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Trauma-Informed Behavioral Health Leadership and Employee Engagement at a Child Advocacy Center

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2023

Abstract

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MA, West Virginia University, 2005

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Employee engagement is essential for an organization to meet its mission and vision. When employees are not engaged, there are higher levels of turnover, secondary traumatic stress, and burnout. Furthermore, when employees are not engaged, there is a decrease in the quality of patient care. Behavioral health leaders can positively impact employee engagement by engaging in trauma-informed behavioral health leadership. This qualitative case study reviews the impact of trauma-informed behavioral health leadership on employee engagement at a large Child Advocacy Center in the northeastern United States who was struggling with low levels of employee engagement and high levels of turnover was explored. The Baldrige Framework of Excellence was utilized as the conceptual framework for this study to assess multiple levels of leadership and organization. Data were collected from semi structured interviews with three leaders of the CAC as well as review of secondary and archival data. Thematic analysis resulted in several emergent themes including the necessity for leaders to focus on enhancing psychological safety and levels of resiliency and well-being among employees. The findings revealed that there is a basic level of psychological safety and resiliency at the CAC, yet the lower levels of psychological safety and resiliency could be a reason for the low levels of engagement and high levels of turnover. Recommendations included implementing strategies to enhance psychological safety and overall levels of resiliency and well-being among employees. This study contributes to positive social change by providing recommendations for behavioral health leaders to create and enrich psychological safety and resiliency in their organizations.

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Dedication

I dedicate this study to the families served at Child Advocacy Centers and the staff and leaders that set the foundation for restoring hope and joy for those families served.

Acknowledgments

I would like to acknowledge my wife, Angie, and my two children, Joie, and Spencer. They provided endless support and were beyond understanding during the past several years when I was working on this study. I would also like to acknowledge the leaders and staff at the CAC1. Their daily work impacts the lives of so many families as they plant the seed to restore hope.

I would also like to acknowledge my doctoral study committee for their support and guidance throughout this project. This includes Dr. Kristen Chesser (Chair) and Dr. Christopher Pels (Second Committee Member).

Table of Contents

List of Tables

List of Figures

Section 1a: The Behavioral Health Organization

Introduction

The organization served as the behavioral health organization in this case study is a Child Advocacy Center (CAC). The study site, CAC1 (a pseudonym), is a large, hospital-based, CAC serving families exposed to trauma. CAC1 has been operating for almost 28 years and is in the northeastern United States. CAC1 has a main office and two satellite offices in neighboring counties. CAC1 provides forensic interviews, medical examinations, and mental health interventions to children and families who have allegedly been victims of sexual or physical abuse, neglect, or acts of violence. CAC1 staff work as part of the multidisciplinary team (MDT), including law enforcement, child protective services, advocates, and the district attorney's office.

The purpose of a CAC is to provide a single location for a child to discuss their alleged abuse so that they do not have to continually repeat their experiences (National Children's Alliance, n.d.). According to its website, the mission of CAC1 is dedicated to reducing the occurrence and aftermath of child abuse, thereby improving the health, welfare, and safety of children and families.

The Mental Health Department provides support, advocacy, screeners, and referrals for all families that have forensic interviews and medical exams. The Mental Health Department also provides evidence-based trauma therapy by licensed and pre-licensed therapists. Interventions include Trauma Focused Cognitive Behavioral Therapy, Alternative for Families-Cognitive Behavioral Therapy, Child and Family Traumatic Stress Intervention, Eye Movement Desensitization Reprocessing, and play therapy.

The leadership of CAC1 includes the vice president (VP) of the service line that the CAC falls under, a director of operations, and a program supervisor. The leadership team ensures that the administrative and clinical operations are implemented and supports all employees.

Practice Problem

One of a leader's roles is to address employee engagement (Moore & Hanson, 2022). Employee engagement has always been an issue for leadership, and the COVID-19 pandemic has significantly impacted the workplace and the phenomenon of employee engagement and retention (Kuzior et al., 2022; Reddam & Azevedo, 2019; Singh & Phoolka, 2023). Research has shown the importance and necessity of altering leadership models, such as trauma-informed leadership (Elwyn et al., 2017; Fink-Samnick, 2022; Mazzetti & Schaufeli, 2022). Trauma-informed leadership refers to implementing the main principles of trauma-informed care into leadership styles. The main principles of trauma-informed care include safety; trustworthiness and transparency; collaboration and mutuality; empowerment and choice; peer support; and incorporating cultural, historical, and gender issues (Mahon, 2021; Substance Abuse and Mental Health Administration, 2014). There are many styles of leadership and based on research several of the most common types of leadership in health care include transformational leadership, transactional leadership, and democratic leadership (Romi et al., 2022). Furthermore, research in education suggested that distributive and compassionate leadership enhanced the well-being of teachers during COVID-19 (Kwatubana & Molaodi, 2021).

Additionally, servant, authentic, and adaptive leadership styles are common in social services and health care (Northouse, 2019).

It is evident that engagement is necessary to keep and retain a productive behavioral health workforce (ContiuumCloud, 2023; Fink-Samnick, 2022; Sepahavand & Khodashahri, 2021). When employees feel comfortable and safe in their workplace, they are more active, open to new ideas, and have a personal commitment to the outcomes of the organization (Edmondson, 2019). The idea of psychological safety at work allows employees to feel comfortable asking questions, making mistakes, and offering suggestions for the organization.

Low employee engagement leads to low retention, which impacts the ability of the organization to achieve its mission and provide quality care to those the organization serves (Covella et al., 2017; Fink-Samnick, 2022). Furthermore, there is considerable low retention and high secondary traumatic stress and burnout levels in the behavioral and social service fields (ContinuumCloud, 2023; Turley, et al., 2022).

Additionally, leadership plays a role in employee engagement (Covella et al., 2017). Further research is warranted, particularly in trauma-informed behavioral health leadership, regarding the role of leadership in employee engagement. CAC1 has experienced decreased levels of employee engagement, as reported in employee engagement surveys, and a significant increase in secondary traumatic stress, burnout, and high levels of staff turnover. Letson et al. (2020) identified high levels of secondary traumatic stress and burnout among employees at CACs. Additionally, research has shown the need for a trauma-informed approach and how this can improve higher levels

of positive work culture and employee engagement as well as lower levels of turnover due to secondary traumatic stress and burnout (Fink-Samnick, 2022).

In this qualitative case study, I looked at current styles of leadership and the impact that the use of trauma-informed behavioral health leadership had on levels of employee engagement. Increased levels of employee engagement can assist in decreasing levels of traumatic stress and turnover. The practice problem that guided this study and required further research was determining the impact of trauma-informed behavioral health leadership on employee engagement at a CAC. The research questions for this study were:

RQ1: How would trauma-informed behavioral health leadership improve employee engagement at a CAC?

RQ2: How does trauma-informed behavioral health leadership impact retention rates and overall patient quality of care at a CAC?

Purpose

The purpose of this study was to explore the role and impact of trauma-informed behavioral health leadership on employee engagement at a CAC. Ultimately, the purpose was to provide recommendations from a trauma-informed behavioral health leadership lens to increase employee engagement, which can decrease secondary traumatic stress, burnout, and turnover rates. Research has demonstrated that employee engagement is a prerequisite for quality work and higher levels of patient care (Taha et al., 2020).

The Baldrige framework provided the conceptual framework for this study (see Baldrige Performance Excellence Program, 2021). The framework is a systems approach

that empowers any organization to enhance its goals and improve its overall levels of performance (Baldrige Performance Excellence Program, 2021). The Baldrige framework is organized into seven categories: (a) leadership; (b) strategy; (c) customers; (d) measurement, analysis, and knowledge management; (e) workforce; (f) operations; and (g) results. In this study, I addressed all areas of the framework but highlighted the leadership and workforce categories because they directly related to the practice problem of low levels of employee engagement. The Baldrige framework provided me with guidance to enhance employee engagement in CAC1 and other behavioral health organizations.

Three senior leaders of CAC1 were interviewed for this study. The leaders included the VP of the service line, the director of operations, and the program supervisor. I conducted semi structured interviews with the leadership team to discuss employee engagement, work culture, the organization's role in addressing secondary traumatic stress, and the leadership styles used. Additional secondary data sources were reviewed, including current employee engagement surveys from CAC1; the organization's employee performance system; CAC1's strategic plan; human resource data, such as retention rates and exit interviews; a resiliency plan; and training and development plans for staff and leadership at CAC1. I also reviewed other secondary data resources from CAC1, including meeting minutes, job descriptions, the mission/vision/values statement, job descriptions, salary ranges, and benefits packages offered. The collected data were thematically analyzed and coded.

Significance

This case study has significance for CAC1 and other behavioral health organizations due to the information found and insights developed regarding the impact of trauma-informed behavioral health leadership on employee engagement. Additional research was necessary to understand the role of trauma-informed behavioral health leadership on employee engagement and increasing job satisfaction while decreasing secondary traumatic stress and turnover (Fink-Samnick, 2022; Geisler et al., 2019; Letson et al., 2020).

This study is also significant due to the current issues with the COVID-19 pandemic and the Great Resignation (see Kuzior et al., 2022). Due to the COVID-19 pandemic, there are higher levels of secondary traumatic stress and burnout in the general workforce; therefore, leadership needs to look at new ways to help support and coach staff to help them remain engaged in their roles. Many organizations, including behavioral health organizations, are currently dealing with burnout rates, low levels of employee engagement, and high levels of turnover (ContinumCloud, 2023). This study was beneficial for the leaders of CAC1 regarding how to lead and influence employees during this time in history. The collective trauma of COVID-19 has had a tremendous impact on the current workforce (Fink-Samnick, 2021, 2022; Kuzior et al., 2022).

Trauma-informed behavioral health leadership can be used to address these current issues. Trauma-informed leadership can help create and enhance feelings of psychological safety and trust in organizations, which equals employee engagement (Miller, 2022). Furthermore, research has highlighted how the number one reason people

leave their organization is due to a lack of belonging; therefore, creating belonging for employees is an essential factor in improving and enhancing engagement and overall organizational performance (Clark, 2020; Edmondson, 2019; Miller, 2022). Leadership can decrease overall anxiety through trauma-informed leadership, especially during the COVID-19 pandemic, which can also increase engagement (Hai-Dong et al., 2022).

This study contributes to positive social change in multiple areas. The findings of this study highlighted the need for professional development and training for current and future leaders in trauma-informed behavioral health leadership. Research has shown the positive impact of employee engagement on the health outcomes of patients and clients served (Taha et al., 2020). Therefore, the current study has significance not only for the workforce, but for the patients and clients served at CACs and behavioral health organizations.

