O'Driscoll (2010) reported the importance of organizations and leaders in recognizing the

significant balance between work and home, while creating a "family-friendly" practice in the

organization. This applies especially during pregnancy (Brough & O'Driscoll, 2010) whether of

the employee or of their partner. Having specific employee benefits like paid parental leave and partner benefits are also important when it came to work-life balance.

As noted previously, successful work-life balance is also improved through employee services like fitness centers, on-site childcare, and dry-cleaning services (Brough & O'Driscoll, 2010). Redesigning the organization, specifically allowing part-time work, flexible hours, development incentives like training are also important in reducing turnover. Another area can be benefits like paid family leave or providing benefits for spouses or partners. When looking at work-life balances, it is important to look at how restructuring hours to part-time work options and flexible work hours can be helpful to the balance of work-life responsibilities (Brough & O'Driscoll, 2010).

Having interventions built into the system can help combat burnout in providers. Incorporating events like peer lunches or mentoring sessions can help with combatting burnout. Another possible intervention that could help combat burnout and staff turnover can be to increase holiday time off or accrual rates of time off for staff (Blankertz & Robinson, 1997). Another intervention is to provide feedback to employees on a routine basis, which can have a significant effect on employee's perceived satisfaction on the job (Martin & Schinke, 1998). Providing a training within the organization around burnout and how to self-assess it, how to talk about it, and what interventions can be used to address it can be helpful in the health of the employees and the organization as a whole (Martin & Schinke, 1998).

Ensuring that the provider is supported is another way to reduce employee turnover. Supervisory support can be viewed as emotional support, agreement with patient treatment goals, and showing support with provider's professional development. In part, when a supervisor supports a provider's work-life balance, while also supporting the provider in achieving job

expectations (Fukui et al., 2020). For example, a provider who is a higher performer at their position is typically more at risk of burnout and employee turnover. The goal of a supportive supervisor is to ensure the provider is successful at their job but not excessively feeling pressure or that they cannot meet expectations. A full literature review regarding work life balance is beyond the scope of this study, however it is important to consider the relevance of this topic for this dissertation study (Fukui et al., 2020).

Ascending Maslow's Hierarchy to Combat Turnover

Employee turnover can be addressed by allowing staff to feel a sense of accountability and independence, with an ability to make decisions within the scope of their work (Ben-Dror, 1994). Organizations have an opportunity to increase employee retention by refocusing on meeting employee needs, specifically the higher needs in Maslow's hierarchy such as a sense of belonging, self-esteem, and self-actualization (Caudill & Patrick, 1989; Gaddy & Bechtel, 1995). While my literature search found no references on this specifically among mental health organizations, several studies used Maslow's framework and found that in nursing homes, attention to such needs significantly reduced the turnover problem (Caudill & Patrick, 1989; Gaddy & Bechtel, 1995). Thio (2000) found that retention of employees was improved in a voluntary welfare organization in Singapore by using participative management, opening up more of the organizational decision-making and broadening discretion in case management among the professional staff. Perceived organizational and perceived supervisor support is important when combatting employee turnover. The daily interaction with the supervisor is important, as well as the events that take place throughout the relationship with each other (Campbell et al., 2013).

It is important to understand that perceived organization support often takes longer to establish and is often impacted by perceived supervisor support. Leading employees impartially

and showing vulnerability in some cases can help with promoting perceived supervisor and organizational support (Campbell et al., 2013). It can also be beneficial for the leadership at an organization to be able to assess an employee's burnout level, showing an openness to flexibility and opening up a conversation around individualized plans to address burnout or emotional exhaustion is also important (Campbell et al., 2013). Ben-Dror (1994) reported that there are four possible solutions that can help address turnover. Regarding individuals, the first solution is specifically letting professionals exercise independence in the work they perform. The second is team factors, specifically relationships with coworkers, feelings around being part of a team, and relationship with supervisor. The third group are the reward factors, like salary, ability to grow within organization, and a merit pay system. The final grouping is around organizational factors, specifically communication within the organization and the role, being able to participate in organizational decision making, organizational policies, values, and goals (Ben-Dror, 1994).

Providers who deliver care and feel satisfied and pleased with the treatment they provide, while also feeling supported by their supervisor and organization. Providers also desire training and education around building and strengthening skills. Once skills are learned, providers often desire environments where they can practice creatively and independently.

Organizational Climate and Culture Affecting Turnover

Increasingly, researchers are shifting from just identifying specific interventions that reduce turnover and its causes to applying ideas about whole organizational climate and culture. These terms have now become widespread in descriptions of how organizations succeed (or fail) and have been applied to the problem of turnover, including in mental health organizations (Aarons & Sawitzky, 2006)

Although the terms "climate" and "culture" as applied to organizations are arguably distinct (Schein, 2000; Schneider, 1990), at this point in my research I will treat them as part of the same set of factors that employees understand about their workplace. *Climate* is about the "individual's perception of the overall psychological impact of the work environment on the individual in positive or negative terms" (Glisson & James, 2002, p. 770) whereas *culture* is seen as the "normative beliefs and shared behavioral expectations in an organizational unit . . . These beliefs and expectations prescribe the way work is approached and are the basis for socializing coworkers in the way things are done in the organization" (Glisson & James, 2002, p. 770). What the concepts share is emphasizing that employees have powerful perceptions of just what kind of place they are working in/for. These affect their commitment and, in high stress environments may make the difference between deciding to stay or leave.

The organization's climate and culture are significantly affected by the kind of overall leadership found there. Green et al. (2013) linked a reduction in burnout and emotional exhaustion in public sector mental health care to having transformational leaders, ones who showed the behaviors described first by Bass (1990): "Idealized influence, inspirational motivation, intellectual stimulation, and individual consideration" (Green et al., 2013, p. 374). Green et al. recommended training mental organizational leaders in transformational leadership as an intervention against high turnover rates.

Several other studies examine how organizational climate and culture can impact employee stress and, thereby, turnover and retention. Aarons et al. (2011), following up on previous work (Aarons & Sawitzky, 2006), showed that the importance of strong leadership and the creation of a supportive culture and climate in 14 publicly funded New Mexico facilities was particularly impactful during times of crisis, like the current pandemic. Strong leadership and a

supportive culture is further defined as promoting positive culture and encouraging professional

relationship building is especially important in the human services field. Given the added strains

of patient need since the COVID-19 epidemic began, this insight is especially important to me as

I undertake discussions with New Hampshire mental health employees. In looking at the many

details that the literature reviewed in this chapter raises, I will also be able to construct a

perspective of what the existing and a better climate and culture, achieved through system-level

change, would work for New Hampshire mental health organizations as well as similar

institutions in other parts of the United States and overseas.

Chapter Conclusions

The themes that surfaced in this literature review were striking. Much is known about the

key aspects seen in Figure 2.1 of the turnover problem, its implications and interventions to

mitigate it in scholarly writing. But much is not. The review has helped me to better understand

how this study can contribute to the research in this area. Gaining detail around some of the

suggested interventions, specifically financial incentives, increasing salaries, and having

manageable caseloads are useful is an area for further study.

It is important to increase and fortify the mental health provider workforce. An area for

this research is gaining an understanding how to improve the culture around community mental

health and gain an understanding around how to improve culture to increase retention of mental

health providers in community mental health. A gap in the research that I found was providing

details around culture and how providers understand the culture that is needed to decrease

turnover. For example, understanding what accountability and independence looks like in terms

of what providers are looking for in their employers.

It is important that the research that the dissertation contributes to the field is relatable and accessible to the public, otherwise it will not help to solve the turnover problem that is currently negatively influencing the mental health field. It is important that it is accessible because if it is not, it cannot address the problem. Accessible research is research that is not only accessible to scholars but also accessible to providers and leaders in the field experiencing the problem of turnover. Accessible research would allow leaders in the field to gain different perspectives, which would in turn allow them to expand their understanding. By expanding knowledge, leaders can possibly find new interventions to address the problem. Increasing retention of staff can then assist in improving consumer access to treatment, while also ensuring that treatment is a little more consistent.

In the next chapter, I will be providing information around methods and methodological fit of the case study research proposed for this dissertation. I will also be providing detail around the study, including site and participants. Data collection and analysis are provided in detail. Chapter III also looks at the ethical considerations around the study and the trustworthiness.

CHAPTER III: METHODOLOGY

This study is a single case study design to explore the central research question: "What motivates master-level mental health providers in community mental health to remain employed in community mental health centers?" This group of professionals was selected due to the problem that was explained in previous chapters. It is difficult to retain master-level providers and even more difficult to retain licensed master-level providers. To "get inside" the thinking behind this critical professional decision, I felt most confident of the case study method which Yin (1989) considers most effective to answer, "a how and why question . . . being asked about a contemporary set of events over which the investigator has little or no control" (p. 20). The study included interviewing master-level clinical staff and their leaders at one community mental health center in New Hampshire to better understand perspectives on what motivates them to remain employed within a CMHC. Concurrently, in this case study I identified and reviewed public information about the CMHC that added background to what the participants say.

This study utilized a social constructivism perspective, through which helped to increase the understanding of an environment or situation through individual perspective. A constructivist perspective centers the participants' perspective and meaning making. I relied heavily on the interviewing process, which gave me the participants' perspective on why master's level practitioners stay in their positions (Creswell & Poth, 2018). The interview questions were general and open-ended, which allowed the participants to share their perspective without being guided by a pre-set framework regarding retention.

Structure of This Chapter

The next section provides an overview of the case study method including what it is and why I chose it. I will then describe the research design and implementation:

1. Dissertation Study Design

2. Study Site and Participants

3. Data Collection

4. Data Analysis

5. Measures to Ensure Trustworthiness

6. Other ethical considerations

7. Scope of Study

In this study, I intended to gain a better understanding of what motivates master-level providers in remaining employed at community mental health centers in New Hampshire.

Overview of the Case Study Method and Rationale for Its Proposed Use

The case study method has been applied to a wide range of settings and research questions, For my understandings of and approach to case study research I have relied particularly on Algozzine and Hancock (2017), Baxter and Jack (2008), and Yin (1989). Case studies can be seen as an extension of human fascination with storytelling; Flyvbjerg (2006) stated that case studies have therefore "been around as long as recorded history" (p. 302).

The literature review in Chapter II covered many quantitative survey-based studies of the reasons for retention versus turnover among employees at health care and other institutions. The issues that I identified as requiring a fuller understanding are not readily probed with surveys but require deeper understanding of how the employee is reflecting on their "stay-or-go" decision. A qualitative case study based on rich discussions with staff on these matters offered a better opportunity to delve into reasoning, motivation, and decision-making. Case studies allow for assessing a situation in detail while considering various, multiple perspectives within that

situation. I wanted to know more about the thinking that lies behind retention and turnover not just the outcome of the thinking.

Case study methodology assists in understanding what is occurring regarding the employee retention problem that is transpiring at the community mental health centers across New Hampshire. Practitioners at other CMHC's will determine whether the findings apply in their context. Case studies provide means for studying complicated and contemporary situations. According to Yin (1989), case study designs are best for when the research study is to answer questions of *why* and *how* something is occurring. Yin contrasted this usage with studies based on surveys when the researcher wants to know about the frequency or incidence of a phenomenon. Interviewing master-level providers—within a CMHC setting in New Hampshire helped in gaining a deeper understanding around the culture that supports the retention of master-level providers. Case studies can also help to develop theory, evaluate programs, and develop interventions, when the methodology is applied effectively (Baxter & Jack, 2008).

When considering case study methodology, the researcher needs to think about what exactly the case should be about and how to define the item or items of analysis, while considering the boundaries of the study. Researchers must ask themselves if they want to evaluate individuals, groups, programs, processes, or the differences between organizations (Baxter & Jack, 2008). One potential problem of using a case study design is that some researchers try to answer questions that are too wide-ranging, or the study has too many goals. To avoid this, researchers need to incorporate boundaries on the study. When establishing boundaries on a case study, these should include time and place, time and activity, and defining context (Baxter & Jack, 2008).

Another important factor related to case study research is being able to utilize multiple sources of data and a method for increasing the trustworthiness of the data being collected. There is a wide range of possible data sources including but not limited to documentation, retention of records, meetings or conversations, observations (Baxter & Jack, 2008). The data is then brought together for analysis. It is important to think of a case study as like piecing a puzzle together; each data source is a different piece and putting all the sources of data together can assist in trying to explain or solve the puzzle.

Study Design

It is important to understand the perspectives of mental health providers regarding what motivates them to remain employed with a CMHC. A significant amount of research on turnover has been about the causes of leaving one's position but less on the factors that *reduce* turnover. That information may hold the key to retaining good employees, which has been stated in different areas throughout the paper.

The CMHC site was chosen specifically due to the location, size of the site, and due to the researcher not being employed at the center. It was very important to focus on a more populated region due to the provider's ability to have more employment options if they decide to leave CMHC. The specific CMHC was also chosen because I had no employment history with the agency.

This research took place at a single CMHC in New Hampshire, one located in the southern region of the state. This CMHC was selected because I believed practitioners' decisions to stay were particularly meaningful given that in a more populated area, they had a range of other employment options. I conducted one-on-one interviews with this CMHC's master's-level mental health providers, members of executive team, human resources, clinical directors, and

clinical supervisors to help me understand the culture around what helps providers at CMHC in New Hampshire remain working in the agency. After obtaining written consent from participants, interviews were recorded and transcribed followed by thematic coding. An expanded discussion of the research methods will be presented in later in this chapter.

I conducted one-on-one interviews with the participants. Most interviews were conducted in person; however, some interviews were over Zoom. I looked at publicly available information on mental health centers and data collected through interviews. Unfortunately, other sources of information were not available to the researcher.

The Study Site

The site for the study is one of 10 CMHCs in New Hampshire. I excluded three of them due to my employment history. This was to reduce potential bias in the study and role conflicts with staff than would be the case if we had had prior working relations. I eventually selected a CMHC in a densely populated area as I believe this gives a clearer picture to the characteristics and qualities of community mental health centers that are actually experiencing high retention rates of mental health providers.

I had a preliminary conversation, with the CEO of the selected CMHC who expressed initial interest in participating in this study. This CMHC offers a wide range of services to the region it serves, specifically mental health services, substance use services, psychiatric services, emergency/acute services, and family support services, who provides services to individuals over the age of 60. The selected CMHC works with adults, children, adolescents, families, and seniors/older populations. These services can be office-based treatment or community-based treatment. These providers work with a variety of patients and families, addressing several

different mental health concerns including depression, anxiety, post-traumatic stress disorder (PTSD), substance use related concerns, psychotic disorders, and mood disorders.

