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Exploring Workforce Retention in a Behavioral Health Organization: A Qualitative Study

Meagan Tamara Copelin
Walden University

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Walden University

College of Allied Health

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Meagan T. Copelin

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.

Review Committee

Dr. Derek Rohde, Committee Chairperson, Psychology Faculty

Dr. Mario Tovar, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Abstract

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by

Meagan T. Copelin

MBA, American Intercontinental University, 2013

BS, Liberty University, 2012

Doctoral Study Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Psychology in Behavioral Health Leadership

Walden University

February 2026

Abstract

Workforce retention among mental health professionals has been a central focus of scholars as behavioral health systems continue to face chronic staffing instability (Hallett et al., 2024). Researchers have demonstrated that burnout, limited organizational support, and resource misalignment significantly influence turnover in these settings (Maslach & Leiter, 2016; Pulman & Fenge, 2024). However, researchers have not yet established how mental health professionals within a single publicly funded, state-operated behavioral health organization interpret the organizational and cultural factors that influence their decision to remain employed. The purpose of this qualitative single-case study was to explore how mental health professionals in a publicly funded behavioral health agency in Texas perceive workplace culture, leadership practices, and organizational supports related to retention. Maslach and Leiter's burnout theory and the Baldrige Excellence Framework guided the analysis of organizational demands, recognition, and workforce systems. Using a qualitative case study method, data were collected through semistructured interviews and organizational documents. The results indicated that leadership presence, psychological safety, peer collaboration, and mission alignment supported retention, while workload strain, staffing shortages, and limited recognition contributed to diminished commitment. This study may contribute to positive social change by informing evidence-based strategies that strengthen workforce stability and improve continuity of care for individuals with complex behavioral health and developmental needs.

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Dedication

This work is dedicated to the resilient and compassionate mental health professionals who continue to serve in nonprofit behavioral health organizations, even when the challenges are immense, and the recognition is minimal. Your unwavering commitment to healing, advocacy, and service in the face of adversity is both humbling and inspiring.

To the individuals who remain on the front lines, navigating burnout, limited resources, and the emotional toll of the work, this study is for you. May your experiences, voices, and insights continue to shape systems that are more just, supportive, and sustainable.

I also dedicate this work to my family, mentors, and those who held space for me during moments of exhaustion and doubt. Your encouragement, belief in my vision, and emotional presence sustained me throughout this journey.

Finally, this is for the communities whose stories too often go unheard and for those who show up every day to make care more equitable. Your impact matters. Your work matters. And your staying power is a form of resistance and hope.

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Section 1a: The Behavioral Health Organization

Introduction

Workforce instability has become one of the most pressing challenges in behavioral health, posing a threat to service continuity and the well-being of those who provide care (National Center for Health Workforce Analysis, 2024). Across the United States, behavioral health agencies are struggling to retain qualified professionals in the face of rising demand, increasing clinical complexity, and workforce fatigue (Armstrong, 2025). These challenges are particularly acute in public systems that provide care for individuals with complex mental health and developmental needs, where staffing shortages and turnover disrupt both service delivery and organizational resilience (Hallett et al., 2024; Brabson et al., 2020).

The rising concern over workforce retention within behavioral health organizations has prompted extensive research, particularly within public systems serving complex populations. This study focuses on BRX (a fictitious name), a publicly funded behavioral health organization located in a metropolitan area of Texas, which provides residential and community-based services for individuals with behavioral health and developmental support needs. The organization includes residential behavioral health programs and functions as a complex care delivery system with high clinical acuity, long-term residential needs, and significant organizational demands. These settings serve individuals who require structured, 24-hour support beyond what is available in community-based alternatives.

Staffing concerns in such facilities reflect a national pattern. The annual turnover rate among behavioral health staff in the United States reached 27.5% in 2023, a marginal improvement from 31.3% in 2022, yet still indicative of structural instability and chronic workforce fatigue (National Center for Health Workforce Analysis, 2024). The public residential care system examined in this study continues to experience persistent recruitment challenges, burnout-related attrition, and organizational strain, all of which threaten service continuity, care quality, and the psychological resilience of its workforce (Ballout, 2025; Fukui et al., 2025; Brabson et al., 2020).

This public organization is uniquely positioned to serve as a site for qualitative inquiry into workforce retention, given its scale of operations, clinical diversity, and the breadth of services offered across multiple regions. The research setting provides a rich environment for understanding how internal organizational dynamics shape retention among clinical and staff.

Through a constructivist lens and grounded in qualitative methodology, this study aimed to understand how behavioral health professionals interpret the organizational, structural, and cultural factors that influence workforce retention. It builds on a growing body of literature identifying burnout, limited career advancement, role ambiguity, emotional labor, vicarious trauma, and systemic underfunding as key drivers of attrition in public behavioral health environments (Ballout, 2025; Pulman & Fenge, 2024; Hallett et al., 2024). At the same time, the study explored protective factors such as values-based leadership, emotional solidarity, and alignment between professional purpose and

organizational mission, which are increasingly recognized as buffering against turnover intent (Fogel et al., 2025; Nyerges et al., 2024).