Summary

CAC1 provides forensic interviews, medical evaluations, and mental health interventions for children who have reports of physical abuse, sexual abuse, neglect, or witness to acts of violence. Their mission is to provide the best possible services for families served as well as provide education and resources to address the public health crisis of child abuse. To provide these necessary services, an engaged and active workforce is necessary. Effective leadership is necessary to ensure that staff are engaged and capable of providing quality care. There has been a lack of employee engagement at CAC1, as evidenced by employee engagement survey results and the levels of turnover, secondary traumatic stress, and burnout. Data was collected for the current study through

semi structured interviews with leadership and a review of secondary resources. I explored the impact of trauma-informed behavioral health leadership on employee engagement and the positive social change that can result from its use.

In Section 1b, I will present the organization's profile, key factors, and background and contextual factors. The discussion of the organization's profile will demonstrate the current practice problem and the need for further study.

Section 1b: Organizational Profile

Introduction

The purpose of this study was to explore the impact of trauma-informed behavioral health leadership on employee engagement at a CAC. The lack of employee engagement is a current problem at CAC1, which impacts retention and overall patient care. The following two research questions guided this study:

RQ1: How would trauma-informed behavioral health leadership improve employee engagement at a CAC?

RQ2: How does trauma-informed behavioral health leadership impact retention rates and overall patient quality of care at a CAC?

Employee or work engagement was originally studied by Kahn (1990) and has been the subject of a plethora of research since then. Engagement can be defined as a state of employees that keeps them motivated, energized, and with high levels of dedication to their work and, ultimately, the outcomes of their work (Bakker, 2022).

Leadership plays a vital role in employee engagement, especially when dealing with the recent COVID-19 pandemic (Kuzior et al., 2022). Prentice (2022) found two emergent themes that impact employee engagement and job satisfaction: the level of employee satisfaction with pay, benefits, and rewards and a supportive environment. In general, leadership has some discretion regarding pay, benefits, and rewards, but is completely entrusted to create a supportive environment.

The leadership style can directly impact employee engagement, ultimately impacting employees' performance levels (Joplin et al., 2021). Additionally, certain types

of leadership, such as resonant leadership, which is related to trauma-informed leadership, can improve staff engagement, patient safety, and overall patient satisfaction. Trauma-informed leadership is linked with other leadership styles, such as servant leadership (Mahon, 2021). Inclusive leadership has decreased psychological distress and increased psychological safety (Ahmed et al., 2020).

The daily work at CACs requires consistent exposure to the trauma of children and families. The work dramatically impacts staff's mental health and well-being and can lead to higher levels of vicarious trauma, secondary traumatic stress, compassion fatigue, and even burnout (Letson et al., 2020). Additionally, Letson et al. (2020) reported the impact of compassion satisfaction on employee engagement. This research highlighted how levels of employee engagement significantly increased when employees had higher levels of compassion satisfaction and enjoyed their work.

With the increased exposure to secondary trauma, changing work dynamics, and changing workforce expectations, it is of utmost importance to look at the role of trauma-informed leadership and the impact on employee engagement at CACs and other behavioral health organizations. In this section, I present the organizational profile and key factors, the background and context of the organization, and the impact of the practice problem on the organization.

Organizational Profile and Key Factors

The organization profile provides a snapshot of CAC1, the key influences or factors of CAC1, and its role in a competitive environment. These are all critical factors to assess to understand the impact of trauma-informed behavioral health leadership on

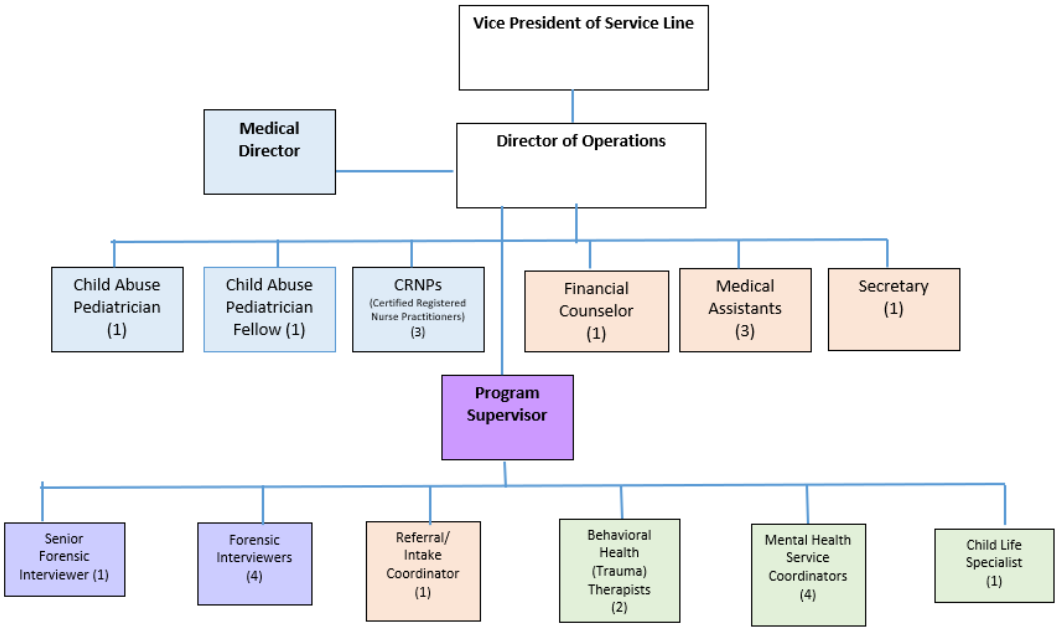
employee engagement. The important factors include the organization's service offerings; mission, vision, and values statements; workplace profile; and strategic planning. Two key factors from the Baldrige framework were significant to the practice problem of employee engagement: leadership and workforce.

A CAC is a centralized location for a child who has been allegedly abused or witnessed a violent act to tell their story only once (National Children's Alliance, n.d.a.). All MDT members, including law enforcement, child protective services, the district attorney's office, victim advocate agencies, and medical and mental health staff, are present at the CAC, which allows a trauma-informed and safe location for the child and family to be interviewed and receive medical treatment, advocacy, mental health screeners, and referrals to mental health treatment.

CAC1 is a large, hospital-based CAC in the northeastern United States. CAC1 employs approximately 25 staff who work to support children and families who have alleged incidents of physical abuse, sexual abuse, neglect, or are a witness to home or community violence. Figure 1 shows the organizational structure of CAC1 as of 2022.

Figure 1

2022 CAC1 Organizational Chart



CAC1 is part of a large, regional health care system that employs almost 100,000 employees. CAC1 staff report to a VP of the service line to which they belong. The VP reports directly to the regional president of the health care system. The director of operations oversees CAC1 and works with a medical director who is on-site 1 day per week yet provides daily support to medical staff as needed. There is also a program supervisor who is responsible for the day-to-day operations of the center. The center is nonprofit as is the larger health system. CAC1 has an advisory board that serves to assist in the oversight of the center and includes key members of the MDT from the various counties served by the center.

There are three clinical departments at CAC1: the forensic interview, medical, and mental health teams. They are supported by a financial counselor and referral/intake coordinator. The forensic interview team is responsible for providing space for the child to tell their story while asking nonleading and nonsuggestive questions. The medical team comprises child abuse pediatricians, a child abuse pediatrician fellow, certified registered nurse practitioners, and medical assistants. They provide medical examinations and treatment for children who have been referred to the center for allegations of abuse. The mental health team has two roles. One is to be with the child and family while they are at the center for their forensic interview and medical exam to provide support, complete trauma screeners, and refer to any mental health or trauma treatment needed.

The second role is to provide trauma therapy. CAC1 also employs two trauma therapists who provide evidence-based trauma therapies to children seen at the center, including Trauma Focused-Cognitive Behavioral Therapy, Alternative for Families-Cognitive Behavioral Therapy, Eye Movement Desensitization Reprocessing, and Child and Family Traumatic Stress Intervention. The mental health team also provides therapy to non-offending caregivers, caregiver support groups, and teen groups for survivors of sexual abuse.

CAC1 adheres to its mission, vision, and values, which align with and complement the mission, vision, and values of the health system to which it belongs. According to the organization's website, the vision of CAC1 is to be known as the best advocacy center for the comprehensive care of abused children. Additionally, the website states that the mission of the center is focused on reducing the prevalence and aftermath

of child abuse, thereby improving the overall well-being and safety of families served. The values of CAC1 and the health system it belongs to include quality, safety, respect, caring, responsibility, integrity, and vision.

The current strategic plan for CAC1 includes five focus areas for the 3 year range of 2020–2023: (a) expanding mental health services, (b) training MDT members, (c) building resiliency among the CAC team, (d) ensuring financial stability, and (e) expanding the footprint of the CAC. All five of these strategic areas can relate to the practice problem of employee engagement. For example, expanding services and areas served has added additional stress and worry for employees. On the other hand, training, building resiliency, and ensuring financial stability have been encouraging to staff members, per the leadership of CAC1. Furthermore, the strategic goals of training, building resilience, and ensuring financial sustainability can enhance employee engagement and aid in retention.

The Baldrige Performance Excellence Program (2021) provides a framework to assess the key factors for organizations, including leadership, strategy, customers, measurement, analysis, knowledge management, workforce, operations, and results. The key factors or areas that are strategically important to addressing the practice problem of employee engagement and the impact of trauma-informed behavioral health leadership for CAC1 are leadership and the workforce. The key factor of the workforce includes the workforce environment and workforce engagement.

Organizational Background and Context

CAC1 provides forensic interviews, medical evaluations, and mental health services to children and families that cover a five-county region in a northeastern state. The center also provides courtesy services for additional counties in their state and additional states. The center has two offices in suburban areas and provides services to families of a diverse population of children and families. Mental health services are provided for any child or nonoffending caregiver, regardless of their ability to pay. The families do not incur any costs for any services provided at CAC1.

CAC1 is funded by multiple state and federal grants and revenue produced by billing mental health, medical, and forensic interview services. Fundraising and donations from the larger health care system provide additional funding for CAC1. Furthermore, CAC1 receives significant financial support and resources from the larger health system, including human resources support, benefits, facilities, and access to training.

CAC1 meets all the requirements for multiple regulatory groups, including the Department of Health, all policies and procedures of the larger health system they belong to, and the National Children's Alliance (NCA). The NCA (n.d.1) is the governing body of CACs and 10 national standards must be met to be fully accredited. According to the NCA (2022), "The Standards help ensure that all children across the U.S. served by Children's Advocacy Centers receive consistent, evidence-based, and evidence-supported interventions that help them pursue safety, healing, and justice" (p.4). The 10 standards are (a) MDT standard; (b) diversity, equity, and access of services standard; (c) forensic interview standard; (d) victim support and advocacy standard; (e) medical evaluation

standard; (f) mental health standard; (g) case review and coordination standard; (h) case tracking standard; (i) organizational capacity standard; and (j) child safety and protection standard. CAC1 is a fully accredited member of the NCA.