Study Participants

The participants in this study were master-level mental health providers, specifically therapists or emergency services clinicians. These providers are individuals who earned their master's degrees in social work, psychology, or mental health counseling. A second group of participants were clinical directors, which expanded my understanding of the organizational culture that may be influencing people to stay in with the institution. Clinical directors are typically individuals who are licensed in mental health counseling, social work, or as psychologists and who also have a master-level education in the fields listed above. Finally, I interviewed organizational leaders, including members of senior leadership, human resource managers, clinical directors, and supervisors. This expanded the perspective on why clinicians stay.

Data Collection

Data collection occurred in all clinical departments that have master-level clinicians, including adult services, the children and families department, and the emergency services/acute care services department.

Focus of One-on-One Interviews

These one-on-one interviews were semi-structured so that I could work from a guide and also ask follow-up questions so participants had the opportunity to tell their stories in their own voice. An example of my interviewing strategy was to encourage participants to provide examples of their own experiences with the CMHC and relate what makes them stay. My interview questions for this study are presented in two appendices: Appendices A includes the *Interview Guide: Management at CMHC* while Appendix B presents the proposed *Interview*

*Guide: Master-Level Provide*r. The open-ended questions shown in Appendix A are specifically for the leadership team at the site while the questions shown in Appendix B will be directed to the master-level providers at the site.

I also discussed each participant's perspective on what the CMHC might do to promote well-being for providers and, overall, what their views on what makes their CMHC workplace a good fit for their career and personal aspirations. Participants were asked what they think the CMHC can do to promote employee well-being and why they feel their CMHC is a good fit or not for them personally. They were also asked to identify what they feel are the primary factors affecting employee turnover. It is also important to know what aspects of their work give them a sense of pride, and motivates them at their job, motivations for staying employed at the CMHC. The demographic questionnaire for this study is presented in Appendix D: Interview Participant Demographic Questionnaire. The demographic information was collected using in person and over email methods. I provided the form to the participants and asked that they fill it out and submit it back to me, prior to the interview and data collection. This allowed me to collect the information and transfer it into Dedoose, qualitative data analysis software, which was utilized for coding and data analysis, which I further explain in detail later in this chapter.

The target sample size was 10 to 12 participants who identified as a master-level clinician. This is within the typical range of qualitative research that relies on interviews (Marshall et al., 2013). Interviews were recorded either via Zoom or audio recording of in-person interviews. Transcripts were prepared from the recordings and subsequently coded to extract recurrent themes. The recording and analysis for my use and storage of the audio and transcripts are described below.

Supplementary sources of data were also important to explore including the physical structure of the CMHC agency, office locations, staff positions and size and so on. Yin (1989) described the kinds of sources for evidence to be used in case studies, subject to their availability and relevance. I intended to follow Yin's guidance and explore the following sources; however, I was not able to access these materials from the CMHC:

- Letters, memoranda, and other communiques;

- Agendas announcements, and minutes of meetings;

- Administrative documents—proposals, progress reports, and other internal documents;

- Previous formal studies and evaluations of the "site" under study, if any; and

- News clippings and other articles appearing in the mass media.

I also attempted to look at any other associated information that might assist me in understanding the culture of the agency. Examining the agency website and its organizational chart helped in gaining an understanding around how it is structured and how that can potentially impact culture. I attempted to gain access to anonymized exit interviews in the CMHC's files, which I hoped would shed light on the other side of my research question: why previous master's-level care providers have left. Unfortunately, that data was not available to me for this study.

Data Analysis

Coding

I utilized Zoom transcription and Otter AI transcription services from the interview recordings. Each interview was transcribed. Once the transcript was sent back to me, I went over it and compared the transcription to the recording to ensure accuracy of transcription. After this,

I gave the participants an opportunity to review their transcript and provide corrections or changes before moving forward in coding the data from the interview. If I did not hear from the participant within 3 working days of the transcription being sent to them, I understood that to mean they did not want to review, revise or redact the information in the interview transcription. I then began the coding process, which allowed me to identify key words, beliefs, and perceptions from the data and to explore emergent themes.

I utilized the Dedoose program to help with coding and analysis of the data. Additionally, I also anonymized the transcript before sharing the data with my coding partner, with whom I worked to serve as another perspective through the coding and analysis process.

Thematic Analysis

Thematic analysis is utilized to detect, examine, and account for patterns in the data (Braun & Clarke, 2006). This method allows the researcher to analyze the data from the responses in this study. Data items are individual fragments of data and in this research study, it would be considered the interviews with leadership and master-level providers, data provided by the CMHC, and even information or data from the public domain (Braun & Clarke, 2006). Thematic analysis was utilized to detect, examine, and account for patterns in the data (Braun & Clarke, 2006).

Measures to Establish Trustworthiness

Nutt Williams and Morrow (2009) suggested that the critical elements for achieving trustworthiness in qualitative research were threefold: "The integrity of data, the balance between participant meaning and researcher interpretation, and clear communication and application of the findings" (p. 576). To achieve trustworthiness in the study, it is important to possess credibility which can be attained when the researcher's reconstruction and representation of the findings are reflective and align with what the participants are voicing. Transferability is

another way to work towards trustworthiness (Schwandt, 2007). For instance, this study provided

enough context and rich data so that staff and administration in community mental health centers

across New Hampshire and even possibly in other regions of the county can determine whether

the findings of this study could be relevant to their organizations. Dependability is another way

to work toward trustworthiness, concentrating on the process of the study, documenting that the

study process was reasonable, observable, and following the integrity of the method. Another

aspect of trustworthiness is to connect claims, results, and interpretations in clear and concise

ways (Schwandt, 2007).

Maintaining Integrity of the Data

Aiming towards integrity of the data, this methods chapter is key because it is here that I

strive to achieve the "clear articulation of methods allowing for [future] replication" (Nutt

Williams & Morrow, 2009, p. 577). I continuously worked towards maintaining the integrity of

the data by correcting the transcriptions for accuracy. This was performed by examining them

and determining that they matched the recordings. I also offered participants a chance to

comment on the transcripts. Another way to work toward integrity of the data was to code the

transcripts close to the participant language, while also working with a coding partner to help

ensure integrity.

Balancing Participant Meaning and Researcher Interpretation

The dangers of having the researcher overly impose their viewpoint on what they hear

and analyze from participants is well-recognized. Poggenpoel and Myburgh (2003) have aptly

expressed both this problem and its solutions:

> The researcher as instrument can be the greatest threat to trustworthiness in qualitative
> research if time is not spent on preparation of the field, reflexivity of the researcher, the
> researcher staying humble and preferring to work in teams so that triangulation and peer
> evaluation can take place. (p. 420)

Reflexivity is important and involves the researcher identifying and acknowledging that their own decisions and experience can bear significantly on every aspect of the research and framework of the study. I believe that professional counselors—and I am one—have a great deal of experience practicing reflexivity because we do strive for this and learn its skills as part of our everyday work (Rennie, 2004). However, additional specific strategies have been used to achieve better reflexivity and balance between the researcher's interpretation and the participants' real meanings. Bracketing has become a conscious strategy in social science research which means pre-identifying potential biases. Starks and Brown Trinidad (2007) suggested that bracketing means recognizing and setting aside prior knowledge and assumptions. This is not a practice, where prior knowledge and assumptions are discontinued but merely put aside, so the researcher can work towards attending to the participant's story and perspective with an impartial mind. Keeping a research journal in which one reflects in detail on the course of the work and day-to-day memoing (McGrath, 2021) are means that I adapted to reflect on the research process as it unfolds.

Another important strategy in balancing researcher interpretation with participant perspectives involves having at least one partner assist in the coding process (Brislin, 1980). Coding entails labeling sections of the text so that the researcher can work through the data to identify themes from the interview transcripts. Having at least one partner who is able to offer their perspective and provide dialogue in regards to their perspective on the data, provided the research a more robust basis for interpretation. Going through the same data and identifying themes can reduce the possibility of a researcher seeing primarily what they believe to be true. I am especially vulnerable to this bias from having worked in the same field as the participants. In

considering the use of a coding partner, I sought advice from my chair, committee, and other Antioch students who have used this approach.

Mention should also be made of *member checking* as an approach to qualitative research to balancing participant meanings and researcher interpretation (Candela, 2019). Member checking means providing the participants with the opportunity to review and confirm the accuracy of transcripts (Birt et al., 2016).

Clear Communication and Application of the Findings

> You may have just completed the most clearly articulated, reasoned, and balanced qualitative study in the history of psychotherapy research; however, if you cannot clearly communicate what you have found and why it matters, we suggest that your study is not considered trustworthy. (Nutt Williams & Morrow, 2009, p. 580)

Given the growing crisis of turnover of professionals in CMHCs in New Hampshire and the resulting "treadmill" that Couture (2022) has described that is "going faster" and for which solutions need to be found "before we can no longer manage to hold on" (para. 9), working towards trustworthiness will also mean that the results of my proposed study be made available. The research here not only contributed to scholarship about employee retention but also about the factors governing career choices of mental health professionals but will help CMHCs and similar institutions in New Hampshire and elsewhere get off Couture's (2022) treadmill. I am offering my findings so that ideally, this study can be used in addressing the employee retention concern within these institutions thereby establishing what Morrow (2005) called "social validity" (p. 253). It is my intention to present the results to the New Hampshire Community Mental Health Association and use this study to develop an approach to analyzing and increasing retention of master-level clinical providers in community mental health institutions.

Other Ethical Considerations

Meeting the standards for ethical research administered by Antioch University's

Institutional Review Board (IRB) was essential. I addressed in detail how I identified and

minimized risks to participants, to achieve informed consent, and seek to maintain

confidentiality.

The fact that this research took place in a facility that itself must adhere to very rigorous

ethical standards heightens the need for my research to be exacting in its protection of the

participants. While the interviewees are not themselves from what would be generally deemed a

vulnerable population as defined in codes of research ethics, I asked them to discuss the crucial

life and career decision of staying. For this candor to happen, as the researcher I needed to meet

the test of highest possible ethical standards, providing assurances to the participants and living

up to such commitments. In this, adhering to the principles from the American Psychological

Association (APA), as summarized by Smith (2003) and elaborated in the APA Publication

Manual (American Psychological Association, 2020) was very important.

Smith (2003) highlighted five principles recommended by the APA Science Directorate,

several of which are relevant here. Smith emphasized the need to adhere to informed-consent

rules and uphold confidentiality and privacy for the participants. She pointed out that merely

circulating a consent form is not enough. One must "devise ways to ask participants if they are

willing to talk about sensitive topics" (p. 59); in my study, as noted, I need to have them say as

much as possible about the life of the organization they are working for so that I gain

appreciation for the most important underlying factors affecting their decision to stay with the

CMHC. I emphasized and explained in detail, as they consider the informed consent form, the

steps I took to maintain confidentiality and protect their identity. These issues are especially key

in my research because the participants—master level mental health care providers—need to be as protected as possible. Illustrations they gave could have compromised their identities and that of their patients. So, the protections I offered needed to be credible. Smith's summary noted the importance not only of having data security and anonymizing, but of making those measures clear to would-be participants.

The consent form was also designed to explain the potential risks and benefits to the participants and designed to ensure that the participants have a full and clear understanding around the study design and purpose (Smith, 2003). I relied on rigorous coding, secure storage of data, and on anonymizing strategies to protect those I interviewed. In addition, I provided all participants with a resource for mental health support (outside of the New Hampshire system) in case they wish to discuss any difficult material that emerged in the interview.

Scope of the Study

This is a single case study research study that was conducted in one of the 10 Community Mental Health Centers in the state of New Hampshire. The intention of this study was to understand the perspectives of master-level providers regarding what motivates them to remain employed with a CMHC. It is important for the study to be transferable, which potentially allows other CMHC to look at the findings and determine whether they are applicable to their community mental health center and gain a larger understanding of the turnover and retention problem and hopefully find new methods for addressing them. Master-level providers and CMHC leadership were the only participants who met criteria to be involved in this study. The intention was to not make the study too broad by including bachelor level and doctoral level providers in the study as that would have created too wide of a range of participants and those providers should be studied at another time.

CHAPTER IV: FINDINGS

This study applied a single case study design to explore what motivates master-level providers in community mental health to remain employed. I undertook one-on-one interviews, roughly lasting from 45 to 60 minutes. Master-level providers and members of leadership were selected to determine what motivates a master-level provider to stay in a community mental health center (CMHC). The retention of master-level providers is extremely difficult for a CMHC, so the study focus was on these individuals. Throughout the data collection process, I sought to increase my understanding of the environment or situation through the interviewee's perspective. The interview questions were open-ended, which allowed participants to share their perspective without my guiding them in a pre-set framework.

The CMHC provided one document, catalogued as "BOD031523," which provided focus areas on its staff recruitment and open positions, vacancy rates, 12-month rolling turnover, days required to fill positions, and terminations. From the BOD031523 document, it appears that the average vacancy rate across the state for all staff in CMHC is 13.4%. This document is shared with the board of directors on a monthly basis as a means of reporting. More information from this document cannot be revealed in this dissertation to prevent confidential information being identifiable. As seen in Table 4.1, the themes discussed earlier are displayed for the reading to better identify the contributors that were found to be associated with the themes in the study.

Table 4.1

Research Themes

Theme	Contributors to Theme
Draw to work in CMHC	- Participant Prior Experience - CMHC Reputation - Wanting to help people - First Impressions & Salary - Salary as a Draw - Gaining Experience - Licensure Supervision
Motivation to do Work	- Alignment of Values - Client Impact - Positive Effects on Clinician - Employment Benefit - Flexibility in Scheduling - Loan Forgiveness Opportunities
Importance of Connection	- Team and Colleagues close-knit - Ability to Collaborate - Similar Mindsets
Connecting with Supervisors & Supervision	- Supervisor Style - Supervision
Role & Perspective of Leadership	- Support - Authenticity & Genuineness - Transparency
Licensure Contract	- Signing & Not Signing Contracts - The Risk of Licensure
Considering Departure	- Excessive Workload - Case Acuity - Caseload Size - Action (and Inaction of) Leadership - No Recognition from Leadership

Theme	Contributors to Theme
	• Turnover of Leadership or Supervisor • Negative Interactions with Leadership • Pay and Compensation • Workplace Dynamics • Limitations of Professional Growth
Why Individuals Stay	• Approachable and Responsive Leadership • Aspects of Successful Retention • Nature of Supervisor & Supervision • Being trusted as professional • Schedule flexibility • Growth opportunities & Role diversity • Alternative Work Opportunities • Promoting Wellness

Participant Demographics

The participant demographics for this study are divided into percentages to reduce identifiability of the CMHC and the participants of the study. I interviewed 21 participants; one participant decided to withdraw their transcript after the interview due to not feeling comfortable with what was shared in the interview. The identified genders who participated in the study were male and female, 15% were male and 85% were female. Given that the state of New Hampshire is primarily White, there was limited representation from other ethnicities in this study (no further detail provided in this document to protect confidentiality). The employment status of the participants in the study were 95% full-time and 5% part-time or per-diem positions.