Throughout Section 1a, Section 1b, and subsequent chapters, I incorporate operational terms used internally by the organization that are relevant to understanding the organizational context of this doctoral study. These definitions are presented in Table 1. The information presented in Section 1a and Section 1b was obtained through exploratory semistructured interviews I conducted with behavioral health professionals employed by the organization, along with a review of publicly available and internal organizational documents as they permitted. These initial qualitative data sources established the foundation for identifying the professional practice problem and refining the study's conceptual framing. As such, many of the topics and findings described in Section 1 are addressed in more detail in Sections 2 through 4.

Organizational Description

The organization under study, referred to here as BRX (fictitious name), is a publicly funded behavioral health agency located in a metropolitan area in Texas. It provides residential and community-based services for individuals with behavioral health and developmental support needs (BRX website, 2024). It functions as part of the state's publicly supported residential care infrastructure and delivers long-term interdisciplinary services to individuals with intellectual and developmental disabilities (IDD) and co-occurring behavioral and medical conditions (BRX website, 2024). Though funded and regulated at the state level, this organization operates its programs locally through a decentralized structure of regional residential behavioral health programs. Each site

delivers intensive 24-hour care, rehabilitation, and habilitation services to individuals with high-acuity behavioral and developmental needs who are unable to be supported in community-based settings.

The organization serves as a critical safety-net provider for individuals with complex disabilities who face significant systemic and structural barriers to community inclusion. Demand for these services has remained high across the state due to the compounded effects of workforce shortages, limited access to integrated behavioral health services, and social determinants of health that disproportionately affect individuals with disabilities (Health Resources and Services Administration, 2024; National Association of State Directors of Developmental Disabilities Services, 2023). As noted by Armstrong (2025), the aftermath of the COVID-19 pandemic significantly exacerbated pressures on publicly funded behavioral health providers, especially those serving high-risk and medically vulnerable populations. This organization's role has therefore become increasingly vital in ensuring equitable access to residential care and stabilization for individuals whose needs surpass community-based capacity (BRX website, 2024).

Rooted in a whole-person, trauma-informed philosophy of care, the organization's mission is to provide compassionate, integrated, and person-centered support to individuals with IDD and behavioral health needs (BRX website, 2024). This mission is enacted through a values framework that prioritizes safety, dignity, recovery, and respect for autonomy. Clinical and support staff are trained to incorporate culturally responsive practices, strength-based care planning, and positive behavior support into all aspects of

service delivery. As emphasized by Alhassan et al. (2025), embedding trauma-informed supervision and systemic equity into organizational culture is essential for both ethical care and workforce sustainability. The organization demonstrates alignment with these national standards through its implementation of interdisciplinary rounds, active behavior support committees, and clinical leadership teams that integrate nursing, psychology, and social work perspectives.

A combination of structural and psychosocial factors, including geographic isolation, low compensation, occupational stress, and perceived lack of organizational support, has contributed to high turnover rates across clinical and direct care roles (Fukui et al., 2025; National Association of State Directors of Developmental Disabilities Services, 2023). These challenges align with national trends affecting the behavioral health workforce capacity, particularly in rural and high-acuity settings (Health Resources and Services Administration, 2024). Moreover, as Nyerges et al. (2024) observed, the success of residential care programs depends on the presence of a cohesive and supportive workplace culture, which is often undermined by chronic staffing shortages and systemic underinvestment.

As of the time of this study, the organization continues to explore policy and practice-based solutions to improve retention, particularly among direct care staff and clinical supervisors. Given the complex interplay between systemic pressures, organizational culture, and individual well-being, the need for qualitative research that captures the lived experiences of staff is especially urgent. As Fogel et al. (2025) and Goyal and Kaur (2023) suggest, understanding why employees choose to stay and what

internal organizational dynamics support their longevity can offer valuable insights for transforming workplace environments.

The study aimed to elevate practitioner voices, center organizational knowledge, and contribute to the emerging body of literature on workforce retention in high-need behavioral health systems. Findings inform strategic interventions aimed at enhancing staff engagement, mitigating attrition, and supporting the long-term resilience of the public behavioral health workforce in Texas.

Staff

The organization currently employs a diverse array of personnel to support residential behavioral health services across multiple campuses. Direct Support Professionals (DSPs), Psychiatric Nursing Assistants (PNAs), Licensed Vocational Nurses (LVNs), Registered Nurses (RNs), Behavioral Health Clinicians, and support staff comprise the core workforce. DSPs are frontline workers who assist residents with activities of daily living, hygiene, safety monitoring, and skill-building tasks (Centers for Medicare & Medicaid Services, 2022). PNAs and LVNs provide individualized care under clinical supervision, including therapeutic support, documentation, and behavioral observation (Ballout, 2025). RNs oversee medication administration, health assessments, and care coordination for individuals with co-occurring physical and behavioral conditions.