CAC1 participates in a yearly budget planning process for the larger health system. The budget for CAC1 is approximately $1.5 million. CAC1 is involved with multiple state and federal grants that help to support the salary of multiple staff members.

CAC1 serves a multitude of stakeholders. The patients and families served at the center are some of the key stakeholders. All families that come to CAC1 are in a time of trauma and uncertainty, and this is the primary reason that staff members need to be fully engaged. Additionally, patients seen for trauma therapy are a stakeholder. Children and nonoffending caregivers are seen at the center, typically diagnosed with posttraumatic stress disorder and adjustment disorders. Private and state-funded insurance is accepted, yet families are not required to pay copays. Patients can also be seen if they do not have any insurance or ways to pay for the services. Additional stakeholders include members of the MDT, which includes law enforcement, child protective services, the district attorney's office, victim advocates, and other community agencies. The work at CAC1 relies on the collaboration of the MDT members to investigate and treat the outcomes of child abuse.

One of the most important stakeholder groups is the employees of CAC1. The work completed at CAC1 is challenging and requires a high level of training and education, which directly relates to the practice problem of employee engagement. When staff is not engaged, it can lead to turnover. The children and families CAC1 help are

significantly impacted by staff not being fully present because there may be longer wait times or a need for more staff to provide necessary intervention. The clinical staff of CAC1 (i.e., forensic, medical, and mental health teams) requires advanced degrees and specific and time-consuming training to be competent in the vital work they complete.

Recent employee engagement survey results from CAC1 highlight several areas of concern regarding employee engagement, particularly in feeling valued, the relationship with supervisors, and a balanced workload. Furthermore, over 15 staff have left the center in the past 2 years. Therefore, there is a need to evaluate how trauma-informed leadership can help increase employee engagement, retention, and levels of patient satisfaction and positive outcomes at CAC1.

Summary and Transition

CAC1's organizational profile, key factors, organizational background, and context highlight the need for leadership to explore what impact trauma-informed behavioral health leadership can have on employee engagement. Employees who work at CAC1 play a critical role in helping to prevent child abuse, aid in the investigation, and treat the adverse outcomes of child abuse. Employees need to be engaged and mentally well to be most effective for the families CAC1 serves. When there are low levels of engagement, turnover can occur, which can cause organizations to lose productivity and decrease performance levels (Shah & Gregar, 2019). Magbity et al. (2020) reported that leadership style can influence turnover intentions; therefore, leadership style can ultimately impact the vulnerable families served at CAC1.

I conducted this study to help CAC1 and other behavioral health organizations increase levels of employee engagement, decrease turnover, and ultimately increase positive patient outcomes through trauma-informed behavioral health leadership. In the following section, I will review the supporting literature, leadership strategy, and assessment as it pertains to the practice problem of employee engagement. The focus of the section will be on the concept of trauma-informed behavioral health leadership.

Section 2: Background and Approach–Leadership Strategy and Assessment

Introduction

Employee engagement is essential for any organization to be successful (Bakker, 2022). It is even more so in recent times due to the COVID-19 pandemic that has altered the present and future workforce and requires leaders to react quickly to changes in the workplace (Kuzior et al., 2022; Rogers et al., 2021). This includes areas of recruitment, workplace flexibility, talent development, organizational development, and addressing the organizational culture (Kuzior et al., 2022; Rogers et al., 2021). Furthermore, Walsh and Kabat-Farr (2022) emphasized the importance of leadership adjusting to changes due to COVID-19 to support their staff, including providing more emotional support and understanding, providing time to process fears, and modeling calmness and optimism. Supporting staff during times of crisis increases employee engagement and satisfaction as well as positive outcomes for those served.

Work in trauma-focused environments creates higher levels of secondary trauma, burnout, and low levels of employee engagement (Fink-Samnick, 2022; Geisler et al., 2019; Letson et al., 2020). Research has shown how vital leadership is in engaging employees (Ahmed et al., 2020; Mahon, 2021; Muddle, 2020). Mahon (2021) stressed the impact of trauma-informed approaches to improving outcomes for social service and health care employees. This is accomplished through implementing the essential principles of trauma-informed care, which includes safety, trustworthiness and transparency, collaboration and mutuality, empowerment and choice, and peer support (Mahon, 2021; Substance Abuse and Mental Health Services Administration, 2014).

Recognizing cultural, historical, and gender issues is a theme incorporated through the previous five principles.

During a crisis, the support of an organization's leadership can decrease levels of anxiety and burnout (Reitz et al., 2021). There needs to be more research on trauma-informed leadership's role in increasing employee engagement (Fink-Samnick, 2021, 2022; Mahon, 2021). This necessary additional research needs to assess specific interventions and assessing outcomes. In this qualitative case study, I addressed the impact of trauma-informed behavioral health leadership on employee engagement at a CAC. The practice problem reflects the growing changes in leadership and employee engagement due to the COVID-19 pandemic.

In the following subsection, I review the current literature on employee engagement and leadership styles, focusing on trauma-informed leadership and the impact of employee engagement on retention and overall patient care. Additionally, later in the section, sources of evidence and data collection methods for this study are presented. I also discuss the leadership strategy and assessment of CAC1 as well as the clients/population served.

Supporting Literature

A significant amount of previous research has been conducted on leadership styles and how they impact employee engagement, retention, and secondary traumatic stress levels. However, there needs to be more research on the impact of trauma-informed leadership on these vital metrics at a CAC. To explore the extant research, I accessed various databases to conduct a search of scholarly literature for the impact of trauma-

informed behavioral health leadership on employee engagement, retention, and patient outcomes. The following databases were used for the search: Thoreau, Ebscohost, Emerald Insight, Sage, and APA Psychinfo. I located peer-reviewed articles using the following keywords terms: *trauma-informed leadership, leadership, employee engagement, Child Advocacy Center, burnout, secondary traumatic stress,* and *trauma-informed care.*

Employee Engagement and Leadership

High levels of employee engagement increase productivity and job satisfaction while decreasing absenteeism and turnover rates (Smith et al., 2020). CAC1 strives to have a positive work culture and high levels of employee engagement. Due to the COVID-19 pandemic, leaders must be even more diligent in employee engagement (Kuzior et al., 2022). Bakker (2022) reported the necessity of employee engagement in all fields and the impact of leadership on employee engagement. Leadership plays a vital role in recruiting and onboarding employees and staff retention (Covella et al., 2017).

According to CAC1's website and information obtained on the organization's intranet, the organization works diligently to address employee engagement through the annual completion of the MyVoice Employee Engagement Survey and the "Total Rewards Package" regarding compensation, benefits, training, and additional pluses to working for the organization. The additional pluses include benefits, such as paid parental leave, adoption assistance, tuition reimbursement, local discounts to services, and ultimately serving CAC1's personal mission of improving the lives of those impacted by

trauma. Additionally, the organization has a healthy culture index and ties it into the values of the health system.

The seminal work of Kahn (1990) focused on the psychological conditions at work that impact employee engagement. Recent research conducted by Mazzetti and Schaufeli (2022) added to the research literature to establish the importance of leadership on employee engagement, finding that leaders can increase engagement by inspiring, strengthening, and connecting employees with necessary resources, supports, and the mission of the organization. Furthermore, by being trustworthy, having open and two-way communication, and allowing staff to participate in decision-making, they can increase engagement levels. Mazetti and Schaufeli showed the importance of leadership styles on employee engagement and the short- and long-term impacts of staffing. The authors reported that when staff has psychological capital, such as optimism, resiliency, self-efficacy, and flexibility, they are more engaged. This capital is created by leaders who are intentional about addressing team effectiveness and engagement. Muddle (2020) discussed the impact that both transformational and transactional leadership styles have on employee engagement. Transformational leadership enhances effective communication and increases problem solving and employee engagement, which then results in improved patient outcomes.

Trauma-Informed Leadership

Trauma-informed leadership is when a leader incorporates and integrates the key principles of trauma-informed care into their leadership practice and style (Fink-Samnick, 2021, 2022; Mahon, 2021). The workforce and organizations are facing a new level of

trauma due to the COVID-19 pandemic. Popular leadership styles, such as servant, transformational, and inclusive models, have been effectively utilized, yet none of these models were developed specifically to address workforce trauma (Fink-Samnick, 2022). Additionally, Fink-Samnick (2021) discussed how trauma-informed leadership is the antidote for collective occupational trauma. When leadership implements the principles of trauma-informed care, they are providing additional support for staff that addresses the trauma staff has experienced. Organizations have an ethical duty to provide resources and opportunities to address staff well-being (Turley et al., 2022).

The trauma-informed approach includes the following essential principles that have been developed and well researched: safety, trustworthiness and transparency, collaboration and mutuality, empowerment, voice and choice, peer support, and cultural, historical, and gender issues (Fink-Samnick, 2022; SAMSHA, 2014). When leaders implement these principles, they provide an additional level of support for staff. The following list provides the 10 tactics to implement trauma-informed leadership (see Brown, 2020; Fink-Samnick, 2021, 2022; National Council for Behavioral Health, 2019).

1. Set a safe, nurturing, holding environment.
2. Foster interactional discussions versus one-way mandates or reprimands.
3. Build camaraderie and trust to embrace group efforts and dialogues, where the input of staff is valued versus discouraged.
4. Get beyond the “process and roll” mentality and recognize nobody has infinite strength or ability.

5. Be accountable for missteps, frustration, or unprofessional behavior; have the leader explain these actions to staff in a way that demonstrates their own humanity and vulnerability to stress.
6. Encourage staff to "Take 10" to emphasize commitment to staff health and mental health.
7. Engage in two-way communication that informs staff of the rationale for actions.
8. Stay visible and accessible.
9. Recognize staff strengths and not just weaknesses to encourage and empower.
10. For virtual/remote roles, visibility matters; have "camera-on" meetings two to three times a week.

CAC1 strives to be a trauma-informed organization and is continually working on improvement in this area. The health care system has a Trauma-Informed Care Steering Committee that is trying to increase knowledge and skills of trauma-informed care for all staff. There are two levels, and CAC1 has made a goal for all staff to obtain Level 1 status this year. CAC1 staff are exposed to varying levels of trauma daily. The leadership team is becoming more intentional in implementing the 10 tactics yet has been working on most of them for some time.