In order to protect the confidentiality of participants, I did not create a single table linking participant demographics to participants. This would potentially increase the risk of identification of participants. Instead, I provide a table for each demographic element to provide context for the study. As seen in the table below (see Table 4.2), the length of employment is divided into four categories, less than a year, one to five years, six to 11 years, and more than 11

years. Majority of participants for this study were employed from one to five years with the

CMHC.

Table 4.2

Participant Demographics: Length of Employment

Length of Employment (Years)	% of Participants
<1	10
1–5	65
6–11	15
>11	10

Table 4.3 shows participants' years of experience in the mental health field.

Table 4.3

Participant Demographics: Years in Mental Health Field

Years in Mental Health Field	% of Participants
1–5	35
6–10	25
11–15	5
16–20	5
>20	30

Table 4.4 shows the professional category that participants identified at the time of the

study.

Table 4.4

Participant Demographics: Participant Professional Category

Professional Category	% of Participants
Master-Level Clinician	60
Management	40

Table 4.5 displays the level of management indicated by management participants: supervisor of clinical staff, director of department or senior management.

Table 4.5

Participant Demographics: Level of Management

Level of Management	% of Participants
Supervisor	37.5
Director	37.5
Senior Management	25

Table 4.6 shows percentage of participants with a clinical license, those who did not have a license, and the participants who were in a position not requiring a license, such as administrative positions.

Table 4.6

Participant Demographics: Licensure Status

Licensure Status	% of Participants
Licensed	30
Not Licensed	60
Not in a Licensed Position	10

Table 4.7 shows participants' department affiliations at the time of the interview. It is important to note that the majority of the participants in this study were in the Adult Services Department and Emergency Services/ACS.

Table 4.7

Participant Demographics: Department

Department	% of Participants
Children/Youth and Family Services	20
Adult Services Department	35
Emergency Services/ACS Department	30
Administrative Departments	15

Additional Research Resources

Unfortunately, I did not have access to exit interviews or other relevant internal materials during the time of the study. I was unable to find publicly available documents at the time of the study. Looking at the current job postings for master-level providers, I noticed that postings began with describing the sign on bonus and the breakdown of how that is paid out. The posting then went on to provide an overview of what services the CMHC provides and how the master-level provider fits into those services. The posting provides a description of the duties that the provider is to be responsible for, qualifications, physical demands, COVID-19 vaccination requirements, and benefits offered at the CMHC.

The Community Mental Health Center in This Study

This section describes general attributes of the CMHC where the study took place, awhat drew the interviewed participants to the institution, and what motivated them to continue doing the work.

The Draw to Work in Community Mental Health

Participants identified several reasons why they were drawn to work in community mental health, including already being connected to CMHC as an intern or bachelor-level provider, reputation, wanting to help people, first impressions they experienced, and wanting to gain experience. In the interviews for this study, clinicians reported that there were several

reasons why they were drawn to this particular CMHC. They elaborated on these experiences by explaining their initial reaction when exploring the CMHC.

Participants' Prior Experience

Clinicians had familial or professional connections to the center. Alternatively, it was discovered that some clinicians were an intern at the CMHC and that their own personal experience helped make the decision to become a full-time employee. There were multiple cases where the clinician had been employed at another level or was an intern within the center and sought out further advancement. Some of the clinicians stated that they were already an employee and working as a per diem master-level clinician or as a bachelor-level position or within an internship program at the CMHC and that their experience prompted their interest in seeking fulltime employment. They reported that their experience was positive and that they wanted to continue to build their working relationship with the CMHC.

CMHC Reputation

Clinicians reported that they knew the CMHC had a good reputation for serving the community and that the CMHC's reputation in terms of community connection and support was a reason to seek work at the CMHC. However, it is important to recognize the most influential source for clinicians to find employment at this CMHC was word of mouth and a reputation that preceded the agency. Clinicians went on to explain that they came for the supportive environment that they heard the agency promoted. They reported that the reviews they read online were positive. Some also reported that they had former colleagues and friends working at the CMHC, heard positive things and decided to apply.

Wanting to Help People

The role of the clinician in helping people was a major attractor for master-level clinicians to seek employment in a CMHC. Clinicians reported wanting to make a difference in

the lives of their patients and to work with people who are lacking resources that tend to be underserved. Clinicians continued to state that they want to "make a difference" and have a positive impact on the community. Members of leadership mentioned that they believe clinicians enter the field and come to the CMHC to help the clients improve their lives. Clients that are being served in CMHC are often underserved, clinicians continued to explain that they wanted to serve these individuals and support them in bettering their lives.

First Impressions

Clinicians explained that they felt welcomed by the staff and leadership. They mentioned that during the hiring process, the interviewer made them feel that the environment was open to professional humility and feedback. Clinicians reported that the interviewer made them feel welcome by being receptive to answering their questions. Participant 11, a clinician, shared that they had a positive experience in their interview:

> Well, they have really good reviews. I've known some people in the field that have switched from previous community mental health centers that they are working at the (CMHC). And they've just spoke so highly about the positive work environment that's fostered here. And so I had an interview, and I kind of just right off the bat, I just got a really good vibe from the leadership team on the acute care team. And felt like it was a great fit for me.

Salary as a Draw

Salary was another aspect that assisted in the draw for some clinicians to work in the CMHC. One reason for clinicians to come work at the CMHC under study was that the salary appeared to be higher than other CMHCs in the state. This salary also seemed stable and not dependent on whether or not a client attends an appointment or not. The stable paycheck—knowing that they would get a paycheck, regardless of who attended their session or not—drew the clinicians to the CMHC.

Gaining Experience and Licensure Supervision

Some clinicians were driven by the opportunity to gain and build upon their clinical experience or skills. Clinicians reported that licensure supervision was another attractor for them. An important aspect of the draw to the CMHC was that the licensure supervision was able to occur without having to sign a contract committing to the agency after licensure supervision is provided.

Motivation to Do the Work

Clinicians explained that there were multiple motivations for continuing to do the work each day: the positive impact on the provider, enjoying the clientele, alignment with values, and positive impacts on their client's lives. The organization's values were reported to assist clinicians in working with highly acute clientele and the associated high workloads that accompany these clients. Feeling a connection to the community was also important for clinicians, specifically the clinicians' feeling that they had a positive impact on the communities they were serving. These providers reported that feeling a sense of community within the organization was also important in doing the direct-care work. The clinicians explained it is important to them to feel that they can go to colleagues and supervisors when needing support or guidance.

Alignment of Values

One theme that surfaced as a reason for continuing to do the work was the fit between the clinicians' values and the values of the agency, the feeling that the agency and clinician were working toward the same goals and were on track to achieve those goals. One important value that was brought up by clinicians is wanting a sense of community. Clinicians explained that seeking community and the CMHC promoting community was one example of values aligning between the CMHC and the clinician.

Impact on Clients

Clinicians reported feeling that they had a positive impact on their clients and that they provided help and assistance that made a difference in clients' lives. This was identified as important in their coming to the CMHC and doing the work each day and staying in the job. Observing growth in a client is an important reason for a clinician to continue to do difficult clinical work. One particular theme that surfaced from client impact was the "lightbulb effect," This insight-oriented effect involves helping the client to connect thoughts and feelings to behaviors as well as making positive changes in their lives from those connections.

Another aspect of client impact was making a difference in the lives of clients, while also creating a safe environment for their clients to thrive in. It was important for the clinician to enjoy the clientele they are serving. Clinicians reported that they want to help high risk and highly acute clients and that the work they do with these individuals makes a positive difference for the client. Several clinicians reported that they very much enjoy working with children, despite the challenges and time involved. Clinicians stated that they want to enjoy the population with whom they are working.

Positive Effects on Clinician

A theme that surfaced about doing the work each day was the positive impact on the clinician. Feeling a sense of reward and fulfillment is important, while also having the opportunity to challenge themselves in their work. One clinician reported, "If I don't do it, it's not right, I just don't feel right." The clinician continued that they are drawn into this work and that not doing the work just does not feel right. Clinicians reported that another positive impact was the ability to have each day be different and that this variability was important to them. Clinicians said this worked to decreases repetitiveness of doing the same tasks over and over. It

was further explained that they do not want to know what their day will look like before they start their day.

Employment Benefits

Several clinicians and members of leadership in the study reported that the benefits at the agency are perceived as good. They spoke of the examples of medical benefits, time off, scheduling flexibility, and loan forgiveness. In particular, they strongly appreciated time off for their birthday. Leadership reported that schedule flexibility with working hours and the ability for an employee to adjust their schedule for a doctor's appointment or other personal reasons was an added benefit of the agency. Scheduling flexibility and loan forgiveness will be expanded upon later in the chapter.

Employees, whether full- or part-time, have the ability to flex their schedule, as long as they are achieving their productivity goals. Members of leadership report that they believe this is one of the reasons individuals stay. However, it is not the deciding factor of whether or not someone will stay at the agency.

The incentive of longevity bonuses was mentioned by clinicians and leadership. Every five years, employees receive a retention bonus for their loyalty. For every year the employee has worked at the CMHC, they receive $50.

Flexibility in Scheduling

Clinicians reported wanting flexibility in their schedules. It was reported that flexibility is a benefit that all employees at the CMHC can practice, whether they are hourly or salary employees. Scheduling flexibility is experienced as the ability to shift appointments and work hours to help with addressing personal obligations in a person's life. These obligations can look like a child's game, a doctor's appointment, or just being able to leave early because the workday ended early. It was explained by a member of leadership that flexibility in the schedule isn't an

ability to cut out half the day and work until midnight to make up hours. Flexibility needs to be conducive to the client's care. A few members of leadership mentioned that flexibility is one of the reasons why people stay but it isn't the deciding factor that determines if the clinician leaves or not.

Loan Forgiveness Opportunities

Loan forgiveness and monetary benefits was also listed as important in the decision process during the interviews from both leadership and clinicians. There are two loan forgiveness programs available to clinicians at the CMH. One is a federal program and the second is a state loan repayment program. The federal program requires a clinician to work at any non-profit organization and provide 10 years of service and allows the clinician to move from one non-profit to another in those 10 years. Alternatively, the state loan repayment program (SLRP) has the clinician sign a contract and requires the clinician to stay at the CMHC for a certain amount of time.

The Importance of the Connections

Team and Colleagues

Clinical supervisors reported that it is important for the team dynamic and the clinical work, that the team gets along and that there is mutual respect. This creates a positive working environment and cultivates support for one another. Supervisors also stated that being able to enjoy working with co-workers helps with coming to work each day. Some of the traits that assist in enjoying working with colleagues include individuals that are team players and colleagues that have the ability to listen and be flexible. Colleagues who are willing to be self-reflective, have a willingness to learn, and being a kind and compassionate person also hold traits that increase enjoyment in working with others.

Clinical supervisors explained that they and their team are close-knit, and some clinicians even reported that their team is almost like a family. They explained that they know their colleagues have their back and that if members of the team are upset with one another, they have enough respect for one another to address their concerns with the person directly. Clinicians went on to say that being able to address concerns directly with the colleague is important to them. They feel that addressing concerns and having the ability to move on with the work, is what makes the team strong. It was further explained by clinicians that being able to connect inside of work is important to them and that hanging out outside of work is unnecessary to feel that connection. In fact, some clinicians reported that they do not want to connect outside of work but want the strong connection inside work. Members of senior leadership explained that it is important to have camaraderie with peers. COVID-19 had a negative impact on bringing new staff on board. These new staff members missed out on the one-on-one learning experience and had fewer opportunities to connect with their colleagues. As a clinician, it is my perspective that new staff may have difficulty grasping what is needed in all aspects of the job due to not having the one-on-one learning experience. The difficulty is also impacted by the lack of connection among colleagues, which inhibits reaching out for support.

Clinical supervisors reported that having the ability to collaborate on cases and talk with colleagues on how the clinician is impacted by cases, discuss frustrations, celebrate successes, is important to why the clinicians choose to remain at the CMHC. If a clinician does not have the ability to collaborate, stress levels surge and the risk of burnout increases exponentially. Clinicians reported that they believe when teams are working with good communication, they appreciate the ability to reach out for support in the moment.

Clinicians reported that it was important to have similar mindsets with their colleagues on the motivation for doing the clinical work and why the clinical staff are at the CMHC. From a leadership perspective, similar mindsets are believed to help increase comradery and ability to collaborate on cases. Multiple clinicians reported that supporting each other is incredibly important, specifically having the opportunity to get that support in the moment. Clinicians reported that it was important to collaborate on cases and have the ability to be comfortable with their team when talking about countertransference.

Teams are often working on the same cases but in different capacities; clinicians want to do the best they can on their cases while also feeling that they can get help from their colleagues. That help can look like case collaboration or emotional support when working with a difficult case. Clinicians also reported that support comes in the form of pushing each other to do the difficult clinical work and collaborating on how to do it most effectively. In addition to supporting each other, clinicians want to feel like they have each other's back, especially if they are working in the community. When further explained, having each other's back means watching for dangerous situations or having the ability to vent to each other and know that it will not go beyond their conversation.

Multiple members of leadership reported taking the time to walk around the building once a week to promote and maintain a personal and professional connection to staff. A few of the members of leadership explained that is important for them to know where clinical staff are emotionally and psychologically. This allows the member or members of leadership to have a continuous pulse on the overall organization, specifically with confidence and competence in the job. This leader went on to say that finding a connection on a personal level is important, specifically knowing some form of detail in the employee's life to help cultivate that connection.