Behavioral health clinicians, including licensed social workers, counselors, and psychologists, deliver therapeutic interventions aligned with individualized treatment plans. These staff must meet credentialing requirements and participate in trauma-

informed and evidence-based practice training (Ballout, 2025). Support staff handle essential non-clinical operations, including custodial services, food preparation, security, and transportation. While not involved in clinical care, these employees maintain the safety and functionality of the residential environment and interact regularly with residents (Hallett et al., 2024).

Clinical supervision is provided by physicians and psychiatrists who oversee treatment fidelity, conduct evaluations, and ensure regulatory compliance across the residential system. Staffing levels are guided by internal policy, acuity levels, and licensure requirements for residential behavioral health settings. Similar to other public behavioral health agencies, the organization experiences high turnover among direct care workers, prompting ongoing investments in staff development, retention incentives, and pipeline initiatives (Health Resources and Services Administration, 2024; National Association of State Directors of Developmental Disabilities Services, 2023).

Service Offerings

The organization provides 24-hour residential behavioral health services for individuals with IDD who require medical, habilitative, and behavioral support beyond what is available in community settings (BRX website, 2024). Services are person-centered and designed to promote safety, stability, and functional independence within a highly structured environment.

Residents receive comprehensive assistance with activities of daily living (ADLs), including bathing, dressing, toileting, eating, and mobility support. Instrumental activities of daily living (IADLs) are also supported, such as managing medications, preparing

meals, and maintaining hygiene routines under staff supervision (Centers for Medicare & Medicaid Services, 2022). Individualized habilitation plans emphasize social skills development, communication, behavioral regulation, and life skills acquisition tailored to each person's goals and abilities.

The interdisciplinary team provides psychiatric care, psychological evaluations, clinical therapy, nursing services, medication administration, and crisis intervention. Therapeutic programming is supplemented with recreational, vocational, and spiritual opportunities that enhance resident well-being (National Association of State Directors of Developmental Disabilities Services, 2023). Support is available from one hour to 24-hour care, depending on the resident's clinical profile and risk level. The structured living environment enables consistent monitoring, rapid response to behavioral escalations, and collaborative treatment planning, all designed to improve health, safety, and quality of life (Health Resources and Services Administration, 2024).

Clients

Over 40% of individuals with intellectual and developmental disabilities (IDD) also experience co-occurring psychiatric disorders such as anxiety, depression, and impulse-control conditions, which can increase the need for intensive residential care (Zablotsky et al., 2021). Adults with developmental disabilities experience disproportionately poorer health outcomes and reduced access to essential medical services when compared to adults without disabilities (McLean et al., 2025).

The clients served by the organization are individuals with intellectual and developmental disabilities (IDD) who require intensive, long-term care that exceeds the

resources available in their home or community settings (BRX website, 2024). These individuals often have complex medical, behavioral, or habilitative needs that necessitate 24-hour residential support, therapeutic interventions, and clinical oversight. Residents may present with co-occurring physical or psychiatric conditions, mobility limitations, or significant challenges with activities of daily living.

The organization offers on-campus housing, individualized care plans, and interdisciplinary services tailored to promote safety, autonomy, and overall well-being. Clients are referred through coordinated entry systems and typically come from a multi-county service area defined by regional healthcare infrastructure and state placement protocols. The population includes both younger and older adults with lifelong disabilities who are aging in place and often experience multiple health risks associated with institutional living or chronic disease progression.

Across sites, the total number of residents ranges from approximately 70 to 375 individuals, depending on the geographic catchment area, capacity, and operational scale. Clients live in structured, supervised environments with access to medical, psychiatric, therapeutic, behavioral, and habilitative support that reflects the organization's commitment to dignity, inclusion, and person-centered care (BRX website, 2024).

Organizational Structure

The publicly operated behavioral health system maintains a centralized organizational structure managed by a state agency responsible for long-term care and residential services. Each regional residential behavioral health program is led by an on-site director who oversees daily operations, personnel, regulatory compliance, and service

delivery functions. Although regional programs retain some local control for staffing, supervision, and workflow decisions, system-wide policy development, fiscal oversight, and programmatic evaluation are guided centrally through an office of disability services coordination. At the regional level, core management teams include nursing supervisors, behavioral health leads, clinical directors, and administrative managers, all of whom collaborate to manage medical, behavioral, and habilitative functions for individuals with complex needs (National Association of State Directors of Developmental Disabilities Services, 2023).

Strategic planning and workforce development efforts are informed by federal and state-level guidance, emphasizing evidence-based practices, trauma-informed care, and interdisciplinary coordination. Centralized leadership provides oversight on performance improvement, staff training, and regulatory compliance to ensure consistent delivery across geographically dispersed campuses (Substance Abuse and Mental Health Services Administration, 2023; Centers for Medicare & Medicaid Services, 2022). This structural model enables balance between centralized accountability and regional adaptability in meeting population needs.