Fink-Samnick (2022) discussed the impact of trauma-informed leadership on collective occupational trauma and described trauma-informed leadership as a new approach to leadership that focuses on building relationship-based skills that equip staff faced with challenging and even traumatic events, both personal and professional. The

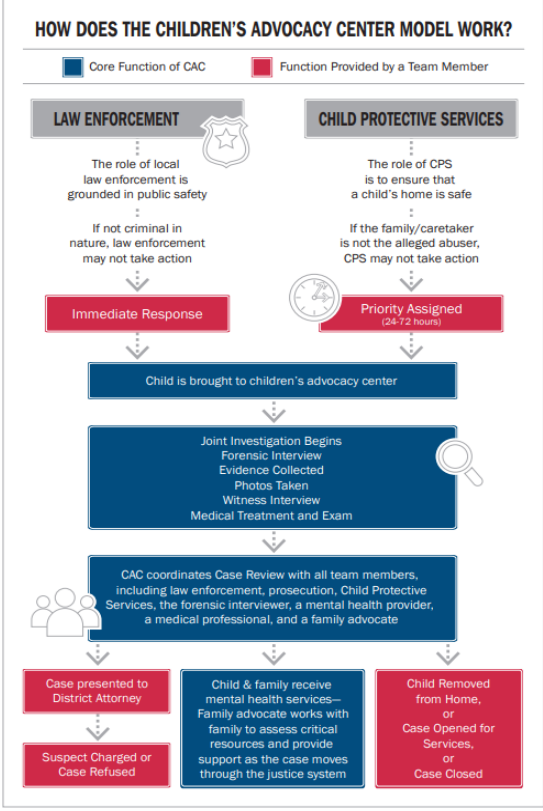
CAC staff most definitely face changing and challenging situations daily. If not adequately addressed, this can lead to secondary traumatic stress and burnout.

Secondary Traumatic Stress, Burnout, Quality Care, and Improvement at CACs

A CAC is a central, neutral, and trauma-informed location for a child to share their story once with a trained team of trauma professionals (NCA, n.d.a.) Due to the nature of the work, staff at CACs are exposed to trauma daily. The CAC model is highlighted in Figure 2.

Figure 2

CAC Model

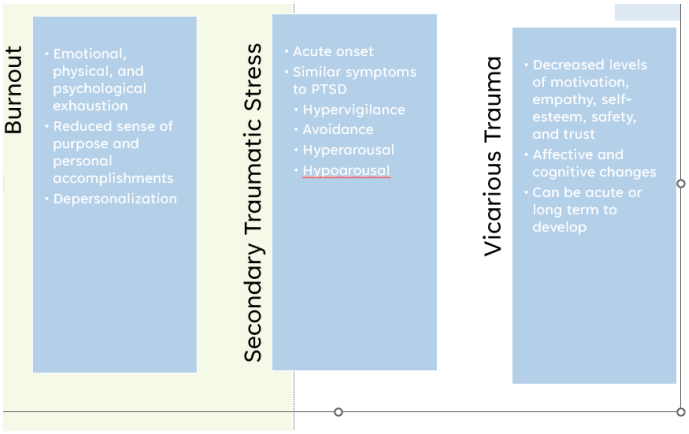


Note. (National Children's Alliance (n.d.). Work is in public domain.

A plethora of research has documented the high levels of secondary traumatic stress and burnout at CACs (Beer et al., 2021; Letson et al., 2020). This can include the psychological responses displayed in Figure 3. Secondary traumatic stress and compassion fatigue refer to the trauma someone experiences from indirect exposure to trauma, which can include hearing stories of abuse and neglect that staff hear daily at a CAC (Letson et al., 2020). However, burnout refers to a psychological term that refers to a person's general exhaustion or lack of interest in their work. Burnout can be experienced in any field, not just in fields exposed to trauma. High secondary traumatic stress and burnout levels negatively impact employee engagement and retention. Compassion fatigue and secondary traumatic stress are common in many social service fields (Fontin et al., 2021; Lev et al., 2022; Singer et al., 2020). Symptoms of secondary traumatic stress, vicarious trauma, and burnout are highlighted in Figure 3.

Figure 3

Psychological Responses to Exposure to Trauma



Note. Adapted from "Compassion Satisfaction to Combat Work-Related Burnout, Vicarious Trauma, and Secondary Traumatic Stress," by C. Cummings, J. Singer, R. Hisaka, & L. T. Benuto, 2021, *Journal of Interpersonal Violence*, *36*(9/10), pp. NP5304–NP5319 (https://doi.org/10.1177/0886260518799502)

CAC1 has its staff conduct the Professional Quality of Life assessment to measure secondary traumatic stress, burnout, and compassion satisfaction (see The Center for Victims of Torture, 2021). The results are confidential but can be discussed during individual supervision. CAC1 has a Resiliency Team, which meets monthly. The purpose of the Resiliency Team is to provide opportunities for staff to increase skills to cope with secondary traumatic stress, which includes weekly "Resiliency Update" email blasts with skills and information, monthly community-building activities, the opportunity for formal debriefings at request, and weekly wellness activities.

CAC1 leadership constantly strives to improve the level of quality care provided to the children and families they serve. The literature shows that employee engagement is "a driver of healthcare quality" (Taha et al., 2020). Furthermore, the type of leadership and relationships leaders have with staff is directly related to employee engagement and, ultimately, patient outcomes. Higher levels of employee engagement result in better patient outcomes (Taha et al., 2020). A trauma-informed approach of choice and flexibility leads to higher employee engagement and the performance level of employees (Shah & Gregor, 2019).

Sources of Evidence

I reviewed a significant number of secondary sources for this study. This included the MyVoice Employee Engagement Survey, which utilizes the more extensive health system that the CAC1 is part of. The MyVoice Survey index includes six anchor statements. These include (a) My work provides me with a sense of meaning and purpose; (b) I consider my work to be challenging and exciting; (c) Most days, I look forward to coming to work; (d) My talents and abilities are used well in my position; (e) I would like to remain at CAC1, even if a similar job were available elsewhere; and (f) I would recommend CAC1 a great place to work. Based on responses, employees are placed into one of four engagement categories (a) Full Engaged;(b) Key Contributor; (c) Opportunity Group; and (d) Fully Disengaged.

Furthermore, I reviewed data on levels of compassion satisfaction, burnout, secondary traumatic stress, statistics regarding the CAC1 being a vicarious trauma-informed organization, policies, procedures, and retention data.

Leadership Strategy and Assessment

The CAC1 has a hierarchical structure, with the center's director reporting to the vice president of the service line of the larger health system. Additionally, the leadership team of the CAC, the director of operations, and the program supervisor meet with an Advisory Board of multidisciplinary team members. These stakeholders can meet and provide feedback to the CAC1's leadership team. Furthermore, the staff of the CAC1 has monthly all-staff meetings, monthly team meetings, and at least one individual meeting or supervision with leadership each month.

CAC1 is responsible for continuing to meet its accreditation through the National Children's Alliance (NCA, n.d. b) and the 10 standards (NCA, 2022). Furthermore, CAC1 is responsible for following the requirements for the money CAC1 receives through local, state, and federal grants.

Clients/Population Served

CAC1 provides services to children and families referred to by law enforcement and child protective services due to allegations of abuse. CAC1 provides forensic interviews, medical evaluations, mental health screenings, referrals, and evidenced-based trauma therapy. Services are typically provided to children ages 3-18, yet they are also provided to adults with intellectual disabilities or developmental delays.

Evidenced-based trauma therapy is provided to children and families seen at the CAC1. This typically includes ages 3-18, yet the therapist also provides therapy to nonoffending caregivers. This is in the form of individual therapy and monthly support

groups. Patients seen for trauma therapy typically carry a mental health diagnosis such as an adjustment disorder, acute stress disorder, or post-traumatic stress disorder.

CAC1 engages clients from the moment of referral. A referral case manager reaches out to the family to explain the purpose of the appointment and what to expect while at the CAC1. Additionally, the family receives written information in the mail to further explain what to expect at the CAC1.

When the family arrives at the CAC1, a forensic interviewer provides an additional overview of what to expect, a review of consent, and a tour of the center. The caregivers meet with medical and mental health representatives while the child is being interviewed to obtain additional information and provide support and advocacy. If a family requires translation services, this is provided for the family. Families are offered an opportunity to provide feedback on the appointment process at the end of their time at the center, as it provides them with the power to help improve the system.

Families never receive a bill for services provided at the CAC1, including ongoing trauma therapy. Federal, state, and local grants and support from donations cover services. If the family has insurance, it is billed for therapy services, yet the family is not required to pay copays or deductibles.

Analytical Strategy

Data analysis was completed in multiple phases. The secondary data and the qualitative semi structured interviews were systematically coded into themes, as described by Saldana (2021).

Archival and Operational Data

Secondary data reviewed include employee engagement surveys (MyVoice Survey), policies and procedures regarding hiring, onboarding, training, and retaining staff, resiliency plan, and exit interviews by staff who leave the CAC1. Additionally, the most recent accreditation report and application of the CAC1 were reviewed. This information was all provided by the director of operations for review.

The MyVoice Survey is a valid representation of levels of employee engagement, as a third-party consulting firm completed it. The additional forms of secondary data were accessed on the shared drive and intranet of the center. The CACs policies and procedures, as well as policies and procedures of the larger health system, were reviewed regarding employee engagement and retention. There has been a higher effort of the larger healthcare system that the CAC1 is part of to attract, hire, and retain quality staff. The COVID-19 pandemic has highlighted the need for increasing employee engagement at all health care system levels.

Evidence Generated for the Study

Participants

The CAC1 is a small department that is part of a much larger healthcare system. Three leaders are trusted to lead the CAC1. This includes the vice president of the service line that the CAC1 belongs to, the director of operations, and the program supervisor of the CAC1. All three leaders keep employees engaged to provide the best possible healthcare for the families served. All three leaders provided written consent to be involved in interviews for this study. Additionally, the leadership team of the CAC1 was

open to all recommendations from the outcome of this study. They discussed their willingness to be transparent to learn all they can to improve the center's outcomes.

Procedures

All three leaders were emailed a written description of the project, the written consent form, and an Internal Review Board approval letter from this interviewer. The IRB approval number from Walden University is 08-25-22-0191481. Confidentiality was discussed in the written information sent to the leaders, and the way the organization would be masked was discussed. All three leaders agreed, and a time was set up to complete the interviews in person based on their availability.

Interview Protocol

At the beginning of each interview, I reexplained the purpose of the interview and the doctoral study. Additionally, I reviewed the consent for the study and reminded them it was voluntary, and they could choose to answer or not answer any of the questions. I also discussed the steps to ensure confidentiality and keep them and the organization anonymous. The 10 questions for the interview are attached in the Appendix.