Another piece that was brought up by clinicians and members of leadership was the ability to create opportunities for connection, specifically teams going out to dinner or lunch, meet-and-greet breakfasts, or being in the office and keeping the office door open for a quick consultation.

Connecting With Supervisors and Supervision

Having a connection with the supervisor was significant theme in this study. Clinicians feel that having a supervisor be attentive and available is significant and this will be discussed later in this section. Supervision style was another important aspect while also clinicians' wanting consistency in supervision.

Supervisor Style

The supervisor's style was one of the themes that surfaced in the interviewing process as an important quality. A supervisors' ability to be humble and allow the clinician to make decisions and "be in the driver's seat" was meaningful. Clinicians continued to report that it is important for the supervisor to listen to them and for them to feel heard. From a supervisor perspective, it is important to hear the clinician's side and support them in problem solving. A significant aspect of style that came up for clinicians was a sense of humor, which gave a sense of connection and an ability to "blow off stream."

Another important quality of the supervisor was the ability to allow the clinician to explore situations and cases from different perspectives, which permits the clinician to apply their own technique to their individual practice. Clinicians want a supervisor who is open with communication and to new approaches and ideas. They do not need to have a scheduled appointment with supervisors to go over a case with them but one available to them as needed for consultation or support. Clinicians reported that the supervisor "being nice" is helpful because it increases their approachability. Respect was another important supervisor

characteristic: clinicians want to know that their time, commitment, education, and skillsets are recognized and valued. Participant 02, a clinician, expressed that being respected means that the supervisor respects their clinical decisions.

Supervisors reported that they check in frequently with their supervisees, asking them how they are doing and that this was an important aspect of the position. Checking in can be done formally or informally. Multiple clinicians explained that checking in on both a personal level and professional level gave a sense of support and connection for them. Clinicians want to feel supported emotionally, professionally, and in their clinical decisions. Clinicians reported that feeling supported meant feeling like they could still be independent in their practice. Clinicians also reported feeling supported when their concerns were "not falling on deaf ears" and their ideas are celebrated and explored, not shutdown or stolen.

Clinicians want a good supportive working relationship and a "united front" in challenging situations. Clinicians want their professional growth supported, whether that is their expertise is expanded upon or their interests are nurtured, specifically training opportunities, leadership opportunities or even policy work at the government level. Clinical decision-making was an important aspect to the clinician and the supervisor being a united front. Supervisors reported that it is important for them to protect the decision-making ability of the clinician, which helps increase trust. One example of a supervisor creating a united front and "backing up" the clinician in their decision was having to involuntarily admit a client to the emergency room when other clinical staff connected to the case were upset and disagreed. The clinician explained that their supervisor talked with them about the decision and agreed.

An important quality that kept surfacing in the interviews for clinicians was that the supervisor had the ability and availability to validate. Clinicians reported that they felt validated

and supported when they needed to go in and talk about an intense case. It was further explained that it does not matter whether this is by video or in-person, only that the supervisor is available. Clinicians explained that it is helpful to them when the supervisor knows the acuity level of the cases and has an understanding around some of the details of the cases. Supervisors and members of senior leadership identified that it is important for leadership at the senior leadership and supervision level to "walk the walk and talk the talk." An example that was provided by senior leadership was a time when there was no option to connect a client with a provider. Due to the level of pathology of the client, one member of leadership made the decision to take on the case.

Several clinicians reported that it is important to them to have a supervisor that understands the work they do each day, and that the supervisor understands the challenges they are facing. One indication that the supervisor understands is by doing the work themselves. When they have done such work recently this helps them to remember what it is like. One clinician reported that a supervisor having recently "been in the trenches" helped with connecting and feeling like the work they are doing is understood.

Clinicians stated that receiving guidance and feedback are important in the working relationship they have with their supervisor. They explained that getting one-on-one training from their supervisor was very important, as well as being able to receive ongoing guidance. The guidance was important specifically around client care and professional growth. The supervisor acts as a sounding board, which is felt to be needed to navigate the work every day and helping to advance a clinician's career.

From a supervisor perspective, it is important to be available for guidance. This guidance can be assigning cases to clinicians in an emergency setting, for example, or guiding the clinician in staying organized.

Having the supervisor create a safe environment is important for the clinician. Clinicians want to know that they could bring their ideas to their supervisor and know that the supervisor will not steal their ideas. Clinicians reported that a safe environment is promoted by the supervisor validating the clinician, showing that the supervisor has the clinician's back, and making sure clinicians feel heard and understood. A safe environment is seen as one where the clinician can vent and know that there is no judgement and that confidential topics are not shared. Clinicians also explained that a safe environment is being able to explain where you are at in the moment, specifically if there is a struggle with their own mental health.

The relationship between the clinician and the supervisor was important on both sides. Both the clinician and the supervisor want to feel that they have a good relationship, one clinician reported that she felt she had a good relationship because she felt the supervisor was easy to talk to and knew the clinician well enough to help the individual identify that a day off or vacation was needed. The clinician experienced this as promoting wellness and that it felt like the supervisor cared about them. Another aspect that helped the clinician feel that the supervisor cared about them was the supervisor helping them grow in clinical skills and assisted in shaping their career, specifically offering feedback and advice around career growth. Advocacy was another important aspect of the supervisor that clinicians wanted to see. An example of advocacy that came up in the interviews concerned providing or enhancing incentive programs for certain teams. Good supervisors, it was said, talk to leadership about manageable caseloads and advocating for resources needed to do the job. One clinician explained that her supervisor

understands that advocating for her supervisees will help increase their happiness in the agency because they will feel that the supervisor "has their back" and helps her feel appreciated. This can increase their happiness and when people are happy, they want to do a good job.

Supervision

From the participant interviews, this section explains how structure and style of supervision impacts the master-level provider. Some clinicians reported that they enjoy structured supervision, wanting a personal or professional check-in, reviewing the clinician's caseload, and providing updates on highly acute clients. One supervisor explained that having balance in supervision is important and later described that the balance is each professional brings an agenda for supervision and having time to explore those lists. Another important theme that surfaced was supervision occurring on a regularly scheduled rotation and time. Clinicians want to know that that supervision will consistently occur.

Another theme was style of supervision, specifically being given feedback and direction. One clinician explained that they enjoy being able to laugh and tell stories in supervision. The clinician elaborated that they like how informal supervision is and the ability to feel like tasks are still being completed. Clinicians reported that discussing self-care and receiving support for how to practice self-care is important to them. One clinician explained that they enjoy the supervision being straightforward, wanting the supervisor to not "beat around the bush" but to get right to the point.

From the supervisor's and leadership's perspective, they reported wanting a structure to supervision. Supervisors explained that their style of supervision is not to dictate but allow the supervisee the room to explore and problem solve with support. Such supervisors believe that supervisees do not like to be dictated to or told what to do, unless it is a life-or-death situation.

Participant 11, a clinician, shared what they are looking for in supervision and what is helpful to them:

> Feeling like I am able to vent and kind of discuss any burnout that's occurring. I think something that's important for supervision and on our team is kind of discussing self-care and like, what is helping us or if we're not taking care of ourselves. I am one that enjoys getting feedback. So, I definitely look for that in supervision. I always go to supervision with an agenda list.

Group supervision was another theme that arose in interviews. Clinicians reported that the ability to meet with other clinicians in a group supervision was viewed as very helpful. A clinician reported that the group supervision appeared to be missing the point, reporting that it was important to the clinician to be able to talk about what they are experiencing. The clinician continued to express the need for camaraderie in that setting.

Role and Perspective of Leadership

Clinicians in the study reported feeling a connection to leadership and explained that the connection they feel to the director is due to that member of leadership being so approachable. A clinician further explained that the director can read the staff well and that helps with offering support and promoting self-care. Clinicians explained that the director knows the staff well enough to recognize when they are not doing well and offer support such as canceling the rest of a day's appointments and exploring the areas that are causing distress. One example of how leadership was seen as approachable was from a clinician who felt that they were being treated as equals and that the leadership "never talk down to us." Several clinicians stated that they were very impressed with how members of leadership will "take a lap around the building [i.e., informal brief visits throughout the institution] and that means something." They further explained that it felt like a connection and like the members of leadership were present. They later mentioned that they had not experienced that in previous employment at other CMHCs, and that the presence of leadership very much stood out to them.

Support was another important quality that clinicians want from their leadership team. Several clinicians reported that the director is their "biggest cheerleader" and often celebrates successes. It is important that leadership should be thinking about what they can do to help therapists and make sure they are ok. One example of support from leadership was helping clinicians with reframing their mindset about needing to take the rest of the day off and canceling appointments. The director helped reframe thoughts around the clinician not being very effective in their current state and that it is acceptable to take time for yourself. It was also stated from a supervisor that collaboration with leadership is necessary for some decision making that needs to occur at times, specifically around clinical decisions or concerns around a case. Participant 16, a clinician, shared that support came from a member of leadership:

> When I had a client who died, one of my first clients and I was pretty sure it was natural causes because of recent discussion but there's always that chance it was not. And the client had tried suicide before I started working with them. Long story short, I was 95% sure it was natural causes. So, the director was the one that called me by face video during a team's call, they didn't email, didn't just phone me, and they let me know the news. The director said, now what would you like to talk about? How is this hitting you? The director took that compassionate approach as a therapist with me and then there's a whole set of procedures we go through where you get more debriefing and reflection with other people. Just the way they dealt with that was amazing.

Clinicians explained that authenticity, genuineness, and true compassion resonated with them and helped to increase the connection they had with that member of leadership. Support is felt when a member of leadership thinks about them for training opportunities outside the agency. This was seen as helping clinicians feel as if the agency and leadership were invested in their professional and clinical development.

One clinician stated that leadership "having our backs" is important to them. This clinician explained that they were in a meeting and a member of leadership showed genuineness and caring by speaking up and letting people know that something that was mentioned in the meeting didn't seem accurate. The clinician saw this as supporting what the staff need. Another

example of leadership having the clinicians' back was clinicians being asked to talk with clients about money due to the CMHC and having monetary balances. A member of leadership spoke up and let it be known that the clinicians are clinicians and that it is not appropriate to ask them to talk with clients about their bills. The clinician felt their position was being protected. A clinician further indicated that they want to be asked about new and/or changing initiatives. This provided an opportunity to provide suggestions, concerns, and thoughts. The clinician explained that this is a way that leadership shows that it cares about them and how their decisions impact their jobs and happiness at the CMHC.

Another important theme that surfaced in this study was transparency and leadership believing in the staff. One supervisor stated that it is important to show transparency and provided the example of letting staff know that even though they may not be doing the same level of work or that it may appear that the supervisor is "just behind a desk," they are completing other responsibilities, specifically, chart reviews, providing supervision, meetings, and the like. One member of leadership explained that it is important to "lead by example." This leadership member gave the example of jumping in and helping the clinicians with the workload or taking an on-call shift when other clinicians were already taking on a lot of shifts. This gave the perception of support and willingness to help when needed. Leadership also reported that staying connected and involved in the work is also important. For example, this can be taking a client or two for services, covering on a per diem shift, or just providing direct supervision to clinicians.

Licensure Contract

As discussed earlier in this paper, a licensure contract is a tool that some of the CMHCs are implementing to attempt to retain master-level providers. The licensure contract is an

important area to gain perspective, specifically from the perspective of leadership and clinical providers. It is important to try to understand how a licensure contract can potentially impact retention of staff. When I asked the clinicians in this study about licensure contracts and whether or not they would sign if presented with the contract, 16% stated that they would sign a licensure contract, 59% mentioned that they would not sign a contract, and 25% did not have an opinion either way.

Signing and Not Signing Licensure Contracts

Several clinicians and supervisors reported that they would have signed a contract with the CMHC and believe that they should have one due to the turnover problem. One clinician further explained that since they were already working in the CMHC as an intern, they would have signed due to being excited for an opportunity to stay. Another clinician explained that they were new to the agency and excited to start and get licensure, reporting that they would have had no problem signing a licensure contract.

Other clinicians in this study mentioned that they would not have signed a licensure contract for various reasons. Some reasons mentioned in the interviews were: not wanting to be locked in, low pay, and missing out on other opportunities. Some clinicians reported that it was a big deal to them that they did not have a licensure contract. Those clinicians said they would not sign a contract. One clinician further explained that they wanted to "go spread my wings as a licensed clinician." Participant 8, a clinician, stated they would never sign a contract:

> Especially in this field, in this department, I think that the nature of things change so rapidly because we are, you know, in a way controlled by the state, the government and what they decide when it comes to like rapid response and stuff. So, I think knowing that and maybe not being comfortable with some decisions that may be happening, based on personal beliefs, moral beliefs, whatever it may be. I think that would kind of make me kind of freeze up.

This clinician further explained that a licensure contract commitment would have stopped her from applying for a position and stated that she would avoid the CMHC. Several clinicians asked rhetorically how they could know that they could stay somewhere for two years, unless they knew the agency and what it was going to be like as a provider. One clinician further explained that they do not want to commit two years, not knowing if they would be miserable or what changes could come and how that can influence the experience at the CMHC. One supervisor said they would not have signed a contract at another agency if they did not have the assets to pay the contract off: This would help them feel they were not locked into the agency and had options. It is important that a few clinicians in the study stated that they would have signed a licensure contract when they began employment; however, after working at the agency for a period of time; they would not have signed it at all.

The Risk of Licensure

Several participants, who identified as clinicians and as members of leadership reported that not having a licensure contract carries the risk for the institutions that once becoming licensed clinicians can and do leave shortly thereafter. A supervisor reported that the risk for a master-level professional leaving after licensure is high; the CMHC provides licensure for two years and once the professional is licensed, they are "out the door most of the time." Another member of leadership said that it is risky for a CMHC to "dump a lot of resources into somebody to just have like a hit-and-run type deal." Some clinicians reported coming to the CMHC for licensure and just doing enough to get their licensure hours. Participant 21, a clinician, stated that a licensure contract may put the CMHC and clinician in a negative situation:

> I don't know that it puts those people in the best position for supervision, either if they're supervisor, someone who is unhappy and you know, I would imagine feeling burnt out not where they want to be. I just don't see that being the best for people supervising providers or for the clients.

When clinicians are under a contract and feeling stuck, it can negatively impact client care or the workplace environment. Participant 16, a clinician, explained that they understood why a business would want to have a licensure contract and went on to explain:

> I think it's interesting that CMHC is willing to take that risk because it says a lot. It says that they believe we can keep you and I think it works here. I really do, I think in this environment, if you set something in stone like that, I don't know that it would work.