Practice Problem

A publicly funded behavioral health organization located in a metropolitan area in Texas is currently experiencing significant difficulty retaining its mental health professionals. Employees in the behavioral health system frequently encounter high levels of stress, heavy workload, and inadequate support, factors strongly associated with emotional exhaustion and burnout, which are known precursors to turnover in healthcare

professions. One internal training resource identifies “short staffing, overtime demands and high turnover,” along with “high levels of stress,” as risk factors for abuse and neglect (BRX website, 2024). Another professional development guide for behavioral health clinicians highlights the emotionally taxing nature of their work, noting that they operate within a “culture of one-way caring,” which illustrates the continual emotional load placed on staff (State Agency Report, 2024).

Burnout, as conceptualized by Maslach and Leiter (2016), is not only a psychological syndrome but also a signal of systemic misalignment between worker needs and organizational capacities. This discrepancy reflects not merely an individual stress response but a failure in organizational design, where structural inefficiencies, unresponsive leadership, and inadequate support mechanisms accumulate to produce chronic emotional strain.

While prior research has established that burnout contributes to workforce attrition across healthcare systems (Salyers et al., 2017), the depth of these experiences remains insufficiently explored within individual behavioral health organizations. Particularly in settings where resource scarcity, high caseloads, and mission-driven service delivery intersect, staff face unique stressors that cannot be adequately understood through aggregate metrics alone. The emotional labor required in such settings is intensified by systemic barriers, including limited funding, bureaucratic constraints, and regulatory pressure, all of which can impair staff morale and reduce long-term retention (Pulman & Fenge, 2024).

Recent studies have largely focused on large-scale, quantitative analyses to assess the prevalence of burnout and its statistical association with staff turnover (Hallett et al., 2024; Poon et al., 2022). These efforts, while valuable for identifying systemic trends, often omit the contextual richness of frontline perspectives. Particularly absent are studies capturing the voices of those who continue working in emotionally and structurally strained environments, those who stay. Understanding retention from the vantage point of these employees is critical, as their experiences provide insight into what sustains workforce engagement despite known stressors. Their decisions to remain employed may reflect a complex interplay of resilience, meaning-making, professional commitment, and perceived organizational fit (Fogel et al., 2025).

Furthermore, many studies overlook the intersection of organizational culture, including leadership behavior, communication practices, recognition, and internal trust, with burnout in influencing retention decisions (Breslin et al., 2022; Johnson & Shamroukh). Organizational culture has been shown to either buffer or exacerbate the emotional toll of high-stress work environments. In behavioral health settings, where mission fidelity and client need often outpace structural capacity, culture becomes a decisive factor in whether professionals experience the workplace as empowering or depleting (Nyerges et al., 2024). Moreover, leadership practices, including the presence or absence of emotional intelligence, transparency, and responsiveness, play a crucial role in shaping organizational commitment and satisfaction (de Vries et al., 2023).

In settings where continuity of care is essential and client outcomes are closely tied to the stability of the therapeutic relationship, understanding why some staff

members stay becomes a question of organizational sustainability, not just staffing.

Addressing this gap is crucial for developing resilient service delivery models that can withstand chronic stressors without compromising the human infrastructure on which care quality depends.

This qualitative study was designed to address that gap by exploring how mental health professionals in a state-operated behavioral health organization interpret their work environment, interpersonal dynamics, and broader organizational culture in relation to their decision to remain employed. Rather than focusing solely on why employees leave, this research shifts the narrative toward resilience, meaning-making, and structural factors that support retention. Insights from this study can provide a foundation for developing targeted, culturally grounded, and psychologically informed retention strategies tailored to the needs of behavioral health organizations serving high-need populations. Accordingly, the research questions that will guide this proposed doctoral study are as follows:

RQ1: How do mental health professionals in a state-operated behavioral health organization perceive organizational factors that influence their decision to remain employed?

RQ2: What aspects of the organizational culture do mental health professionals identify as most influential in their retention decisions?

RQ3: How do workplace dynamics and interpersonal relationships shape employees' decisions to stay or consider leaving?

RQ4: In what ways do environmental and contextual factors (e.g., workload, support systems, leadership) contribute to employees' sense of organizational commitment or satisfaction?

Although researchers have investigated this issue, there is very little or no literature or organizational practice knowledge on how mental health professionals within a single state-operated behavioral health organization perceive the specific workplace dynamics, environmental stressors, and cultural conditions that influence their decision to stay. Most studies have focused on identifying predictors of burnout and attrition using quantitative methods, but few have explored the lived experiences of those who remain in their roles and what contributes to their retention, especially in resource-constrained, mission-driven behavioral health settings (Breslin et al., 2022; Choy-Brown et al., 2025).