Summary and Transition

Section 2 highlighted the recent research on employee engagement and the impact of trauma-informed leadership in behavioral health organizations. Additionally, in Section 2 I provided a review of the type of resources being reviewed and the analysis process. Furthermore, in Section 2 I discussed those involved in the interviews, the consent process, and the interview questions utilized. In Section 3 I will provide a review

of the CAC1's workforce, operations, measurement, analysis, and knowledge management components.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Introduction

Employee engagement is essential for any organization to fulfill its mission, vision, and values. CAC1 has struggled with low levels of employee engagement, as evidenced by scores on employee engagement surveys, high levels of secondary traumatic stress, and high levels of turnover. The problem being studied focuses on the impact of trauma-informed behavioral health leadership on employee engagement at CAC1. The research questions that guided this study were:

RQ1: How would trauma-informed behavioral health leadership improve employee engagement at a CAC?

RQ2: How does trauma-informed behavioral health leadership impact the rates of retention and overall patient quality of care at a CAC?

Sources of evidence for this study included secondary data and semi structured interviews with three leaders of CAC1 (i.e., the VP of the service line, director of operations, and program supervisor). The interview questions focused on employee engagement, leadership styles, and the impacts of secondary traumatic stress on employee engagement. The secondary data included employee engagement surveys; retention data; minutes from leadership meetings; levels of compassion satisfaction, burnout, and secondary traumatic stress; and policies and procedures regarding employee engagement and retention. I used qualitative coding to determine themes regarding trauma-informed behavioral health leadership and employee engagement at CAC1. I also

reviewed peer-reviewed journal articles and other sources of published information on employee engagement, retention, and trauma-informed leadership.

Analysis of the Organization

Workforce Environment

The workforce of CAC1 begins with the recruitment by the human resources department of the health care system to which CAC1 belongs. There is a two-step approach to the interview process. The director of operations and program supervisor meet with the applicant to assess qualities, experience, and cultural fit into the department. If the leadership determines an applicant fits the department's needs, then they move on to a peer interview, where they are assessed by staff to see if they fit into the department's culture. This approach assists in assessing the applicant's capability and capacity to complete the work at CAC1.

There is an orientation and then an onboarding process for new staff to learn the values of the larger health care system and CAC1 as well as position requirements. Ongoing training and professional development are provided throughout an employee's time at CAC1, which includes annual required training through the health system and opportunities for job-specific training. All staff is required and provided with the opportunity to complete necessary continuing education for their specific licenses.

CAC1 provides above average salaries and benefits for its employees, such as the "Total Rewards Package," which includes the salary; various benefits, like including medical, dental, vision, and additional options; and a liberal paid time off program.

Workforce Engagement

The staff of CAC1 is engaged daily through open communication. Each day starts with a morning huddle that reviews the day and the forensic interview and medical appointments with assignments. CAC1 provides biweekly or monthly supervision and 1:1 meetings, monthly staff meetings, and monthly team meetings. Additionally, the mental health team has weekly group supervision.

CAC1 engages in the annual employee engagement survey conducted by the larger health system. This is department specific and allows staff to provide feedback and evaluate levels of engagement. With the information gathered, the center creates an employee engagement action plan that is developed and led by the employees. CAC1 has recently introduced stay interviews to further connect with staff and assess levels of engagement. The staff also engages in self-evaluations, and then leadership provides the final assessment on a 5-point scale, which from highest to lowest includes top performers, superior performers, solid performers, marginal performers, and deficient/poor performers.

CAC1 takes the organization's role in addressing secondary traumatic stress and vicarious trauma seriously. Staff at a CAC are exposed to high levels of trauma daily, and organizations need to provide the necessary support (Beer et al., 2020; Fink-Samnick, 2022). A Resiliency Plan and Blueprint outline the support provided to staff and shows how CAC1 addresses the results of the Vicarious Trauma-Organizational Readiness Guide (VT-ORG). The VT-ORG is completed on an annual basis by staff to assess the current environment. The five focus areas of the VT-ORG are (a) leadership and mission,

(b) management and supervision, (c) employee empowerment and work environment, (d) training and professional development, and (e) staff health and wellness (Office for Victims of Crime, n.d.). The Resiliency Plan also provides the specific steps to reach the goals of the center to improve resiliency of staff.

CAC1 provides advancement opportunities and annual merit raises based on annual performance management protocol. CAC1 has also recently worked with the human resources department to develop career ladders for each position, which provides additional incentives for highly engaged staff and those who perform at a high level.

The work of a CAC is based on the accreditation standards of the NCA2022). The 10 core NCA standards are (a) MDT; (b) diversity, equity and access to services; (c) forensic interview; (d) victim support and advocacy; (e) medical evaluation; (f) mental health; (g) case review and coordination; (h) case tracking; (i) organizational capacity; and () child safety and protection. The core services provided at CAC1 include forensic interviews, medical evaluations, and mental health screening and treatment. The leadership team continually assesses and reviews the process through the NCA reaccreditation process, internal reviews and analyses of programs, and keeping with the requirements of multiple grants.

CAC1 leadership ensures effective management of operations through having weekly leadership meetings, continually monitoring and updating policies and procedures, and a recent increase in the assessment of quality assurance and quality improvement. Leadership meets with staff via monthly staff meetings, monthly team

meetings, and monthly individual supervision or 1:1s to ensure operations are working effectively and efficiently.

Knowledge Management

The leadership of CAC1 has the role of measuring, analyzing, and improving the organizational performance of the center. Additionally, the leadership team evaluates how the center manages its organizational knowledge assets, information, and information technology infrastructure. Organizational performance is assessed in multiple ways at CAC1.

The Outcomes Measurement System (OMS) is administered to caregivers after their appointment at CAC1 and yearly to the MDT members. The caregiver OMS survey results can be reviewed daily, yet reports are typically run monthly. The results can be compared during the same periods to other CACs in the same state and national averages. The surveys are anonymous and can be completed on paper and then entered into the system manually by staff, yet the preferred method of collection is electronic by the caregivers (NCA, n.d.).

Performance and organizational assessments are informally completed regularly through individual supervision, team meetings, and all-staff meetings. The flow of the appointments, logistics, and best practices are discussed during these meetings. The ultimate goal of leadership and staff is to provide trauma-informed services, comply with NCA standards and best practices in the field, and be beneficial to the families served.

The information and knowledge assets are stored in various medical records and electronic systems. NCAtrak (n.d.) is a case management tool that is created by the NCA.

NCAtrak is compliant with the Health Insurance Portability and Accountability Act, has secure data storage, can develop custom reports, and coordinates with MDT members. An additional electronic medical record system that the health care system and CAC1 uses is Epic. Epic (2023) is a software suite and electronic medical record system that also holds records and can bill insurance companies for services provided. Furthermore, CAC1 utilizes Microsoft Office and the health care system's information technology services to store information in the system's networks.

Summary

In Section 3, I described the workforce, operations, measurement, analysis, and knowledge management for CAC1, including the way employees are hired, trained, retained, and engaged. Various quality and operation improvement programs were also discussed. In Section 4, I will provide my analysis of the interviews with the leaders of CAC1 and secondary data as well as share the implications of the findings and my recommendations for CAC1.

Section 4: Results–Analysis, Implications, and Preparation of Findings

Introduction

Employee engagement is essential and required for any organization to fulfill its mission, vision, and values. CAC1 has struggled with low levels of employee engagement, as evidenced by scores on employee engagement surveys, high levels of secondary traumatic stress, and high levels of turnover. In this study, I examined the idea of trauma-informed leadership to assess CAC1's results on employee engagement, which led to an analysis of psychological safety at CAC1. The problem being studied focused on the impact of trauma-informed behavioral health leadership on employee engagement at CAC1. The research questions that guided this study were:

RQ1: How would trauma-informed behavioral health leadership improve employee engagement at a CAC?

RQ2: How does trauma-informed behavioral health leadership impact the rates of retention and overall patient quality of care at a CAC?

Sources of Evidence

Sources of evidence for this study included secondary data and semistructured interviews with three leaders of CAC1 (i.e., the VP of the service line, director of operations, and program supervisor). The interview questions focused on employee engagement, leadership styles, and the impacts of secondary traumatic stress on employee engagement. Additionally, I assessed the idea of being a trauma-informed leader and creating psychological safety at CAC1. The secondary data reviewed included employee engagement surveys; retention data; minutes from leadership meetings; levels

of compassion satisfaction, burnout, and secondary traumatic stress; and policies and procedures regarding employee engagement and retention. I used qualitative coding to determine themes regarding trauma-informed behavioral health leadership and employee engagement at CAC1. I also reviewed peer-reviewed journal articles and other sources of information on employee engagement, retention, and trauma-informed leadership.

Analysis, Results, and Implications

Analysis of Client Programs, Services, and New Initiatives Effectiveness Results

CAC1 offers multiple services to children and families that are referred to the CAC by law enforcement and child protective services. CAC1 serves families in three offices and provides services for a large geographic area of the state. The center provides forensic interviews, medical exams, mental health and advocacy services as well as evidence-based trauma therapy to children seen at the center and their nonoffending caregivers. Additionally, the CAC1 provides support groups for nonoffending caregivers and teens who have been victims of sexual abuse. Furthermore, CAC1 provides educational programs regarding childhood trauma and the role of the CAC to various child-serving organizations and law enforcement agencies. CAC1 is also beginning to develop prevention programs and working with local schools to provide psychoeducation on trauma and the role of a CAC.

Client-Focused Results

Client-focused results are assessed using the OMS. The Initial Visit Caregiver Survey is offered to families at the conclusion of their visit to CAC1 (see NCA, n.d.). The OMS is used to assess the caregiver's reactions to the center, staff, and services offered at

the CAC. The results of each individual OMS is entered into a centralized online system and can be compared to past results of the CAC as well as compared to state and national reports. The OMS can be completed via paper and pencil or on an iPad at the center. The family can also complete the survey via an email that is sent out about a week after the appointment.

CAC1 consistently has high scores on the survey (i.e., averages 90%+), which is equal to or higher than both state and national averages. Anecdotal data from interviews with all three leaders also highlighted the levels of satisfaction from clients. Families do not always get the results they would like following appointments at the CAC (e.g., charges in the criminal justice or child protective systems) but feel supported and believed while at CAC1.