Several reported that the licensure contract feels like it is giving back or paying it forward. Both clinicians and leadership reported that the contract could lead to people feeling trapped and unhappy, which can lead to decrease in performance and clinical care.

Considering Departure

Clinicians mentioned several different reasons for considering leaving the CMHC. Excessive workload, compensation, and workplace dynamic were all themes that surfaced from the interviews in the study. Both clinicians and members of leadership explained that people are leaving due to family, relocation, and some, to explore private practice or other clinical options.

Excessive Workload

Some clinicians in this study reported that they were feeling "bogged down" by productivity expectation. A few clinicians stated that to meet client care hours or productivity, they need to "over schedule." Over scheduling impacts the ability to complete paperwork and documentation. They explained that this feels like "pushing numbers" and is not client-centered. Several clinicians explained that needing to over scheduling and having to see "client after client after client" often leads to burnout. Members of leadership further said they are noticing some clinicians leaving the CMHC due to the job workload. It is important to remember that excessive workload can manifests in several ways: the acuity of cases and the overall volume or size of the caseload.

Case Acuity

Human resources, which included leadership and human resource associates reported that clinicians are leaving for "easier clients." When clinicians experience highly acute cases for a noticeable period of time without feeling relief, thoughts of wanting to leave and get relief by doing something outside the CMHC can be strong. Participant 7, a member of leadership, explained that the population being served has a higher acuity level than it was 30 years ago:

> You know, it's, it's, it's that the thing that I've seen, which is really too bad is back in the 80s, early 90s, New Hampshire used to be at the top for service delivery. And now I think we're looking at the bottom three. And I don't know how that happened, because it really is the same services that we had. I do think the case loads are much higher. I do think there's a sicker population. And I do think that symptoms are more acute, They're sick, they're much more sick than they were back in the 80s. But I don't understand how you go from here to here with still delivering the same services. Maybe because we haven't expanded our services. I mean, we've added PACT & ACT over the years and we've added CTI and we've added some other serves, so I just don't know how it's deteriorated so much.

Clinicians explained that meeting all the needs of a highly acute client is incredibly difficult. Going into the community to help a highly acute client is also stressful. This was seen as stressful due to not knowing what they are entering into when going into the community or into a client's home.

Caseload Size

Clinicians reported that caseload size can also contribute to thoughts of wanting to leave the CMHC. Multiple clinicians in this study have reported that their caseload consists of roughly 70 to 80 clients. They reported that the caseload is unmanageable and explained that the clinician is officially working 37.5 hours but often has a caseload in the high 80s. With caseloads this high, clinicians reported feeling that they feel they are not effective in their work, which increases burnout and thoughts to leave the agency.

Actions (and Inaction of) Leadership

Some clinicians in this study reported that they feel that senior leadership may not understand the bigger picture of mental health care. Clinicians also stated that if there was turnover of the leadership team, they would consider leaving due to not knowing how the culture would shift. Negative interactions with leadership were also brought up in the interview process. Clinicians reported that negative interactions can be seen as emails, in-person interactions, phone calls, or over video interactions.

No Recognition from Leadership

Clinicians reported that they feel senior leadership is missing the bigger picture, specifically that the clinicians are "not ok" and having a hard time in the therapy role. A few of the clinicians did report that they felt like they are merely a number at the CMHC, and that senior leadership do not know who they are or the impact they have on the community. A few interviewed clinicians said they feel they are not receiving recognition for the difficult job they are doing and the challenges they are experiencing. Lack of recognition and acknowledgement increases the thoughts and feelings that the clinician is just a number and not appreciated for their efforts. Clinicians further explained that they want to be heard by the leadership at the CMHC and want to be recognized for the clinical work they are doing.

Turnover of Leadership or Supervisor

It was explained that if senior leadership experienced turnover, some clinicians would think about leaving the agency due to the perception that the culture would change and what will occur then is very uncertain. Getting a new supervisor or member of leadership was one of the themes that surfaced in this study; several clinicians stated that if their own supervisor left the agency, they too would strongly consider leaving. Clinicians reported that if they were to get a new supervisor, they would have a difficult time trusting the new person and feeling comfortable

with them. It was also mentioned that if the new supervisor came from outside the agency, that would have a stronger negative impact than if an internal clinician were promoted to supervisor. One clinician explained that their trust would be a "little higher" for an internal clinician who is promoted than with someone coming into the CMHC. The new supervisor would be familiar with the CMHC culture and overall system. Several clinicians reported that they would attempt to give the new supervisor a chance but the thought of leaving the CMHC would be present.

Negative Interactions With Leadership

Several clinicians mentioned that there was some frustration with a weekly email from senior leadership, talking about financial stability of the CMHC. Clinicians reported that they do not want to hear about the surplus of the agency, specifically a surplus for the month. Stating that they get upset when they hear about the surplus and in return, they are getting a 4% raise. Clinicians explained that they came to work at CMHC to help people and knew they were not going to make a lot of money. They said that they understood this and when they saw the surplus being communicated yet only getting 4% increases, it makes them wonder where that money is going. They then consider whether they should think about going somewhere else to have a similar impact on clients but making more money.

Pay and Compensation

Pay and compensation were brought up in interviews when participants were having thoughts about potentially leaving the CMHC. Both leadership and clinicians reported that they feel compensation was a problem and that by crossing into a bordering state, they could make "10 grand more" in salary at another agency. Some clinicians went on to explain that they hear about private practice and that for some, it is enticing to make more money for a fraction of the workload. Leadership and clinicians reported feeling underpaid for the demand of work that is required in a community mental health center in New Hampshire. They understand that the pay

scale is set by the State of New Hampshire. However, that does not mitigate the frustration around compensation and the feeling of being overworked.

A licensed provider mentioned that they are still making under $60,000 a year. The clinician explained that they are feeling a "cycle of bitterness." Stating that they went to school for a master's degree and accrued a massive amount of debt, then became specialized in a clinical area and yet are having a difficult time paying student loans—or are not able to pay them at all. One clinician mentioned that they are considering a part-time job to help with expenses such as paying bills, paying rent, food. The clinician went on to explain that the cycle of bitterness is heightened due to having believed that a master's degree would provide enough salary to at least be able to pay bills.

Workplace Dynamics

The influence of workplace dynamics on decisions to stay or leave was another theme that arose in the study. Clinicians reported that lack of autonomy and limitation in growth increased their thoughts to want to resign from the CMHC and find employment elsewhere.

Autonomy

An important aspect of autonomy that surfaced in interviewing clinicians was the ability to practice autonomously, specifically with their clients. Clinicians want to be able to make appropriate clinical decisions on client care and maintain the ability to close a client from services when appropriate. A few clinicians explained that when a client is being planned for discharge, the provider needs to make three outreach attempts, then meet with the team, where everyone needs to agree with the discharge. Once that occurs, the clinician sends out a letter that gives the client 30 days to respond and if they reach out on day 29, then the whole process starts again. Clinicians reported that this feels as if autonomy has been taken from them and they do not have an authority to make key appropriate decisions around the case, which feels demeaning.

They report that this feels demeaning given that they went to school for a master's degree. It feels as though they cannot be trusted to make these kinds of decisions.

Multiple clinicians and members of leadership have reported that the feeling is demeaning, they know their client best and the fact that they cannot make decisions around client care contributes to the lack of autonomy clinicians feel. Clinicians also reported wanting the ability to learn, practice, and have the flexibility to utilize different forms of therapy, like Eye Movement Desensitization and Reprocessing, play therapy, and other approaches. Some specified that they want to learn and practice forms of therapy other than cognitive behavioral therapy, trauma-focused cognitive behavioral therapy, dialectical behavioral therapy or modular approach to therapy for children with anxiety, depression, trauma, or conduct problems.

Limitations of Professional Growth

Some clinicians described working at the CMHC as being on "growth plateau," while others reported a lot of growth opportunity there. Members of leadership explained they are investing in providing educational sessions for supervisors to help increase skillsets around providing supervision to clinicians. Several clinicians in this study saw the growth plateau as being more about their clinical skillsets. They reported that they have grown clinically and continue do so. However, they also said that they are ready to grow the clinical skills in more ways and do not feel that they can necessarily do that at the CMHC. They reported wanting to look at private practice which could be more helpful in skill development.

Both clinicians and members of leadership have reported that providers are leaving for opportunities in other places, sometimes related to clinical growth and sometimes, for opportunities for career advancement. Specifically, they said they were looking for the ability to grow in both responsibility and in position. Both leadership and clinicians reported that having room to grow and advance were important to them and a benefit of working at the CMHC.

Clinicians said they wished that room to grow was guaranteed at the CMHC, and that there should be more roles and opportunities to lead.

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Why Individuals Stay

</div>

The Nature of Upper-Level Leadership

Upper-level leadership was a major factor for why individuals stay in CMHC. Having leadership that is approachable and experiencing positive interactions are very important. This section also looks at the perspectives that members of leadership shared in regard to successful retention of master-level clinicians.

Approachable and Responsive Leadership

Clinicians reported that they stay when they feel leadership is approachable and when they have had positive interactions with upper-level leadership. Members of leadership stated that they work to be open and honest with their employees, to "put things on the table," and aim to be receptive to new ideas. Being receptive and open to feedback is important to clinicians and members of leadership. Clinicians and members of leadership reported wanting to be heard and having the ability to have a voice.

The clinicians in the study felt that leadership had their back both when positive things occur or for when negative things happen. Clinicians reported that they believe the leadership team will "have your back and will not leave you hanging." Leadership was seen as "super responsive" and not just acting approachable but responding appropriately when needed. Clinicians said that staying at the CMHC was due to feeling that they were respected as clinical professionals by leadership.

Successful Retention

Successful retention was seen by leadership on a spectrum: some viewed it as staying over a specific time period while others believed that successful retention meant that providers

have grown and learned at the CMHC. Supervisors interviewed for the study mentioned that this

CMHC is the only place they have worked where they have received a cost-of-living increase.

Several members of leadership stated that they believe salary increases contribute to retaining

staff. One supervisor reported not seeing successful retention in terms of the length of time a

clinician stays. In contrast, they saw successful retention as giving the clinician the ability to

"run their course" professionally at the CMHC. The question of success in retention was whether

the clinician had been able to do what they wanted and had learned and grown in their clinical

skills. Some members of senior leadership stated that people tend to stay at the CMHC once they

have been there for five years. One member of senior leadership stated that the first year appears

to be when the highest level of turnover occurs. There is no data to support this statement,

participant 05, a senior member of leadership, mentioned the following:

> We have an interesting stat here, so people leave in the first year or so. That's our highest turnover. People that stay more than five years tend to stay. And I don't know what the magic is, you know, in those two years, two or three years in the middle. That's what we're trying to find out. So for, at least (agency), that's successful. Successful retention is five years.

> According to members of leadership, clinicians' being able to grow their clinical skills

and having the ability and opportunity to contribute is what they consider successful retention.

Leadership felt that if the CMHC can retain someone for longer than three years, there is a strong

possibility of some further retention. Participant 07, a member of leadership, mentioned that

successful retention of clinicians can increase after three years:

> I think if you can keep somebody longer than three years, you have a possibility of some retention. That's, that's been my experience. You know, because it takes anywhere from two to three years for somebody to get licensed. And after that, it's a bally whack you know, whether they're getting to stay or not. So, your kind of, for lack of a better words, hopes to groom them where they're going to really enjoy being in the community mental health center. There. They've gotten the documentation piece down pat where it's not taking them very long. (agency) has a very cumbersome EMR. So that takes us I mean, the onboarding and learning that to 100% is a very long process. So, if I if you can keep

somebody longer than three years, I think somebody may really enjoy being in community mental health center.

Some members of leadership stated that they believe successful retention is when clinicians do not leave the agency. One member of senior leadership described successful retention as a "two-way street" with both the clinician and the CMHC benefiting from the employee's decision to stay. Both members of leadership and clinicians reported that when professionals can grow and advance in title changes and enhancements, this tends to increase retention. With advancements often comes increased compensation and responsibility, both which increase staff retention. Feeling that leadership treats the clinician as if they are on the same level, even though there is an obvious difference, also contributes to retention.

The Nature of the Supervisor and Supervision

A supervisor's positivity and willingness to accommodate a clinician's need for support and guidance was seen by clinicians as making a big difference. Supervisors' being open and comfortable talking about professional and personal things was reported to be a significant part of why clinicians stay at the CMHC. Feeling heard by the supervisor was an important aspect in a reason to stay. Participant 5, a senior member of leadership, said that retention is strongly affected by the supervisor level:

> I think it's pivotal. I think the supervisory level is where it's at in terms of retention. That's where the training happens. That's what the identification of problems happens in terms of vicarious trauma. That's where their personal relationship I think is really important to know. Something going on in your life, let's talk about you taking some time off or let's talk about you not taking, you know, clients over the next couple of weeks, because you've got a bunch of heavy hitters on your caseload. I think. I think that's pivotal.

Clinicians reported that getting support from their supervisor is a very important part of the reason why they stay at the CMHC. One clinician said, "It's huge, I would say it's 75% of why I'm still here." Their supervisor helps address the issues and concerns that they may be

experiencing within the system and in addressing clinical challenges with their clients. This support also supports them in addressing distress and burnout, which will increase retention. Consistent supervision was another reason clinicians gave for remaining at a CMHC. It provides support and structure to the clinician and their growing clinical skills. Consistency was seen as weekly supervision and by the same supervisor.

Being Trusted as Professional

Being trusted as a professional had two dimensions as seen by clinicians interviewed for this study: being given autonomy in their work and having opportunities and "role diversity."

Autonomy

Clinicians said they wanted the ability to find a niche that they can work with in CMHC. This meant having autonomy to work with specific populations or age groups that the clinicians choose. Clinicians also explained that they value the opportunity to vocalize and discuss circumstances when they are not feeling equipped to work on a case and, when this happens, wanting to be connected to training or educational opportunities to help close these gaps. As noted previously in this chapter, schedule flexibility is also important for clinicians and will be explored in further detail later in this chapter.

The ability/authority to make clinical decisions was also an important factor that clinicians reported in the interviewing process. This means being able to make decisions on whether a client needs to be discharged from services and having the responsibility to do what the clinician feels is best regarding clinical care. It is important that the clinician feels they are being guided and supported but not told what to do on a regular basis. This gives the clinician flexibility to explore, learn, and practice different modalities.