The specific organizational problem addressed in this study is the lack of qualitative insight into how mental health professionals perceive organizational culture, workplace dynamics, and environmental factors that influence workforce retention within a state-operated behavioral health organization. Understanding these dynamics from the perspective of those who have chosen to stay may illuminate underexplored mechanisms of organizational resilience and inform sustainable retention strategies that align with the values and challenges unique to behavioral healthcare.

Purpose

The purpose of this qualitative case study is to explore how mental health professionals within a publicly funded behavioral health organization in a metropolitan area in Texas perceive the organizational culture, workplace dynamics, and internal

environmental factors that influence their decision to remain employed. The study aimed to gain insight into the specific organizational conditions that support or hinder staff retention, as perceived by individuals currently working in behavioral health roles. By focusing on the lived experiences of current employees, this study can contribute to an applied understanding of workforce sustainability in publicly funded behavioral health settings and support leadership-driven strategies for improving retention. This purpose aligns with the identified practice problem: high rates of burnout, limited organizational support, and emotional exhaustion contribute to ongoing difficulty retaining mental health professionals (Maslach & Leiter, 2016; Pulman & Fenge, 2024; Hallett et al., 2024).

This study applied a single qualitative case study methodology guided by the Baldrige Excellence Framework for Health Care (Baldrige Performance Excellence Program, 2021), with special focus on the Workforce Criteria (Category 5). These criteria emphasize workforce environment, capability, well-being, and engagement, and were used to examine how internal organizational systems influence staff retention. The Workforce Criteria was used in three integrated ways. First, interview questions were adapted directly from Category 5, using wording consistent with the Baldrige framework and tailored to behavioral health organizational contexts (Baldrige Performance Excellence Program, 2021). Second, responses to these questions were analyzed to identify how organizational leaders, supervisors, and staff interpret current strategies for supporting mental health professionals and to determine which areas may require improvement (de Vries et al., 2023; Choy-Brown et al., 2025). Third, the Baldrige

Framework was used as a conceptual tool to compare findings from the behavioral health organization to published best practices and empirical evidence drawn from the scholarly literature (Fogel et al., 2025).

The ultimate goal of this study was to develop evidence-informed, culturally responsive, and employee-centered recommendations for improving staff retention within state-operated behavioral health settings. These recommendations are grounded in both empirical data and the Baldrige Framework's emphasis on systems thinking, operational alignment, and strategic leadership (Baldrige Performance Excellence Program, 2021).

Primary Data Collection

Primary data collection consisted of semistructured interviews with clinical mental health professionals currently employed by the organization. Participants were recruited through purposive sampling to ensure a range of perspectives across service areas, including outpatient therapy, crisis stabilization, case management, and administrative support. Interview questions were informed by the Baldrige Workforce Criteria, with a particular focus on how participants perceive leadership, communication, recognition, support systems, and their connection to the organization's mission (de Vries et al., 2023; Choy-Brown et al., 2025).

Table 1*Sample Interview Questions on Workforce Retention and Organizational Culture)*

Topic	Sample Interview Questions
Workforce Environment	<ul style="list-style-type: none"> • How would you describe the overall work environment in your current role? • In what ways does your organization support your health, safety, and well-being? • What formal or informal supports are available to help staff manage work-related stress or emotional exhaustion? • How does the organization promote accessibility and equity across different job roles or service areas?
Workforce Capability	<ul style="list-style-type: none"> • How well do you feel your role aligns with your skills and professional goals? • What opportunities exist for you to build new competencies or pursue career development? • How is onboarding, mentorship, or training provided for new staff, and is it effective in preparing them for the realities of this work?
Workforce Capacity	<ul style="list-style-type: none"> • How would you describe your current caseload or workload? • Do you believe your team is adequately staffed to meet client needs? • How does the organization handle staff shortages or turnover when they occur?
Workforce Engagement	<ul style="list-style-type: none"> • What motivates you to stay with this organization despite the challenges? • How are your ideas or concerns heard and acted upon by leadership? • Do you feel recognized and valued for your contributions? • How would you describe the sense of trust and collaboration within your team or department?
Organizational Culture	<ul style="list-style-type: none"> • In your view, what values are most reflected in the way the organization operates? • How would you describe the communication style of leadership? • What makes this organization different—positively or negatively—from other places you've worked? • Do you feel that leadership is emotionally present and responsive to staff concerns? • How would you describe the ways leadership responds to staff burnout or stress?
Retention Decision	<ul style="list-style-type: none"> • Have you ever considered leaving? If so, what made you stay? • What specific factors have influenced your decision to remain with this organization? • What changes do you believe would enhance workforce retention in your department or organization-wide?

Note. These questions are adapted and aligned with the *Baldrige Excellence Framework*

(Health Care): 2021–2022 Workforce Criteria (Baldrige Performance Excellence

Program, 2021) and are designed to generate rich, qualitative data responsive to the

study's four research questions on workforce retention, organizational culture, and staff

perceptions.