Workforce-Focused Results

CAC1 has grown significantly since its inception in 1994. There are now over 20 full-time staff with additional contracted medical staff, including a medical director, a child abuse pediatrician, and a child abuse pediatric fellow. From 2020–2021, 13 employees left CAC1 for a multitude of reasons; however, overall levels of engagement were relatively high on the center's employee engagement survey. The intranet of the health system provided a plethora of information on the "MyVoice" survey. The health system defines engagement as "engagement is characterized by feeling passionate, energetic, and committed to one's work." The five key drivers of employee engagement as defined by the health system and the "MyVoice" survey include meaning, autonomy, growth, impact, and connection. The "MyVoice" survey includes 41 anchor statements

that are scored on a Likert scale. Responses to the statements place the employee's level of engagement into one of four engagement categories: fully engaged, key contributor, opportunity group, or fully disengaged. The most recent scores of CAC1's "MyVoice" survey included 94% of staff being fully engaged or being a key contributor. This was well above average compared to other departments in the health system. Despite the high scores on the assessment, the perceived levels of engagement and connection to the work are poor as evidenced by the high levels of turnover.

Leadership and Governance Results

I interviewed three leaders of CAC1: the VP of the service line, director of operations, and the program supervisor. They were all asked the same 10 questions. All three leaders are female and have been in the social services/health care field for at least 20 years. All three leaders stressed the importance and necessity of being trauma informed in their leadership roles and have found this to be even more true due to the COVID-19 pandemic. The consensus of the three leaders was that trauma-informed leadership can increase levels of employee engagement.

I completed qualitative analysis and coding of the interviews and secondary data in three stages. Stage 1 included descriptive coding, where I reviewed the transcripts of the interviews and appropriate secondary data sources and developed codes. The second stage included coding the concepts and identifying common themes that were documented in Stage 1. In Stage 3, I completed memo notes and a reflection/reflective journal, which included various ideas, thoughts, questions, and highlights from my coding.

The themes related to the concept of trauma-informed care and aligned with SAMHSA's (2014) trauma-informed care principles of safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment; voice and choice; and cultural, historical, and gender issues. Furthermore, the themes also incorporate the 4 Rs of trauma-informed care: realize, recognize, respond, and resist retraumatization (Goddard, 2021). According to the 4 Rs, leaders need to: (a) realize the impact of trauma and how widespread trauma is in society and the workforce, (b) recognize how trauma is impacting their employees, (c) respond to employees in ways that employees feel safe and heard, and (d) resist retraumatizing staff and assist all staff to do the same. The 4 Rs of trauma-informed care were applied to leadership in the current study and were integrated into the themes that were identified from the interviews. The two main emergent themes in the current study were the need for leadership to focus on psychological safety and the staff's resiliency and well-being.

Theme 1: Psychological Safety

The concept of psychological safety was the most frequent topic and theme that arose in all three interviews. Clark (2020) described psychological safety as a condition in which an employee feels included, safe to learn, safe to contribute, and safe to ask questions or challenge ideas without the fear of being embarrassed or ridiculed. The role of psychological safety can be applied to the research questions on the impact of leadership on employee engagement, retention, and being present to provide the best

quality of care to patients. This is critical to assisting leaders at CAC1 because it may help to understand the "missing piece" to explain the issue with employee engagement.

For example, CAC1 Leader 2 discussed the connection between trauma-informed leadership and psychological safety, which directly aligned with the practice problem being addressed in this case study:

> I mean, from what I understand, there is a correlation between having a trauma-informed environment and people feeling safe. But I feel like we have gaps and I'm not really sure why because we do a lot of work. And yet, there's that sort of disconnect, and I don't know why.

Furthermore, CAC1 Leader 3 discussed how the lack of engagement may be due to employee's traumas and levels of engagement, stating:

> You have to figure out why a person isn't engaged. And many times when a person is not engaged something happened, like a trauma. Something happened that has shut that person down, either in the workplace, outside workplace, or a combination of both. So, if a person is not engaged, you know, asking those questions like how you feeling? What's going on? And once you figure out what is going on, you can help support that person.

This is something that the leaders need to question or ask employees on a regular basis. Leaders have regular monthly check-ins or supervision with staff, which could be opportunities to have this conversation. This may be a difficult conversation that some leaders may feel uncomfortable to discuss or approach. Furthermore, leaders may feel

they are blurring the line between business and someone's personal business; however, this is an essential discussion for leaders to have to build psychological safety.

Additionally, there is uncertainty amongst leaders if psychological safety exists at CAC1. CAC1 Leader 1 said the following when discussing the current levels of psychological safety at CAC1:

> Because you're with the person who make you feel safe or who creates an environment for you to be your true authentic self. So then that makes me wonder. Do people have more psychological safety than what maybe we think they do? Because I think some people might say that they have psychological safety, but I think that other people would say that they don't have psychological safety.

The employee engagement surveys revealed solid levels of engagement, yet there continue to be high levels of both turnover and secondary traumatic stress. Psychological safety is the area that may be lacking, which is contributing to the high levels of turnover and secondary traumatic stress. In further discussion with the leaders, I asked about ways to increase psychological safety at CAC1. CAC1 Leader 1 discussed how a leader can develop staff by modeling expectations to increase psychological safety:

> I think that you have to model it. And I also think that you have to model it in your own interactions. I think that you have to be vulnerable and say things that you maybe wouldn't say or let other people know about that they can see that your people can see you as human too.

Additionally, CAC1 Leader discussed how they must create opportunities to provide employees to share information by "just creating safe places and listening" and that:

> There are certain things that can impact, everything from outside impacts folks when they come into the workplace. And I think it's just being aware that that happens and giving people that safe space to talk about things like that.

CAC1 Leader 3 went on to state that physical safety needs to be met, prior to obtaining psychological safety, saying that "You can't have psychological safety if you don't have people feeling they are physically safe at work.".

The leaders elaborated on the idea of physical safety with all that is going on in the world with social and political unrest, a global pandemic, and the increase of gun violence. The leadership of CAC1 does a thorough job of ensuring the physical safety of staff is met on a regular basis. There are multiple types and levels of safety with the most basic level being physical safety (Clark, 2020). If this does not exist, it would be difficult or near impossible to address psychological safety.

CAC1 Leader 2 added concerns regarding levels of psychological safety at CAC1 and how staff struggles to trust each other, stating, "they don't feel comfortable sharing with everybody, you know, even to have like a group discussion about their feelings in a case." This lack of trust prevents the possibility of psychological safety developing. There is a need for trust before psychological safety can be obtained. The leaders need to reflect and assess what is preventing employees from trusting each other, which could be

occurring for a multitude of reasons but needs to be determined to address trust and, ultimately, psychological safety.

The leadership of CAC1 have developed some ways that could help build both trust and psychological safety. CAC1 Leader 3 highlighted one of the key tenets of psychological safety when she state,: “and, you know, not being afraid to fail sometimes, too. But in some areas, we have to fail in order to get better.” Additionally, CAC1 Leader 2 stated, “And I think that’s important giving them autonomy and giving the ability to influence how they do work.” CAC1 Leader 3 responded that: “And if you can’t have honest communication, in a way that is psychologically safe about some of those things, then you get stuck and can’t move forward.”

The concept of psychological safety can be enhanced through communication. This was a common thread in both the participant interviews in the current study and the trauma-informed care literature. Communication ties into multiple principles of trauma-informed care, especially collaboration and mutuality and empowerment, voice, and choice (SAMSHA, 2014).

All three leaders referenced and highlighted the importance of communication. CAC1 Leader 3 shared that, “You find things out when you do a little more interpersonal communication with folks to understand.” CAC1 Leader 1 expressed that, “It’s important to communicate what the philosophy is of the leadership and to say what is expected,” while CAC1 Leader 3 said, “I always try to pause and just check in and see how they’re doing.” These examples of open and positive communication show how leaders can build

psychological safety and be trauma informed. The communication needs to be intentional and consistent.

Additionally, all three leaders discussed how communication can assist with creating psychological safety, enhancing resiliency, and building positive workplace cultures. For example, CAC1 Leader 3 stated that a leader needs to model healthy communication, saying that:

> So, you have to have that delicate balance of letting them know that everything isn't a crisis. And I talked about that pause moment, like let's take a pause and figure out where we are. When you come to me, we're going to have a discussion. Also, we're going to figure out the best way to move forward, but it's that empowerment piece, having a voice and having people think about the decisions that need to be made, so that you're not the only one making them, so that they have buy-in, and then it circles back to the inclusion piece. Having a voice feeling like you're making a difference.

The same leader discussed the importance of listening to staff. "They just want you to listen, and like, affirm their existence, and just have empathy. And in order for us to be inclusive and engaged, I think empathy is a big piece of that". The same leader added: "I just think it is important to ask the questions to figure out what folks need. Listening is just as important as what you communicate to employees". The leaders discussed the importance of communication and how it is a two-way process. Leaders and employees need to both share information and listen to what is being shared by leadership. This was highlighted when the CAC1 Leader 3 stated: "You do have

expectations and you understand the roles that people are supposed to fill" and "If I don't know, I can't fix it. We can work on it together. But if I don't know, we can't move forward and you stay stuck".

These quotes highlight the magnitude and importance of communication when it comes to creating and maintaining psychological safety and being trauma informed. The leaders have the understanding of the importance of communication and its role in leading a successful organization. This is an area where leaders need to be transparent, consistent, and as open as possible.

Trauma-informed leadership includes being a team player and asking what staff needs as highlighted from CAC1 Leader 3:

> I just think it's communication and actually knowing, you know, trying to understand the work that individuals are doing, and making sure they have the appropriate tools to do it. Sometimes all you can do is say how can I help you? And it's either help you overcome, help you grow, help you learn, but sometimes it's just to know, yeah, it might not be the right place.

Psychological safety is a foundation for trauma-informed leadership and has been highlighted in the interviews as an area that needs to be addressed at the CAC. Communication can assist in creating psychological safety while being more trauma informed. Research has demonstrated the positive impact of psychological safety on employee engagement and the positive results on work performance (Mitterer & Mitterer, 2023).

Theme 2: Well-Being and Resilience

Resiliency and well-being of staff have been a "hot topic" and major area of study, especially since COVID-19 (Finstad et al., 2021; Munn, et al., 2021; Yu et al., 2022). The leaders of the CAC1 all discussed the connection of one's personal and workplace mission, vision, and values. Additionally, continual encouragement and support assist in creating resilience. For example, CAC1 Leader 1 stated:

> So, I do also think that for me, like one of my strengths is being an encourager, and being a developer, and so I feel like that is something that I like to do to recognize the good work that people are doing.

Additionally, CAC1 Leader 3 discussed this by stating: "I align my own personal mission, vision, and value with the work that I'm doing in an organization I'm working for". They discussed how this helps with their own levels of resiliency and well-being. The same leader also stated "because I support them and what they're doing and their initiatives, I know, whatever goes down, they're going to be there to support me". It is vital for leaders to model resiliency. Leaders can model for employees the power of the connection of one's purpose to the work they do. This is instrumental in maintaining levels of resiliency and well-being. All three leaders discussed the importance of being active in their own resiliency and taking care of their overall levels of well-being. CAC1 Leader 3 commented:

> First of all, them seeing you being able to move forward, helps them be able to move forward. As a leader, I think you have to walk the walk and talk the talk. I think people have to see that.