Schedule Flexibility

Both leadership and clinicians reported that flexibility in scheduling is important to them and assists in retaining staff. Clinicians said they want to stay at the CMHC due to having the ability to be flexible with their schedule, being able to flex their appointments with clients and having to address their own life demands. This includes their doctors' appointments; mental health counseling or other forms of personal needs being met. Clinicians and members of leadership also said that having the ability to work a different schedule—such as choosing to work a four-day instead of a five-day schedule for example—provided the flexibility that clinicians are seeking. Some want flexibility for childcare while others value the ability to explore other options like eventually moving to private practice.

Having Growth Opportunities and Role Diversity

Clinicians want opportunities, whether for growth in clinical skills, growth with position, and being able to explore opportunities outside of the CMHC, whether joining boards, legislative opportunities or private practice part-time. The ability to explore other options, while having an ability to keep a foot in the door is important to some clinicians. Some clinicians may end up being not the perfect fit for certain positions or roles. Having the flexibility to transition to different roles and trying these to see what does fit for each provider can help with retention. Internships with diversity built into the program and having the ability to rotate into different roles can be a way to provide those opportunities.

Role diversity was another theme that surfaced related to opportunities. Clinicians want the opportunity to assist in client care and advance the mission of the CMHC, rather than only providing direct service. This could look like a hybrid position, the ability to provide supervision, provide a portion of therapy or program leadership and development. Participant 16, a clinician, mentioned that role diversity is about balance:

The balance [is important]—I've always been a person who likes variety. When I was in a [names a previous career], I changed jobs roles at a company about every 18 months. I get restless. I need to learn while I'm on the job. And if I'm not learning, then I start to get bored and then I don't do my best work and I know that about myself. So, this variety is great.

Several clinicians interviewed in this study explained that they do not feel that they can provide therapy 100% of the time. This could also mean that some clinicians may do intakes part of the time and see a caseload of clients the rest of the time. One clinician explained that "I'm going to need something big to work on—so that would make me stay."

Room for Growth

A member of leadership explained that growth for them is the ability to "go after their vision." Going after a vision is seen as the ability to set goals for yourself and having the flexibility from the CMHC to do it. An example was reported as having the ability to create, enhance or change clinical programs and services being provided. Participant 14, a member of leadership, explained their opportunity for growth and going after their vision:

> Being allowed to go after my vision. So having the ability to go and present an idea or a thought process and then have it strongly backed, that's what's kept me here. They've allowed me to create a whole baby model of what I would have my crisis center look like. And they allowed me to hire case managers, and they allowed me to bring on peers before this contract started. We have the walk-in center here and although I'm not 24/7, yet that's my goal. And so, you know, I had one team on the weekends. Now, I have two teams on the weekend and scheduling appointments seven days a week. Being allowed to continue to push the envelope and serve the community and serve the clients. That, it's that, it's leadership that respects the vision and ideas that aren't their own. And so, I try and give that to my team as well. You know, I say it in every meeting that we have clinical staff, I'm the director, that does not mean I have all the answers or all the right answers, right. And the best way to come to an answer is to collaborate, it's talking out cases, it's working together, to come to a decision and a plan of action that we all feel together is the best next steps. And so, I never, I never want to be that person. It's that collaboration, it is so important to me. But really, being allowed to grow and develop and serve the community is just, I don't think I could go somewhere else and be able to do that like I have the ability to do here.

Members of leadership and several clinicians reported that over the years, they have noticed that retention tends to increase if professionals can advance in their position, specifically

becoming a member of leadership. One clinician stated, "I could maybe see myself staying long term, if there were growth opportunities in terms of, like, management and leadership." The clinician went on to explain that they could not see themselves doing therapy 100% of the time but only for set hours during the week.

Alternative Work Opportunities

Clinicians said that they would like to have an ability to explore options outside the CMHC, while being able to remain in the agency on a part-time or per diem options. Some clinicians have a calling to do this work in a CMHC. Due to some of the reasons noted earlier in this research, clinicians want options to explore while staying connected to the CMHC. One way to stay connected is by becoming a part-time employee or becoming a per-diem employee.

A member of leadership stated that there was a clinician who wanted to experience private practice but still stay connected to the CMHC and provide treatment to clients that they have been working with since starting at the CMHC. This gave them the opportunity to remain in the CMHC and work in private practice to earn more compensation and explore options outside beyond what the CMHC system has to offer.

Promoting Wellness

Promoting their own wellness was very important to both clinicians and members of leadership. Clinicians believe it is important to be able to talk about the importance of wellness and finding activities to practice in and out of the CMHC. Monetary benefits were also seen as factors in employee wellness. Clinicians want a work-life balance and have support from leadership and their supervisor when practicing work-life balance.

Talking About Wellness

The belief of members of leadership and supervisors was that discussing wellness will help prevent burnout. It also supports providers to practice skills for wellness from when they

start in a new position or have been there for a considerable length of time. Members of leadership mentioned that discussing wellness during the interview process is important. It provides an opportunity for the team and members of leadership to identify warning signs of burnout and gain an understanding on how the supervisor and team can assist in supporting wellness for the clinician. Promoting wellness often means talking about strategies with the treatment team and with individual supervisees.

Wellness Activities

Many different activities at the CMHC that enhance wellness were mentioned during interviews. A member of senior leadership included providing opportunities to celebrate within the clinical departments. This, they said, could be in the form of dinners out and being provided by the CMHC. This gives the opportunity for comradery and an ability to build working relationships and friendships.

The CMHC has had various professionals come in from outside the agency to promote wellness—a nutritionist, a professional providing guided meditation, and someone on site skilled in Reiki—which a senior member of leadership started during a Mental Health Awareness week. During this week the CMHC provided a series of week-long activities, including food for celebration and chair massages.

Monetary and Other Benefits

One way that wellbeing is promoted at this CMHC is through monetary incentives and bonuses. One interview made note of "meaningful" tuition reimbursement. So, for example offering $1,500 was not seen as meaningful, but an amount around 10, 20, or 30 thousand dollars can make a significant difference. A member of senior leadership reported that clinicians are leaving for those larger amounts of money, either in salary, tuition reimbursement or other monetary benefits.

Work-Life Balance

Clinicians and members of leadership said they were seeking flexibility in their schedule. This work-life balance is seen in such events as being able to step out, taking a break by having the opportunity to meditate, and generally being able to take the space and time needed for life as well as work. A supervisor said of the work clinicians are doing, "[It's] heavy stuff they're doing and sometimes we're just bumping along." This supervisor went on to explain that being able to take breaks or a lunch meant taking time for oneself. Members of leadership and clinicians do not want to feel like they are on an assembly line with just appointments after appointments. Providers want the ability to get water, a snack, or to take a breather to re-center oneself before the next appointment. Participant 4, who was identified as a member of leadership, explained that promoting work-life balance is important:

> I think promoting good work life balance is huge. Because we do have, you know, productivity numbers we have to meet. And, you know, on top of that, the documentation and notes and treatment planning and things like that, and I know, at least for us, like, our director, and they are really good at seeing when we aren't having a good work life balance and really encouraging us to use our earned time and, you know, take a day if we need it. I think that helps a lot and I think (agency) is also really good at like, promoting people within, so like encouraging people to, to, you know, branch out, or try something new, or there's always internal opportunities that that come up as well.

Receiving encouragement to use paid time off is another way to practice work-life balance. Clinicians and members of leadership want to be able to take a break from the important work they do. These individuals explained that encouragement is sometimes needed at times to take time off. They explained that forgetting to take time off can be part of the problem of work life balance. It is important that a supervisor helps them identify when it is time to take the break. Another important aspect when practicing work life balance is not to do work when taking time off.

Chapter Summary

This chapter described the different themes that surfaced from the one-on-one interviews that took place with master-level clinicians and members of leadership. The first theme that surfaced in the codes was about why master-level clinicians are drawn to the CMHC. In this chapter, I looked at how reputation and already being an employee was a factor in joining the CMHC. This chapter also explores how doing the work and perceived benefits all play into how clinicians remain in CMHC.

The next grouping of themes was about the connection master-level staff want to experience in CMHC. They want a connection to their team and colleagues, while also having a connection to their supervisor and the leadership at CMHC. I reviewed perspectives that master-level clinicians and members of leadership have around licensure contracts and the risks that are perceived around signing a contract. Workload, case acuity, caseload size, leadership and supervisor turnover, negative interactions with members of leadership, pay and compensation, and the workplace dynamics play into why master-level clinicians stay in CMHC or decide to leave the CMHC.

The last grouping of themes that surfaced in the codes were surrounding why individuals stay in CMHC. Stability in leadership and supervisor are important to master-level clinicians, they want their leadership team and supervisor to be approachable. The master-level clinician also wants to have autonomy of practice autonomy in the field with access to guidance when needed. Scheduling flexibility was also an important factor in relation to retention of master-level clinicians, as well as having opportunities for growth and the ability to practice role diversity, as stated earlier in the chapter. Wellness was also present in the coding that surfaced from the one-on-one interviews. As described above, clinicians want a work-life balance, they

want the ability to talk about wellness, and know that the CMHC supports them in practicing

wellness and work-life balance.

In the final chapter, I provide analysis of the findings along with implications for

practice. Specifically, I offer analytical insight through the standpoint of leadership, the

standpoint of the clinician, and the standpoint of clinical work educators. The last chapter also

explore areas for future research, discusses the scope of study, and concludes with my

reflections.

CHAPTER V: DISCUSSION

This study addressed research gaps about retention of master-level clinicians in Community Mental Health Centers. The research was designed to help identify why master's level clinicians remain in a particular CMHC. In Chapter IV, I highlighted the themes that surfaced in the data collection process. Findings were broken down into four different categories, looking at what draws clinicians to CMHC, the connections they have at the CMHC, why they tend to leave and why clinicians stay. The findings from this study can potentially assist CMHC leaders in increasing their retention of staff and assist clinicians in sharing their perspective on what could help them to stay. The purpose of Chapter V is to provide analytical insights, explore implications for practice, look at future research opportunities, and provide reflection from the researcher standpoint.

Scope of Study

The scope of this single case study was limited to master-level clinicians, currently working in one CMHC in the state of New Hampshire. Twenty-one individuals who identified as clinicians and members of leadership were interviewed for this study. One clinician decided after the interview to withdraw from participating in the study, so I removed that participant's data from the study and did not include that information in the findings.

Of the 20 interviews, 55% occurred over Zoom and 45% were in-person. Interviews were conducted between January and February of 2022. Voluntary participants were recruited from my attending virtual team meetings along with one team meeting in-person team meeting. The aim was to interview both clinicians and members of senior leadership and middle management like supervisors and directors. The data from these participants helped in understanding ways to increase retention and gain perspective around concerns these individuals are experiencing. As

discussed in Chapter III, the study was performed in one CMHC in New Hampshire. To maintain privacy of participants, I do not provide detail on the geographic area or other possible identifying factors of the CMHC where the study took place.

Engaging and Retaining Master-Level Clinicians: A Snapshot

A composite narrative is a way to describe the findings in a qualitative study that is especially useful when anonymity is critically important, yet vivid detail is sought (Willis, 2019). Willis (2019) described such a narrative as "an effective means of presenting anonymized interview data, while maintaining the richness and complexity of personal stories" (p. 480).

In this study, I have created three composite narratives, designated as Clinician A, Clinician B, and Manager A. The narratives form a story based on the overall experiences of participants identified as clinicians and a manager in this study. I tell the story through their lens. The following composite narratives are intended to provide a portrait of the studied CMHC and the elements and the culture that tend to draw and retain master-level providers. It is important to mention that this is not a single snapshot based on one interview but a compilation and blending of the experiences and perspectives of the participants of the study, who identify as clinicians. The key insights were represented in all composite narratives.

The CMHC Setting

When one steps onto the CMHC grounds, it is clear that they are well maintained. Clients and providers are going in and out of the building. As I walked into the building, I noticed providers greeting each other pleasantly. Unfortunately, I was unable to see facial reactions due to providers and clients wearing masks throughout the building due to COVID-19. Being in the waiting room, waiting for one of my interviews, I observed multiple clients being greeted by a seemingly friendly receptionist, smiling and welcoming some clients by name. It appeared that

the receptionist has built somewhat of a connection with the clients seeking treatment at the CMHC. Clinicians greeted their clients with warm and welcoming tones, while they led them to their office for mental health services.

Composite Narrative: Clinician A

Clinician A has worked at the CMHC for two years. She was drawn to this CMHC after working at another community mental health center and feeling that the other CMHC was not a good fit. Clinician A heard positive things about the leadership team from a friend who used to work at the CMHC. She knew she would need licensure supervision and appreciated that she would not have to sign a licensure contract. Her belief was that the licensure contract would make her feel trapped, and she knew she wanted to have the option to possibly explore other opportunities after receiving licensure. Clinician A was excited to gain experience, learn how to collaborate with other agencies and other providers working on the same case, and build clinical skillsets with different populations and acuity levels. She finds the work exciting because every day is different. This helps her avoid the repetitiveness she experienced in previous jobs. Coming to the CMHC actually meant a pay increase for Clinician A, which helped her to make the transition from the previous CMHC.

Clinician A feels a strong bond with her team; they are approachable, and she can talk with any of her colleagues for clinical consultation or to vent about the difficult day she sometimes is having. Working with the severe and persistent mentally ill, she appreciates the ability to connect with her team each day. She feels it is an invaluable support. Working on the same cases with colleagues has helped her to know that she is not working in a vacuum.

Being able to talk with the supervisor is also very important. She wants to know that she can connect with her supervisor when needed and that the supervisor is available for consultation

in the moment of need. Clinician A also appreciates having regularly scheduled supervision weekly, knowing that the supervision is her time to raise concerns, discuss successes or just bring up personal aspects in her life that may impact her clinical work. She knows the supervisor cares about her and her development as a clinician. She feels this because the supervisor is consistently wanting to check in, while also relying on her clinical expertise in specific situations. The time in supervision has felt safe because she knows it is a time to get questions answered without judgment and be able to receive clinical and career guidance. Clinician A also believes that a safe environment means she can talk about her own mental struggles, recognizing when a day off may be needed, or identifying transference and countertransference with clients.