Secondary Data Collection

Secondary data were requested from organizational leadership after IRB approval. These materials were reviewed to enrich the organizational context and provide triangulation for interview findings. Examples of relevant internal documents include the following:

- Strategic plans to assess stated priorities around workforce development;
- Organizational charts and leadership structures to understand administrative alignment;
- Employee handbooks and policy manuals to examine formally stated staff expectations and support mechanisms (BRX website, 2024);
- Position descriptions for mental health roles to analyze scope of duties and role clarity (BRX website, 2024);
- Internal staff surveys or exit interview summaries, if available, to explore staff sentiments and turnover motivations;
- Redacted performance reviews, onboarding protocols, or training guides to assess skill-building and competency alignment (BRX website, 2024).

Documented policies were compared to interviewee perceptions in order to identify congruence or disconnects between written systems and lived experience. This approach supports triangulation and strengthens trustworthiness in qualitative case study methodology (Yin, 2018). Access to internal documentation was subject to confidentiality protocols and must align with ethical standards established by Walden University's Institutional Review Board (IRB). All documents were reviewed with the

express purpose of contextualizing participant narratives and not for evaluative or compliance purposes.

By integrating Baldrige-informed interview data with organizational documents, this study generated applied insights that can support leadership-driven improvements in workforce engagement and staff retention within the state-operated behavioral health system. These findings may also contribute to broader scholarship on sustainability, professional well-being, and systems alignment in publicly funded mental health organizations (Ballout, 2025; Breslin et al., 2022).

Significance

This study is significant in that it addresses the persistent challenge of workforce retention in a publicly funded behavioral health organization by focusing on the lived experiences of mental health professionals at a behavioral health organization based in a metropolitan area in Texas. The organization serves as one of many publicly funded behavioral health systems in the state, providing comprehensive care to individuals with serious mental illness, intellectual and developmental disabilities, and co-occurring conditions. With staff that operate across multiple high-pressure service areas, including residential programs, outpatient clinics, forensic services, and community-based supports, the organization faces ongoing challenges related to emotional fatigue, staff disengagement, and burnout. These issues compromise not only employee well-being but also the continuity and quality of care delivered to vulnerable populations (Maslach & Leiter, 2016; Salyers et al., 2017).

The study focuses on the mental health services division, particularly on clinicians, case managers, and direct care staff whose day-to-day responsibilities place them at the core of the organization's service delivery model. By examining how these professionals perceive their organizational culture, leadership dynamics, and internal systems of support, this study uncovered specific environmental and relational factors that contribute to staff retention. These insights were structured using the Baldrige Excellence Framework for Health Care, which allows for a systems-level analysis of leadership, workforce engagement, and operational effectiveness (Baldrige Performance Excellence Program, 2021). In particular, the Workforce Criteria (Category 5) provides structured guidance on how organizations can create environments that support capability, well-being, and engagement, factors central to staff satisfaction and long-term retention.

This study is also significant because it shifts the research narrative from turnover to retention, recognizing that understanding why professionals choose to stay offers critical insight into organizational resilience. Existing studies often rely on quantitative metrics to measure attrition, omitting the qualitative richness of employee experiences. By contrast, this research explored retention as a process of meaning-making and emotional alignment within the organizational context. As Pulman and Fenge (2024) note, retention is often influenced by how employees perceive leadership presence, recognition, and psychological safety. Alhassan et al. (2025) similarly emphasize the importance of culturally responsive and emotionally intelligent leadership in fostering workforce commitment. These dimensions are particularly vital in state-operated settings,

where staff often remain committed due to alignment with mission and community impact rather than material incentives.

The potential value of this project to the behavioral health organization lies in its capacity to inform targeted retention strategies grounded in staff voice and experiential knowledge. Findings from this study may guide the development of workforce policies that enhance professional development, improve supervisory relationships, and align organizational practices with employee values. For example, if participants emphasize the role of transparent communication or trauma-informed leadership in their decision to stay, these elements can be integrated into training and evaluation systems (Fogel et al., 2025). The Baldrige Framework provides a structured foundation for transforming these findings into operational change by linking individual experience to systemic performance domains such as leadership, workforce, and results (Baldrige Performance Excellence Program, 2021).

This research contributes to effective behavioral health organizational practice and leadership by providing a practice-informed, theory-grounded perspective on workforce sustainability. De Vries et al. (2023) found that empowerment, psychological safety, and authentic leadership were consistent predictors of reduced turnover in health care settings. By building on such findings, this study will advance leadership practices that prioritize emotional wellness, voice, and alignment with mission. Furthermore, the research will help organizational leaders interpret and respond to staff needs with greater precision, thereby enhancing both staff morale and organizational effectiveness (Alhassan et al., 2025).