The CAC1 had developed a Resiliency Committee that developed a Resiliency Blueprint and Plan to help support the staff at the CAC1. All staff are required to create a personalized self-care plan, there are opportunities for informal and formal debriefings, regular supervision, and monthly opportunities to connect with staff at events, such as potlucks. CAC1 Leader 2 highlighted this by stating:

> Well, I feel as though we do a lot in our department to increase employee engagement. We have our resiliency committee. And with that, we have potlucks and resiliency boosters, and the resiliency boot camp which introduces resiliency to people. We have team meetings monthly so that teams can work on projects and talk about challenges they're having.

Having resources for resiliency are important, but they are not enough. Leaders need to find ways to encourage employees to engage in personal self-care while taking advantage of what the organization may offer. Resiliency needs to be intentional, and time needs to be provided for staff to take advantage of resources.

Due to the nature of the work completed at a child advocacy center, resiliency and self-care are necessary to remain engaged and to be able to complete the work. CAC1 Leader 2 stated:

> This is the kind of job that I think you have to have engagement or else you're going to burn out. If you can't see the bigger picture and see that you're continuing to you know, that you're impacting the lives of children you're going to burnout and turnover.

The leaders of the CAC1 highlighted how they need to be able to adapt to what staff needs. This may include providing time and space to process staff's own traumas and making sure they are aware of resources, such as employee assistance programs and other community resources. For example, CAC1 Leader 1 commented:

> The other thing I'll say about you know, being adaptable, is that we can't expect that as leaders, we can't expect that our people are the ones that always need to adapt. Sometimes we need to be able to adapt to them.

The ability to adapt to employees helps to create a culture where staff can thrive and feel valued. The culture of the workplace impacts many levels of an organization (Burns, 2023; Kim et al., 2023). This includes levels of employee engagement, retention, and overall well-being. This was highlighted when CAC1 Leader 1 reported:

> But I feel like when employees are disengaged, they think more about how their needs are getting met, and they don't care about whether or not other people's needs are getting met. They tend to just care about their own.

The same leader added: "I do want to inspire people to be able to work together and to be excited about the mission that we're trying to accomplish". Some of the challenges have been low staffing which increases the workload of others. When staffing is low, employees are often forced to take on more responsibilities, and often cut out time for their personal well-being. Due to the high levels of turnover that the CAC1 has been dealing with, the ability of staff to take care of themselves has been directly impacted. The increased exposure to trauma in their roles and limited time for resiliency has a direct

impact on their abilities to be as effective in their roles. It is vital for leadership to create time and space for staff to take care of themselves.

All three leaders discussed the impact of employee engagement and the culture of the organization on the outcomes of patient care. For example, CAC1 Leader 1 stated:

> Employee engagement impacts the quality and outcomes of patient care. That it does because if you have people that are highly engaged, I have found that they are the ones that are more likely to go the extra step and to make sure almost as if the way, I would describe it as sort of running their own business.

CAC1 Leader 3 added similar thoughts when they said:

> So I think it's critical that people understand the importance of what they're doing and the impact they're having. And if you have folks that are just showing up for the dollar, it shows up sooner or later in their work. And it shows up with how they interact with patients and how they interact with each other.

This ties into aligning the mission, vision, and values of the organization to motivate employees on their work. The values of the larger health system include: quality and safety, dignity and respect, caring and listening, responsibility and integrity, and excellence and innovation, per the website of the organization. These all align with providing the best quality care to patients. Furthermore, this directly correlates with the research questions of this study.

CAC1 Leader 3 focused on the necessity of having a workplace culture that focuses on diversity, equity, and inclusion. When employees feel they belong, they are more resilient and engaged. They stated:

> Now I want to say something about engagement, and they talk about belonging and having people bring their full selves. So, one of the things I always warn, especially new leaders about, is you've talked about wanting to have an inclusive environment and you want people to belong and be authentic, but have you done the work on what it really is and what it looks like? It is different for everyone.

This leader highlighted the need to be aware and sensitive to all staff. This ties into the trauma-informed care principle of including cultural, historical, and gender issues (SAMSHA, 2014). The same leaders summed up all four themes and the importance of being trauma-informed during our current times of the post-COVID era:

> We're not in the best business times right now. So, we have to take care of our team, turnover is real, and people get burnout. This isn't an easy job. It isn't for the faint of heart. So, if I'm caring for my team, I'm going to say let's slow down.

Financial and Marketplace Results

Financial and marketplace results were not analyzed for this study, as they did not directly relate to the practice problem. The CAC1 is part of a $26 billion health care system that is one of the largest employers in the state, per the center's website. The CAC1 and the larger health care system are nonprofit and in the last fiscal year, contributed $1.5 billion in benefits to the community, including covering the costs of uninsured patients, per the center's website. The CAC1 is primarily funded through federal, state, and local grants, support from the healthcare system, and some billable services. No family ever receives a bill from the CAC1. The current fiscal year's budget is $2,223,640. Approximately 75% of these expenses are for staff salaries.

Implications Resulting From the Findings

There are multiple implications from the findings of this case study. First, it highlights the impact of leaders being trauma informed. The themes resulting from qualitative data analysis, psychological safety and resiliency and well-being, highlight areas that leaders can address. These are two areas in which they can focus their attention.

Additionally, the need for psychologically safe environments appears to be a foundation for leaders to support staff and create productive work cultures and environments. The seminal work of Baier and Frese (2003) revealed the direct link that psychological safety has a direct link on work performance. Psychological safety has been researched in the past, yet there has been an increase in the focus on psychological safety in the workplace, and this is an additional area to research specifically in CACs (Clark, 2020; Edmondson, 2012; Edmondson, 2019; Mitterer & Mitterer, 2023).

Additionally, there is a need for leadership to focus on the overall well-being and resiliency of their staff. This could help them remain engaged and prevent burnout. COVID-19 has reinforced the importance and necessity for leaders and organizations to prioritize the well-being of their staff (Rene, et al., 2021). This includes provided specific resources, access to support such as employee assistance programs, access to appropriate medical benefits, and access to paid time off. Furthermore, communication and creating a positive workplace culture can enhance the employee experience. These are all areas for further study and reflection of leaders.

Implications for Positive Social Change

This case study has multiple implications for positive social change in the areas of leadership, leadership training, increasing employee engagement, decreasing burnout, secondary traumatic stress, and turnover. One of the major implications for positive social change is for organizations to focus on psychological safety. This topic has received an increase in recent literature (Jeong et al., 2023; Selander et al., 2023).

The concepts of psychological safety apply to all levels of an organization. For example, recent research has focused on the role of psychological safety at the CEO level (Dwivedi et al., 2023). This research discussed the role of various reasons for turnover, including psychological safety. Psychological safety has the power to create positive social change at all levels of an organization. When leaders and employees are fully engaged and feel the benefits of psychological safety, this trickles down to the work they do and the families they serve.

One of the implications can be the training of current and future leaders in the concept of trauma-informed leadership and the impacts of psychological safety, well-being and resiliency, communication, and workplace culture. If leadership, in any setting, increases their ability to become more trauma informed, it could potentially increase levels of engagement and patient outcomes, while decreasing turnover, burnout, and secondary traumatic stress.

Strengths and Limitations of the Study

Strengths

There are multiple strengths to this study. The qualitative case study of a CAC was analyzed using best practices of qualitative coding and triangulation (Saldana, 2021). Additionally, my study was reviewed by my doctoral committee in which I incorporated any feedback and suggestions. This allowed the study to be reviewed by additional researchers.

Furthermore, the study utilized the Baldrige Framework as the framework to evaluate the CAC1. The Baldrige Framework is an evidence-based and recognized framework for many organizations (Baldrige Performance Excellence Program, 2021).

Additional strengths of this study include the in-depth analysis of the CAC1. The data was collected from a variety of sources. These included a thorough literature review, three semi structured interviews, and various secondary resources. Finally, the data analysis and results of this study can be implemented and utilized by the leadership at the CAC1 immediately to address the practice problem of employee engagement.

Limitations

There are some limitations to this case study. Despite all attempts to remove any potential biases, the research was conducted by a current employee of the CAC. There were also a limited number of interviewees and a small sample size, as there were only three leaders for the CAC1. The sample size limits the ability to generalize the results of this study. Additionally, the organization is a specialized type of organization, a child advocacy center that focuses only on trauma. Other behavioral health organizations may

have different results. Although all efforts were made, there are limitations in this study due to the possibility of researcher biases. I was the only researcher involved in this study.

Summary

In Section 4, I provided an analysis of results related to the CAC1's clients, workforce, leadership, governance, and marketplace performance. Furthermore, I summarized the implications for social change and the strengths and limitations of the study. There was a plethora of data for analysis from the CAC1 and the three interviews of leadership. The data provided the necessary information to explore the CAC1 and the practice problem of employee engagement. The four main themes that were derived from the interviews provided insight into the practice problem. The themes included psychological safety, well-being and resiliency, communication, and workplace culture. The recommendations and impact of these findings will be discussed and highlighted in Section 5.

Section 5: Recommendations and Conclusions

Introduction

CAC1 is a hospital-based, well-established, and productive CAC in the northeastern United States. The center provides a plethora of trauma-informed services to children who have reports of being abused or neglected. CAC1 has had a significant amount of success, yet has struggled to engage staff, particularly during the COVID-19 times. The most recent employee engagement survey shows that 90% of the staff are at high levels of engagement, yet other indicators are not congruent, including retention rates and levels of secondary traumatic stress and burnout. Therefore, I conducted this case study to determine the impact of trauma-informed leadership. The research questions for this study were:

RQ1: How would trauma-informed behavioral health leadership improve employee engagement at a CAC?

RQ2: How does trauma-informed behavioral health leadership impact the rates of retention and overall patient quality of care at a CAC?

The responses to these questions were answered through the recommendations I made based on the results of this case study. I discuss the four main themes derived from data analysis (i.e., psychological safety, resiliency and well-being, communication, and workplace culture) in this section. My recommendations include ways to assist CAC1 to become more trauma informed as well as increase the psychological safety of employees and enhance levels of resiliency and well-being amongst employees. Following my

recommendations will improve communication and the overall workplace culture at CAC1.