Clinician A's interactions with leadership have been very positive. She believes that there is a connection with the leadership team: they are not just in their offices or at home: they care enough to be involved. She is impressed with how leadership members make sure to walk around the building and engage with staff regularly. She feels that most of the leadership team know who she is and that she is not just a number. She believes that it is important to be able to engage with CMHC leadership and feel that they respect the clinical staff and that they hear their concerns. Clinician A believes that the leadership team "has her back."

Clinician A said she felt frustrated at times—which can sometimes lead to feeling burnout. The acuity level of her clients is severe, and sometimes she feels as if there is no relief in sight. Her caseload is 78 clients which sometimes makes her feel that she cannot keep up or make a difference in their lives with a caseload that large. Sometimes, these frustrations make her think about leaving the CMHC and going somewhere where the caseload and acuity levels are not as high.

Another factor that contributes to Clinician A thinking about leaving the CMHC is pay. She is currently working two jobs, one as a clinician at the CMHC and the other as an emergency services clinician. She is feeling frustrated because she went to school for a master's degree, thinking that she would make enough to pay her bills, student loans, and maybe have some fun, but she does not even make enough to cover her bills or be able to move out of her parents' house. Sometimes she feels that if she were to leave and go to private practice, it would make things so much easier.

When having thoughts of leaving, Clinician A said she experienced guilt about leaving her clients and colleagues. She will often take time off to help center herself again and to try to remember why she is at the CMHC. The support she receives from her supervisor is another important reason for her to stay at the CMHC. She feels that the supervisor cares about her as a person not just as an employee. She said that she feels as if they want to help and support and that what she does matters to them, as much as the clients.

Flexibility also helps Clinician A to stay at the CMHC, feeling that she can attend a doctor's appointment or get her birthday off to celebrate with friends and family is important to her. Being able to "flex hours" means she can successfully strive for a work-life balance, which helps her to stay at the CMHC. Clinician A feels that if clinicians were able to practice better work-life balance, they would be likely to stay. Work-life balance can be having time to go to the bathroom, having a little break throughout the day or even a lunch would help to relieve some of the pressures from the day.

Composite Narrative: Clinician B

Clinician B has worked at the CMHC for almost a year. She was drawn to the CMHC when she worked there as a bachelor-level provider. From that positive experience as a

bachelor-level provider, she made the decision to continue to be employed at the CMHC after completing her master's degree. Having a positive connection with her team and supervisor helped her decision to stay. Clinician B also chose to continue to remain with the CMHC and not explore other options because she knew the clientele and wanted to continue to make a difference in the lives of her clients and the clients in the region.

It is important for Clinician B to know that the CMHC is a place to gain clinical experience, and she appreciates that it does not require a licensure contract. Her feelings are strong around the licensure contract: she wants to be able to potentially look at other options after licensure. She is not sure she wants to leave the CMHC but does not want to be boxed in and unable to do what she wants to do. Clinician B also feels that the CMHC's values match her own and that it is driven to support the community. She wants to help support members of the community and aid them in improving their lives however they see as most beneficial.

Clinician B likes working with the severe and persistent mentally ill clients and feels a sense of connection with them. Talking with her supervisor and colleagues about the cases being worked on helps to get everyone on the same, or at least a similar, page and moving towards the same goals. She feels a sense of pride in the work she is doing and the support she provides her clients. She wants to specialize in her current work and provide trainings and support to other clinicians. She believes having a balance between providing care to clients and doing other tasks such as training others or addressing concerns that her team and the CMHC are experiencing over funding, workload demands, and other concerns that may come up with legislative is a good balance for her.

She believes working long days and seeing six, seven, or even eight clients each day is a lot but she feels that she needs to "over schedule" for the sake of productivity. She believes that

having flexibility in her schedule helps with the work-life balance. Being able to keep her own personal appointments is important to her. When attending school, it was helpful to have flexible time and to adjust the schedule to account for classes or homework assignments.

Clinician B is very close to her team and feels they are one of the main reasons why she stays at the CMHC. Being able to reach out to other clinicians and get guidance or just being able to chat about the weekend they had, is important to her. Another key factor that keeps Clinician B at the CMHC is the ability to openly talk to her supervisor. Talking about personal things and professional things makes working each day very helpful. Clinician B was not sure how COVID-19 protocols would impact her ability to be close with her team or her ability to connect. She was pleasantly surprised that even with COVID-19, she was able to connect with her team and supervisor whenever needed.

Not having to sign a contract helps Clinician B's morale—she feels that she has options and is not locked in. Another important aspect of the CMHC that helps her stay, is the loan forgiveness program. Even though the pay is not quite where she wants it and being able to financially be independent is very difficult, knowing that working at the CMHC and working towards loan forgiveness is helpful to her. She is considering signing the SLRP program contract but for right now, she is engaged in the federal loan forgiveness program and feels that gives her some options if she wants to search and engage with those options.

Clinician B feels there is a lot of stress at the CMHC, specifically about caseload sizes, acuity levels, and feeling that sometimes leadership is not really understanding the bigger picture. There is a frustration that she experiences from needing to over schedule with clients, just to try to make productivity expectation. Her caseload is often between 70 and 75 clients,

which can feel overwhelming at times. She says it is like being on a conveyer belt at times, specifically to push productivity numbers.

Clinician B knows that there is a good connection with her supervisor, her team, and even the program director. Yet, she sometimes feels that senior leaders are disconnected and not seeing the challenges that the clinicians currently face. Recognition for clinicians at the CMHC is not present and Clinician B stated that she sometimes feels "like a number" just to bring in revenue. She believes some senior members of leadership know who she is and what she does for the CMHC and also believes they *should* know all staff by name and what they do at the CMHC. She wants recognition for her clinical work and the impact she has on her clients.

Clinician B feels that greater autonomy at the CMHC could improve morale. She wants to be able to make decisions for her clients within parameters of professional ethics and the state regulations. Sometimes, she feels that she and other clinicians cannot do anything without going through many steps to get permission. An example is being able to discharge a client from services due to not engaging and or not doing so for some time. Feeling that she knows the client best, she thinks that, generally, she should be able to make important clinical decisions.

Clinician B continues to work at the CMHC for her team, her supervisor, and her clients. She considers the support she receives from the team to be invaluable. She feels she can reach out to them for support on cases and about her personal life. Clinician B and the team will spend time together outside of work, which increases the bond she feels she has with her team. Clinician B feels that the supervision she receives is extremely important and helpful to her as she grows her clinical skills and advances her career. She knows that her supervisor cares about her and that supervision is a safe place because the supervisor does not take her ideas and then try to pass them off as their own. She also chooses to stay at the CMHC because she does not

know what other opportunities will be like for her. She seems to fear the unknown beyond this employment and feels better staying in a place that is familiar, where she knows the parameters of the job, and potentially, has room to grow professionally. Clinician B feels that there is room to grow at the CMHC and can envision moving into a leadership role where she can help others build their clinical skills and professional development.

Composite Narrative: Manager A

Manager A has been at the CMHC for seven years and currently working as a supervisor. She believes that clinicians come to work when they feel a sense of purpose and have a connection with their colleagues and supervisor. Team meetings are a way to share connections and provide support around the cases that are shared with colleagues. Manager A makes sure she is available to her staff when they are needing to connect about a case or needing to address a concern, which helps increase the clinician to come do the hard work they do each day.

Morale is something that she works to create within her team, while also encouraging her staff to engage in the efforts that the CMHC uses to help boost morale for the staff. Taking staff out for a team dinner was one way to show appreciation, while also celebrating birthdays and professional accomplishments like achieving licensure. Manager A believes that these small acts can help to positively influence morale. Another quality that Manager A feels is important in leading her staff is helping to promote well-being. She feels that promoting well-being is done by encouraging her staff to take vacations, take breaks and lunches, and balancing the schedule throughout the week.

Manager A feels that being consistent with providing supervision consistently on a weekly basis and following through with what she says is a way to positively influence retention. She mentioned having an open-door policy and how that policy can positively impact her staff.

One way that the open-door policy impacts is by making sure that if a clinician is needing to connect, they can swing by at any time for support. Another way to connect when needed is being able to call whenever needing support or guidance.

Some of the challenges that her staff are experiencing are high caseloads and acuity levels in the caseload. Manager A's staff have reported that they feel burnt out after the pandemic and feel that with all the turnover that has been occurring, they are unable to take a break or even take a lunch because they need to make sure they see everyone. She believes that they are reluctant to take vacations due to the workload around paperwork and not having anyone to help cover their cases when they are away for a week. She is currently trying to work with CMHC senior leadership to address these concerns and find ways to help alleviate some of these challenges. Being able to collaborate with staff and talking openly about these concerns has helped to encourage staff to talk openly with Manager A about their concerns and exploring possible ways to address the concerns. She believes it helps to at least work on communication and making sure that staff know they are being heard by their direct supervisor and the direct supervisor is relaying these concerns to senior leadership.

Manager A feels that successful retention of staff occurs when a clinician feels they have received all the opportunities that are available at the CMHC. These can look like specific trainings, certifications or licensure, and career advancement opportunities. She also stated that providers tend to stay if they can get through the first year. Leadership A feels that if providers can get through the first year, which consist of trainings and learning the job thoroughly.

Conclusion on the Three Composite Narratives

These three narratives are a composite of what the clinicians and supervisors participating in the study shared in the interviewing process. They demonstrate the draw to CMHC, the

frustrations experienced, and the factors that help increase retention. In the first two scenarios, the clinicians want to help clients, are having positive experiences with their supervisor and team, and can vocalize why they want to remain at the CMHC. The last is a leadership composite, combining what senior leadership and supervisors shared in their interviews. One important aspect to note was that the clinicians are not under a licensure contract. They are at the CMHC because they want to be there, and they are able to describe what helps to keep them there. The next section is on the implications for specific roles within practice.

<center>**Implications for Specific Roles Within Practice**</center>

This section explores issues to consider in regard to different roles, specifically leadership, clinician, and clinical educator. Looking at these three specific roles can assist in identifying what can help support and hopefully increase retention of master-level clinicians at the CMHC.

Implications of Findings for Leadership

It is important for leadership practice to include the ability to assess their clinical staff, especially the size and nature of the caseload. They need to continually assess the level of work they are requiring of master-level clinicians and consider whether that level of work is realistic. This includes assessing acuity level, caseload size, and licensure contracts. It is also important to promote advocacy of clinicians, promoting the relationship between supervisor and clinician, and promoting advocacy of reimbursement rates by insurance providers.

Client Acuity Level and Caseload Size

Leadership has a responsibility to continuously "take the temperature" of the staff and try to gauge mindsets, emotions, and potential burnout. This can be done by surveying employees or doing one-on-one interviews with the help of a third party. This reduces the power imbalance and works towards helping the interviewee feel safe in the interview. Multiple clinicians in this

study thanked me for the opportunity to meet one-on-one and tell their perspective on what drew them to the CMHC, why they do the work they are doing, their considerations about leaving—or choosing to stay. It is important to continue to assess if the licensure contract is worth having in place and assessing expectations and workflows.

Throughout the interviews, clinicians reported that demanding workload and case acuity are significant stressors for them, ones that are contributing to thoughts of leaving CMHC. As noted, it is important for the leadership team to assess the workloads and workflows being asked of the clinician. One way to assess is by looking at expected work hours and the list of tasks and time requirements. Subtracting the working hours with the total tasks expectations provides a rough estimate on what the clinician can realistically do. It is also important for the members of leadership to remember that this is not a "one-and-done" challenge; annual reassessments are essential. Time studies can assist with assessing time being spent on tasks, which can provide insight into the appropriateness of time spent on tasks. Assessing these areas would also potentially help to address the concerns around work-life balance and improving morale.

Licensure Contract

The CMHC in this study does not currently utilize a licensure contract, however it is an important element to explore due to the licensure contract appearing to be a common practice in these type of organizations in New Hampshire. In this study, some clinicians seem to be open to signing a licensure contract while others said they would not sign one and would actively avoid applying to any CMHC that has a licensure contract requirement. Several participants mentioned that they would have signed such a contract when starting at the CMHC but would not do so now that they have worked at the CMHC for a period of time.

It is important to remember that a licensure contract is a commitment from the clinician to the CMHC that if the CMHC provides two years of licensure supervision, the clinician will

provide two years of service at the CMHC after they achieve their licensure. This contract/commitment may be a band-aid approach for the CMHC. The contract may just prolong the inevitable, if an employee is looking to leave then they will most likely leave the CMHC. It is important for the CMHC to ask themselves if the contact is doing what they intended it to do. If a clinician is unhappy and not providing their best work due to feeling trapped, is it beneficial to the CMHC, the client, or the clinician. Feeling unhappy or trapped can lead to employee turnover. Several clinicians mentioned this in their interviews.

It would be beneficial for the CMHC to look at their licensure contracts and determine if the perceived benefits outweigh the perceived negative effects. Typically, clinicians receive an hour of supervision a week. This is a combination of administrative supervision, clinical supervision, and licensure supervision. If a clinician is already getting an hour of supervision, it most likely does not cost anything extra to provide licensure supervision to the clinician. If the contract will stop potential employees from applying, it may cut the employee workforce before these potential employees even apply for a position at CMHC.

The cost would be in the employee turnover, needing to recruit and train clinical staff is a process that takes a significant amount of time. Cost to employee turnover varies from CMHC to CMHC. Assessing the CMHC culture and what can help increase retention is important to improving the staffing situation. Lastly, it is important to remember that CMHC organizations can be exceptional places for training and learning for master-level providers.

Culture and Training

CMHC leadership are encouraged to promote a culture wherein if a clinician finds that a supervisor is not a good match for supervision, the clinician can change supervisors with no stigma or penalty. It is important for this option to be part of the culture and seen as a positive aspect of the culture and not seen as a negative. The relationship between supervisor and

clinician is very important, as it was brought up on multiple occasions in this research. Training to provide effective supervision and ways to cultivate those strong and supportive working relationships is very important to the culture of the CMHC. In addition, enhancing the culture to build trust within the organization and not just between two supervisor and clinician. As noted earlier in the study, many of the clinicians expressed trust with their supervisor or a specific member of leadership and did not appear to express a lot of trust with the organization itself, which could contribute to some turnover of clinicians.

Lobbying and Reimbursement Rates

It is important for the members of leadership at the CMHC and state officials look at reimbursement rates. One recommendation would be to look into adjusting reimbursement rates based on acuity level of patients, another recommendation would be to evaluate when the last time reimbursement rates were adjusted, while simultaneously looking at how those reimbursement rates may be negatively impacting client care. Leadership is encouraged to support clinicians who are interested in advocacy work by providing training and release time for interested staff to attend and speak at relevant hearings and related meetings. Leadership and clinicians could build further trust through these kinds of efforts, potentially increase the likelihood of influencing policy, and these engagements could serve as meaningful opportunities for professional growth and contribution for practitioners.