The study also supports positive social change by strengthening the behavioral health workforce's capacity to deliver consistent, culturally responsive, and ethically grounded care. High staff turnover undermines client stability, service continuity, and public trust. By illuminating the structural and cultural conditions that support retention, the study contributes to the development of more resilient, equitable, and person-centered care environments. As Fogel et al. (2025) argue, workforce retention is not merely a logistical issue but a moral imperative, especially in settings that serve marginalized populations. The potential findings of this study may serve as a model for other state-operated behavioral health organizations seeking to improve staff well-being and organizational sustainability through intentional, values-driven leadership.

Summary

The purpose of this qualitative case study was to examine how mental health professionals working within a publicly funded behavioral health organization in a metropolitan area in Texas interpret their organizational culture, workplace dynamics, and environmental factors in relation to their decision to remain employed. Guided by the Baldrige Excellence Framework for Health Care (Baldrige Performance Excellence Program, 2021), this study aimed to produce a detailed understanding of retention processes by collecting and analyzing the narratives of current behavioral health staff. The significance of the study lies in its potential to inform actionable, staff-informed retention strategies and to contribute to effective organizational leadership, service continuity, and positive social change (Fogel et al., 2025).

The research is grounded in a growing body of literature that identifies burnout, emotional dissonance, and leadership disengagement as key contributors to workforce instability in behavioral health settings (Pulman & Fenge, 2024; Choy-Brown et al., 2025). However, few studies have taken a qualitative approach to explore the perspectives of employees who remain in such organizations (Fukui et al., 2025). This study addressed that gap by centering the lived experiences of employees and exploring how their interpretation of internal organizational factors contributes to decisions to stay (Nyerges et al., 2024).

In Section 1b that follows, a comprehensive organizational profile of BRX is provided to connect the workforce retention problem to the agency's mission, strategic priorities, and regulatory environments. This section highlights how organizational systems, leadership structures, and performance improvement efforts influence workforce sustainability in complex behavioral health environments (Ballout, 2025; de Vries et al., 2023).

Section 1b: Organizational Profile

Introduction

The professional practice problem to be explored in this study focuses on workforce retention among mental health professionals. The study's purpose is to examine this problem for one publicly funded behavioral health organization located in a metropolitan area in Texas. Research questions center on how organizational culture, workplace dynamics, and leadership practices influence the decisions of mental health professionals to remain employed within this organization.

This section presents an organizational profile for BRX (a fictitious name) and discusses key strategic factors. It describes the organization's mission, vision, values, governance, structure, and service offerings. It also provides an institutional context for the study, describing the organization's resource planning strategy and performance improvement system.

Organizational Profile and Key Factors

The organization under study, referred to as BRX (a fictitious name), is a publicly funded behavioral health agency located in a metropolitan area of Texas. It operates as part of the state's health and specialty care system, which provides residential and community-based services for individuals with intellectual and developmental disabilities (IDD), serious mental illness, and co-occurring behavioral and medical conditions. BRX functions within a dual governance model in which a centralized state agency provides regulatory oversight, fiscal management, and performance accountability, while regional facilities retain operational control to address the unique needs of their local populations

(State Agency Report, 2024; National Association of State Directors of Developmental Disabilities Services [NASDDDS], 2023). This structure facilitates the alignment of state-level policy directives with localized service delivery, ensuring consistency in care quality while allowing for programmatic flexibility in high-acuity environments.

Key factors identified as being of strategic importance to BRX include workforce stabilization, the integration of trauma-informed care practices, and the advancement of culturally responsive service delivery. Workforce stabilization has emerged as a critical priority due to persistent challenges in recruiting and retaining qualified behavioral health professionals, particularly in residential programs serving individuals with complex needs (Health Resources and Services Administration [HRSA], 2024). Strategic initiatives are informed by federal and state-level guidance, including the U.S. Department of Health and Human Services' behavioral health workforce reports and the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2023–2026 Strategic Plan, both of which emphasize system-wide priorities such as expanding workforce capacity, enhancing provider well-being, and fostering equity in care (SAMHSA, 2023; HRSA, 2024).

The organization's trauma-informed approach further underscores its commitment to creating safe, person-centered environments that support both clients and staff. Embedding trauma-informed supervision, emotional intelligence in leadership, and strength-based practices within organizational culture aligns BRX with national standards for ethical care and workforce sustainability (Alhassan et al., 2025). Additionally, culturally responsive service delivery has been prioritized to ensure that the agency's

mission, vision, and values reflect the diverse populations it serves, thereby enhancing engagement, trust, and long-term program effectiveness (BRX website, 2024).

Collectively, these key factors provide the foundation for BRX's strategic direction, aligning its operational priorities with evidence-based practices to promote resilience in both its workforce and the individuals it serves.