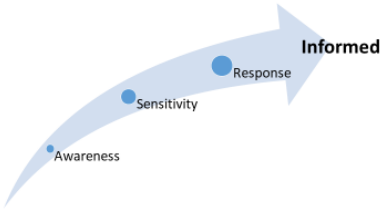
Recommendations

Recommendation 1: Increase Leadership's Knowledge of Trauma Informed Care and Assess the Current Levels

The leadership and staff at CAC1 are well versed in trauma-informed care, yet there is always room for improvement. My first recommendation in this area is to assess the organization for the level of trauma-informed care. The Missouri Model of Trauma Informed Care breaks down the implementation of becoming trauma-informed care into four phases. The use of the assessment will determine what stage CAC1 is at and what the organization should focus on one area at a time. Figure 4 shows these four phases.

Figure 4

Four-Phase Model for Trauma Informed Care



Note. Developed from "A Trauma-Informed Approach to Workforce: An Introductory Guide for Employers and Workforce Development Organizations, by V. Choitz & S. Wagner, National Fund for Workforce Solutions, 2021 (https://www.nationalfund.org/wp-content/uploads/2021/04/A-Trauma-Informed-Approach-to-Workforce.pdf).

Trauma-Informed Oregon (2018) has an assessment process that illustrates the phases in Figure 4. Phase 1 is being trauma aware. This includes recognition and awareness of trauma. Phase 2 is being trauma sensitive. This phase includes foundational knowledge, agency readiness, and process and infrastructure. Phase 3 is being trauma responsive. This entails gathering information about trauma informed care, while prioritizing and creating a plan. Finally, the Phase 4 is where an organization is trauma informed. This includes the following steps: (a) implementing and monitoring and (b) adopting policies and practices. There is continual assessment of outcomes and the overall trauma informed culture.

There are additional screening and assessment tools that are available if the leadership team of CAC1 would prefer a different instrument. Prior to improving the level of trauma-informed care, the center needs to know where they currently land in the continuum in Figure 4.

CAC1 needs to develop a framework where all aspects of the organization are trauma informed. The principles of trauma-informed care, including safety, transparency and trust, healthy relationships and interactions, empowerment, voice and choice, equity, antibias efforts, and cultural affirmation need to address the operations of the center, including operational leadership, policies and decision making, training and workforce development, the physical environment, and continuous quality improvement (Massachusetts Childhood Trauma Task Force, 2020).

When organizations are trauma informed and responsive, there are positive impacts at both the individual and organizational levels, including increased job satisfaction, reduced secondary traumatic stress, and increased compassion satisfaction, which results in increased performance and retention (Fink-Samnick, 2022). These positive impacts ultimately lead to overall higher levels of quality care provided to families served (McGowan et al., n.d.). Therefore, I am making the following recommendations to assess and enhance the current level of CAC1 being trauma informed and responsive:

1. Assess the organization's current level of being trauma informed and responsive.

2. Develop a workgroup to reassess all current practices and policies to assess for levels of being trauma informed and responsive.
3. Incorporate discussing personal well-being in monthly 1:1 meetings/supervision.

Recommendation 2: Increase Understanding of Psychological Safety to Implement Specific Strategies to Improve Culture

My second recommendation is to increase the leaders' knowledge and understanding of psychological safety. The goal of the leadership team should aspire to have psychological safety implemented at levels of the organization, including individual, team, and organizational levels, as highlighted in Table 1. Psychological safety must be present and evident at every level of the organization (Hunt et al., 2021). Furthermore, leadership needs to be able to model and have buy-in to create organizational change.

Table 1

Goals to Achieve of Psychological Safety at Various Levels of Center

Individual Level	• They feel safe to report errors and/or mistakes • They can discuss and question roles and responsibilities with others • They can make suggestions for improvement of processes and polices without fear of ridicule
Team Level	• Encourage compassionate problem-solving with team members • Ability to challenge negative behaviors of peers • Encourages innovate and experimental changes in processes • Encourages opportunities to learn from mistakes
Organization Level	• Leadership models and encourages psychological safety • Provides networking opportunities and opportunities for professional development • Engage in compassionate and trauma-informed leadership approaches • Development of fair and equitable processes and procedures

Note. Developed from "Enhancing Psychological Safety in Mental Health Services," by D. F. Hunt, J. Bailey, B. R. Lennox, M. Crofts, & C. Vincent, 2021, *International Journal of Mental Health Systems, 15,* p. 33 ().

The first step is to develop baseline knowledge and to have standard terminology and understanding of the topic of psychological safety. I recommend that a book club be established for the leaders to gain knowledge and insight. The books in Table 2 are recommended to be read and discussed as part of a leadership book club. The book club can occur for 20 to 30 meetings during the weekly leadership meeting that is already

scheduled; therefore, this will not create an additional meeting during an already busy schedule.

Table 2

Books for Leadership Book Club

Title	Author
The 4 Stages of Psychological Safety: Defining the Path to Inclusion and Innovation	Timothy R. Clark
The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth	Amy C. Edmondson
Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy	Amy C. Edmondson

The following steps can then be implemented by the leadership of CAC1 to increase psychological safety and improve the workplace culture (see Hunt et al., 2021):

1. Develop a CAC1 workgroup to address psychological safety.
2. Have the workgroup assess current strategies and plans that may be impacting psychological safety. This includes the following committees already developing and operating at the CAC1: Resiliency, Engagement, Outreach, Diversity, Equity & Inclusion, and Education Committees
3. Develop an operational definition of psychological safety and provide education on psychological safety to the staff at an all-staff meeting (because there is already an education component at each meeting).
4. Develop and implement surveys and focus groups to assess the current levels of psychological safety at CAC1.

5. Review current documents, policies, and procedures that may either support or detract from psychological safety. Adjust and create policies and procedures as necessary.
6. Have the concept of psychological safety become a standard topic during monthly 1:1 meetings/supervisions and team meetings.

By implementing these strategies, the leadership team can enhance their knowledge and show the importance of having psychological safety at all levels of the organization. When leaders are more trauma informed and have higher levels of psychological safety, there can be positive changes in communication and the overall culture of the organization. Dusenberry and Robinson (2020) highlighted the importance of psychological safety on communication patterns and team cohesiveness, finding that when employees have developed relationships, they are more likely to feel safe and express their thoughts without the fear of failure.

Recommendation 3: Implement Community Resiliency Model

Staff at CAC1 experience high levels of exposure to traumatic stress daily due to the nature of their work. The center has a thorough Resiliency Plan and Blueprint developed, yet there is not a specific model utilized to assist with the resiliency development of staff. I would recommend that CAC1 include the implementation of the Community Resiliency Model (CRM) into their current Resiliency Plan.

The CRM was developed by Miller-Karas (2015) to increase resiliency in communities and organizations that are exposed to trauma. Miller-Karas (2021) described resiliency and the purpose of the program as:

> Resiliency is an evolving concept that includes the compassionate knowledge of suffering as part of the human experience. Even during and after traumatic experiences, people across the world have shared how they cultivate their well-being with optimism and humor. They have not lost their capacity to nurture their relationships. They have shared their assets and strengths which have included honoring traditions of kinship networks, community, culture, country, and religion. We have witnessed a hopefulness of the human spirit often woven into the fabric of suffering that helps communities begin to create realistic and innovative solutions to obstacles. The concepts and wellness skills of the Community Resiliency Model have contributed to greater well-being in mind, body, and spirit (p. 4).

CAC1 is a community that can benefit from this resource to increase their overall levels of well-being. The CRM consists of six wellness skills: (a) tracking, (b) resourcing, (c) grounding, (d) gesturing, (e) help now!, and (f) shift and stay (Miller-Karas, 2015, 2021). The model is based on the most recent neuroscience and trauma research, and each skill is taught with practical, hands-on techniques to practice. This specific program can be an intentional and proactive approach to the areas of resiliency and overall levels of well-being. The program can be implemented in the following steps:

1. Identify a staff member (i.e., leader or employee) to lead the program.
2. Have identified staff attend the training program offered through the Trauma Resource Institute.
3. Have the trained staff/leaders train leadership in the model.

4. Provide overall training on the model to all staff at an all-staff meeting.
5. Begin to implement the skills during already scheduled meetings, such as staff meetings and team meetings. Can also schedule a voluntary-weekly CRM activity once a week for staff.
6. To assess effectiveness, have staff complete the Professional Quality of Life assessment prior to implementation and then every 6 months.

The effectiveness of the CRM has been highlighted in the research (Freeman et al., 2021; Grabbe et al., 2020; Miller-Karas, 2021; Park et al., 2021). Research with nurses showed that the CRM increased levels of well-being and resiliency while decreasing levels of secondary traumatic stress and physiological symptoms of trauma (Grabbe et al., 2020). This is a promising practice that could be as beneficial for the staff of CAC1.

Future Research

This study was a single case study of one CAC. Future research should look at various behavioral health organizations with a different variety of sizes, locations, and services provided. There has been a significant increase in the need for leadership to be more trauma informed and focus on the well-being of the staff due to the stressors exacerbated by the COVID-19 pandemic.

Additionally, there needs to be future research around psychological safety and its connection with trauma-informed behavioral health leadership. There needs to be additional research on what leaders can do to create psychologically safe environments.

This research needs to occur in all areas, not just behavioral health. Future research could show how psychological safety could retain and support employees.

Research also needs to continue to focus on specific strategies that leaders can implement. Furthermore, research needs to focus on educational programs and the professional development of leaders in the area of being trauma informed. This is vital for leaders in behavioral health but is also necessary in all sectors because trauma is universal. Research can focus on the best ways to educate and prepare leaders to address the growing need and requirements to support their staff in a holistic manner.

Conclusion

In this qualitative case study, I explored the impact of trauma-informed behavioral health leadership on employee engagement at CAC1. I developed recommendations on how to address the practice problem based on the results of data gathered from the interviews with CAC1 leadership, a review of secondary resources, and a thorough literature review. CAC1 has a solid foundation to address these issues yet could implement the recommendations to enhance levels of employee engagement, increase retention levels, and improve overall levels of patient care. I provided the leadership team at CAC1 with an executive summary and presentation outlining the findings of this study and my correlating recommendations.

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Appendix: Interview Questions

1. What does it mean to have an employee who is engaged?
2. How do you measure engagement?
3. Why do you do to increase employee engagement?
4. How do you create an environment for ongoing training and professional development?
5. How does employee engagement impact the quality and outcomes of patient care?
6. What is your leadership approach?
7. How do you incorporate trauma-informed care into your leadership approach?
8. How do you prepare your team for changing capability and capacity needs?
9. How does lack of engagement lead to burnout, secondary traumatic stress, and turnover?
10. How do you foster a trauma-informed organizational culture that recognizes high performers, is psychologically safe, and promotes an engaged workforce?