Implications of Findings for Clinicians

Clinicians also have an opportunity to address some areas that surfaced in the research. It is important for clinicians to communicate their concerns, perspectives, and ideas to members of leadership. One way to increase this communication is appointing clinicians to join committees and other important meetings of the CMHC—and taking these commitments into account for

clinicians' workloads. This could help to increase collaboration between leadership and master-level providers.

Another way for the clinicians to have a positive impact in these areas is to find opportunities or look for invitations to share their voice and perspective. One such opportunity could be to participate in research studies surrounding retention of providers at CMHC. Joining legislative movements, committees, and meetings can be another way to promote the necessary changes that were brought up in the interviewing process. Using these platforms can potentially help promote change necessary to increase retention of master-level providers.

Implications of Findings for Clinical Educators

While I did not interview clinical educators, I believe the findings from my research can inform program development. Being prepared for the clinical work is crucial to the success of the clinician and the success of their clients. It is important to continue to work towards clinicians being as prepared as possible for the clinical provider roles they occupy.

When preparing for the role, it is vital for the clinician to not only understand the clinical aspects in the role, like diagnosis, treatment planning, and being able to sit with someone who is having a hard time, but to understand the different components of a presenting case. Specifically, they need to have strong understanding of homelessness, co-occurring disorders, psychosis, and even ways to address emergency situations This means looking at the current needs of the client, navigating gaps in resources, and having the opportunity to manage their own stress levels. These aspects change over time, so it is important for the educational institution to change as well. This means that educators need to create training and support directly relevant to providing the treatment and getting an understanding of what is needed to be successful at providing that treatment.

Another important aspect of curriculum for individuals studying to be clinicians would be collaboration with different areas in the field. Collaboration between the CMHC system and the educational institutes could help address changing situations while also assessing program on both sides to ensure they are effective. Creating a system to receive feedback from students is also important, however the feedback should occur *after* the student graduates so as to avoid the teacher-student power dynamic, which can influence the feedback. Finally, work-life balance was reported as being important to clinicians and members of leadership at the CMHC. It is important for educators to begin to instill the practice of work-life balance and wellness activities into the routines of future clinician. Talking about wellness and building it into continued discussion is also a way to help promote practicing wellness for future clinicians.

Areas for Future Research

This study examined the aspects in a community mental health center that help retain master-level providers. The study did not include the perspective of bachelor level providers, peer support specialists, medical staff, or administrative staff. Gaining the perspective of these individuals in future research could help CMHCs in understanding what they can do to increase the retention of these providers. Expanding the focus of future studies on licensed providers could also help in understanding what these individuals are seeking to remain employed at the CMHC.

Members of leadership and clinicians both had mixed feelings about the licensure contracts. Some felt they would sign while others reported that they would not sign the contract. I found very little critical thinking and research about the licensure contracts and suggest that gaining the experience from those who are currently working towards completing their contract would provide significant insight. It may also be helpful to talk with professionals who are

currently completing their clinical degrees to understand their insights into the licensure contract commitment. Another area to look at regarding the licensure contract is whether it inhibits future clinicians from applying at the CMHC. Gathering the perspective around those currently completing their clinical degrees could provide insight into retention and what they those close to graduating are looking for in CMHC culture.

Future researchers may also want to engage providers who have left the field of community mental health to better understand what might have helped to retain them in CMHC. The role of the supervisor and supervision was a significant theme that surfaced in this study, and researchers should study the potential need and development of a training program for supervision. Looking at how supervisors lead clinicians and how a training program for them may increase retention—some leadership members reported that there they had not had a lot of training and relied more on training on the job. Given the high stakes of mental health patient care, leaving such supervisor learning to the vagaries of on-the-job experience may not be good enough.

Researcher Reflections and Conclusions

I began this dissertation journey with a personal connection to the subject. Working in the CMHC system in New Hampshire at multiple CMHCs and at multiple levels, I have experienced the problems with clinician retention. I knew what I wanted to study throughout my doctoral voyage. It was clear to me that the dissertation needed to be scholarly work that is relevant, meaningful, and applicable to the current problem. It is my goal to provide the outcomes of this research to CMHC systems in NH, throughout the United States, and possibly the mental health systems throughout the world.

This work is very pertinent to the current challenges and climate in community mental health and the very real staffing concerns occurring in the field. It is clear from the data in this study that clinicians want to feel a connection to leadership, their supervisor, and their team. These providers want autonomy and flexibility in their clinical work and work schedule. It is also clear from this research that the first step in helping to retain master-level providers is greater collaboration. Gaining their perspective and bringing them to the table to profit from their experience, insight, and knowledge can be invaluable. It allows the leadership team members and clinicians an opportunity to collaborate with each other. This could be done through joining quality improvement meetings, committees, and new initiatives.

I believe that surveying employees has a place and time and can be helpful, however interviewing staff in a safe space can provide more detail and insight to the CMHC leadership team than a survey. In trying to recruit participants in future studies, it will be beneficial to attempt to recruit in-person, rather than over telecommunications. I very much enjoyed meeting with clinical staff and found more energy to continue after clinicians expressed their excitement about being able to talk with someone who has experience in CMHC and not having to do a survey. Clinicians seemed happy to have the opportunity to express their perspectives around the retention problem.

When I started this doctoral journey, I never saw myself as a researcher. I saw this dissertation as my first and last research study. However, after experiencing this research study and the experience of collecting data, analyzing the data, and reporting the findings, I cannot wait to continue to address this retention problem at my CMHC and hope that others will want to jump on the wave and contribute to the research. Finally, retention of master-level providers is not going to be a simple adjustment or a flip of a switch, it is important to note that this kind of

change must come from all levels simultaneously. All levels working with each other and being

committed to making the necessary adjustments needed for success.

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APPENDIX A. INTERVIEW GUIDE: MANAGEMENT AT CMHC

What do you believe helps master-level providers with coming to work each day?

How does (name of CMHC) influence the morale of its master-level providers?

What opportunities do you feel a CMHC should have that would promote well-being for a master-level providers?

How do you think your leadership influences retention of master-level providers?

What do you think are the challenges that master-level providers face in working at (name of CMHC)?

How do you think your supervisions influences the retention of master-level providers? (For direct supervisors only)

What else do you believe helps with retention of master-level providers at (name of CMHC)?

APPENDIX B. INTERVIEW GUIDE: MASTER-LEVEL PROVIDER

What makes you want to do this work each day?

How does (name of CMHC) influence your morale related to the work you do each day?

Tell me about your experience with your supervisor?

What role does your supervisor play in your decision to stay at (name of CMHC)?

Tell me about the impact that overall leadership here at (name of CMHC) has on your decision to stay?

Have you ever thought about leaving and if so, can you tell me more about that?

What would help you to stay at (name of CMHC) and make this your long-term place of employment?

APPENDIX C. INFORMED CONSENT FORM FOR RESEARCH PARTICIPANTS

This informed consent form is for **CENTER FOR LIFE MANAGEMENT COMMUNITY MENTAL HEALTH CENTER EMPLOYEES** who we are inviting to participate in this dissertation study titled **"RETENTION OF MASTER-LEVEL PROVIDERS IN CMHC: WHAT MAKES THEM STAY?"**

Name of Principle Investigator: William E. Keating, LCMHC, MLADC, NCC
Name of Organization: Antioch University, PhD in Leadership and Change Program
Name of Project: Retention of Master-Level Providers in CMHC: What makes them Stay?

Introduction
I am William Keating, a PhD student enrolled in the Leadership and Change program at Antioch University. As part of this degree, I am completing a dissertation study to gain understanding around perspectives of mental health providers and what motivates them to remain employed in the CMHC system. I am going to give you information about the study, and take time to reflect on whether you want to participate in the project or not. You may ask questions at any time.

Purpose of the Project
The purpose of the study is to understand the perspectives of mental health providers regarding what motivates them to remain employed with a CMHC. The mental health field is continuously changing and due to the challenges and growing obligations, it is often difficult for the CMHCs to retain highly qualified professionals. CMHCs are often not properly staffed, which decreases their ability to provide services to the population. This dissertation is intended to provide the insight into the challenges around employee retention and effective ways to address the concerns.

Project Activities
This project will involve your participation, for example in a 1:1 interview, lasting approximately 60 to 90 minutes in length. The interviews could be held in person or over zoom/other video platform due to Covid-19 protocols. Interviews will be tape recorded solely for the purpose of this study.

Participation Selection

You are being invited to take part in this study because you meet the following criteria:
- Member of the leadership team at Center for Life Management
    - President, Chief Executive Officer
    - Vice President, Clinical Services, Quality, Compliance and Housing
    - Vice President, Human Resources and Administration
    - Clinical Director, Adult Services
    - Director, Child, Adolescent & Family Clinical Services
    - Director, Acute Care-Emergency Services
    - Director, Community Support Program
    - Director, Marketing and Community Relations
    - Master-Level Mental Health Provider

Voluntary Participation

Your participation in this dissertation study is completely voluntary; you may choose to not participate. You may withdraw from this study at any time. You will not be penalized for your decision not to participate or for anything of your contributions during the project. Your position and employment at **CENTER FOR LIFE MANAGEMENT COMMUNITY MENTAL HEALTH CENTER** will not be affected by this decision or your participation.

Risks

I do not anticipate that you will be harmed or distressed as a result of participating in this study. You may stop being in the study at any time if you become uncomfortable.

Benefits

There will be no direct benefit to you, but your participation may help the investigator to learn more about what can help develop and strengthen retention of clinical providers in a community mental health center.

Reimbursements

You will not be provided any monetary incentive to take part in this study.

Confidentiality

All information will be de-identified, so that if cannot be connected back to you. Your real name will be replaced with a pseudonym. This list, along with any tape recordings will be kept in a secure, locked location.

Generally speaking, the evaluator can assure you that they will keep everything you tell the evaluator in private. Yet there are times where the evaluator cannot keep things private/confidential. The evaluator cannot keep things private/confidential:

- a child or vulnerable adult has been abused
- a person plans to hurt himself/herself
- a person plans to hurt someone else
- a person plans to damage property

There are laws that require many professionals to take action if they think a person is t risk for self-harm or are self-harming, harming another individual or if a child or vulnerable adult is being abused or plans to harm another person. Please ask any questions you may have about this issue before agreeing to be in this study. It is important that you do not feel betrayed if it turns out that the evaluator cannot keep information private.

Future Publication

This dissertation study will be published as a dissertation and the results may be further

published as an article(s). The results could also be presented to various communities to help

address employee retention concerns in the CMHC system.

Right to Refuse or Withdraw

You do not have to take part in this project if you do not wish; you may withdraw from the study at any point in time. There will be not penalty or negative consequences if you choose to withdraw.

Who to Contact

If you have any questions, you may ask them now or later. If you have questions later, you may contact, William Keating, LCMHC, MLADC, NCC at (*author's email addess*)
If you have any ethical concerns about this study, contact Lisa Kreeger, PhD, Chair, Institutional Review Board, Antioch University PhD in Leadership and Change,
Email: (*Dr. Kreeger's email address*)

DO YOU WISH TO PARTICIPATE IN THIS PROJECT?
I have read the foregoing information, or if have been read to me. I have had the opportunity to ask questions about this study and any questions I have been asked have ben answered to my satisfaction. I consent to participate in this study on a voluntary basis.

_____

Print Name of Participant

_____

Signature of Participant   **Date**

_____

Printed Name of Witness/Researcher

_____

Signature of Witness/Researcher   **Date**

APPENDIX D. INTERVIEW PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

Interview Case Number:

Participant Email?

Identified Gender?

Male	Female	Non-binary	Prefer to self-describe, below
Self-describe:			

Age?

20–25 Yrs. Old	26–30 Yrs. Old	31–35 Yrs. Old	36–40 Yrs. Old	41–45 Yrs. Old
46–50 Yrs. Old	51–55 Yrs. Old	56–60 Yrs. Old	61–65 Yrs. Old	66–70 Yrs. Old
71–75 Yrs. Old	76–80 Yrs. Old	81–85 Yrs. Old	86–90 Yrs. Old	Older than 90 Yrs. Old

Identified Ethnicity?

White	European	Middle Eastern	Black/African American
American Indian	Alaska Native	Asian	Native Hawaiian
Other Pacific Islander	Hispanic/Latino/Latina	Other:_____	

How long have you worked at (Name of CMHC)?

Less than a Year	1–4 Yrs.	5–8 Yrs.	9–11 Yrs.	12–15 Yrs.
16–19 Yrs.	20–23 Yrs.	24–27 Yrs.	28–31 Yrs.	32–35 Yrs.
36–39 Yrs.	40–43 Yrs.	44–47 Yrs.	48–51 Yrs.	52+ Yrs.

Full-Time or Part-Time Employee?

Full-Time Employee	Part-Time Employee

What is your current position at (Name of CMHC)?

Management?

Yes	No

Level of Management

Supervisor Level	Director/Department Head Level	Executive Level

If currently in management/leadership position, have you ever worked in a clinical/direct care role?

Yes	No

Department working in at (Name of CMHC)?

Emergency Services/Acute Care	Adult Services	Children/Youth Services
Other:_____		

How long have you been in that position?

Less than a Year	1–4 Yrs.	5–8 Yrs.	9–11 Yrs.	12–15 Yrs.
16–19 Yrs.	20–23 Yrs.	24–27 Yrs.	28–31 Yrs.	32–35 Yrs.
36–39 Yrs.	40–43 Yrs.	44–47 Yrs.	48–51 Yrs.	52+ Yrs.

Field of Study in Master Degree Program?

Social Work	Clinical Mental Health Counseling
Other:	

Years in Field?

Less than a Year	1–4 Yrs.	5–8 Yrs.	9–11 Yrs.	12–15 Yrs.
16–19 Yrs.	20–23 Yrs.	24–27 Yrs.	28–31 Yrs.	32–35 Yrs.
36–39 Yrs.	40–43 Yrs.	44–47 Yrs.	48–51 Yrs.	52+ Yrs.

Licensed Professional?

Yes	No	Not Licensed Position

Does your position require you to work in a patient's home or in community?

Yes	No