Treatment Offerings and Services

As stated on the BRX website, the organization operates a fully integrated continuum of residential and community-based behavioral health services for individuals with intellectual and developmental disabilities (IDD), serious mental illness, and co-occurring medical and behavioral health needs. Core offerings include psychiatric care, nursing support, crisis stabilization, individualized habilitation programming, and long-term residential services. These clinical services are complemented by structured psychosocial supports that aim to foster independence, build adaptive skills, and improve quality of life. Residents receive assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as well as structured skill-building, vocational training, recreational programs, and opportunities for social engagement. Leadership emphasizes that these services are delivered within trauma-informed, person-centered environments designed to balance clinical need with dignity and respect (BRX internal documentation, 2024). In line with state and national standards, services are designed to be highly individualized, evidence-based, and culturally responsive, ensuring that each client's unique needs are addressed holistically through interdisciplinary care planning (Texas Health and Human Services Commission [HHSC], 2024).

Strategic Direction

BRX's strategic priorities center on workforce stabilization, embedding trauma-informed practices organization-wide, and advancing culturally responsive, person-centered service delivery. This strategic direction reflects the recognition that service excellence cannot be achieved without an engaged and stable workforce supported by meaningful development opportunities and responsive leadership. Statewide planning documents indicate that these strategies align with state and federal frameworks emphasizing staff well-being, workforce equity, and service accessibility. Organizational leadership has affirmatively linked these strategic goals to both workforce development initiatives and efforts to better meet the complex needs of its service populations (BRX internal planning, 2024; State Agency Strategic Plan, 2024). Additionally, strategic initiatives emphasize expanding community integration efforts, improving client transition pathways, and advancing equity across residential and outpatient care systems, reflecting a comprehensive approach to population health management within the state's Health and Specialty Care System (HHSC, 2024; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).

Mission

BRX's mission statement commits to delivering compassionate, trauma-informed, and person-centered behavioral health care. It emphasizes recovery, autonomy, and inclusion for individuals with complex behavioral health and developmental needs (BRX internal documents, 2024). This mission is enacted through operational priorities that seek to balance clinical excellence with a deep respect for client dignity and choice,

thereby ensuring that each individual is supported in achieving their highest level of independence and quality of life.

Vision

BRX envisions a system of care in which individuals, regardless of the severity of their disability, can access culturally responsive, integrated services. The vision strongly emphasizes reducing systemic barriers and fostering environments where both clients and staff can thrive (State Agency Strategic Plan, 2024). By pursuing this vision, BRX aims to create a sustainable behavioral health ecosystem where care is not only clinically effective but also socially inclusive, culturally attuned, and emotionally restorative for the individuals it serves.

Organizational Values

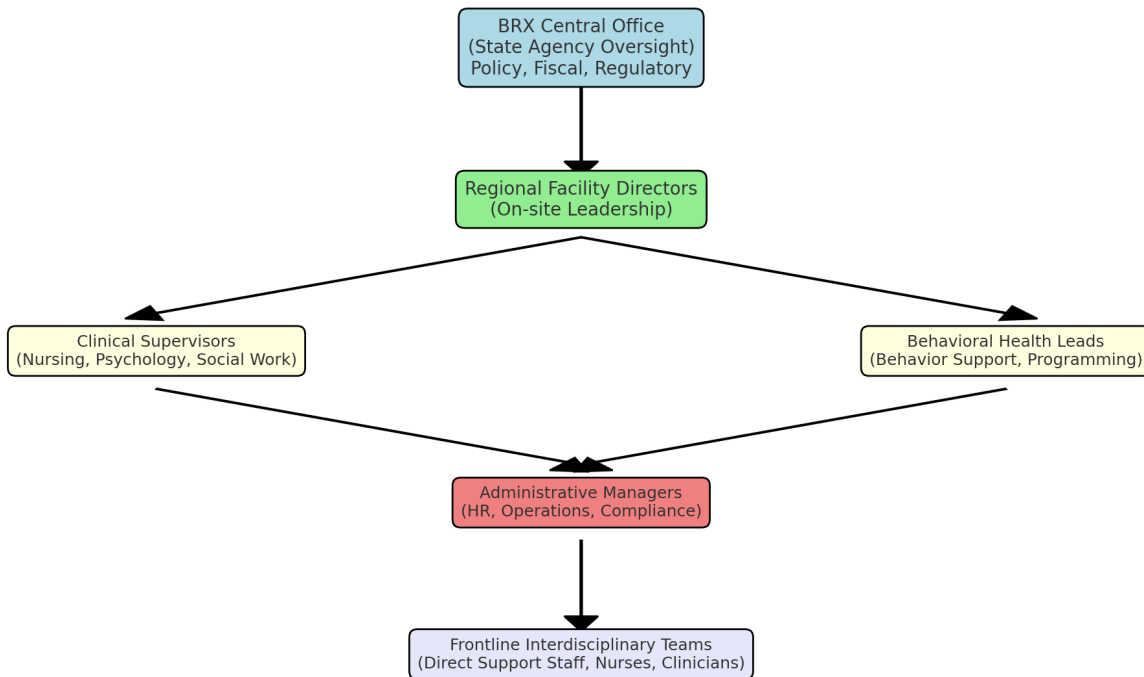
The organization operates within a framework of values that includes safety, equity, respect for autonomy, and a recovery-oriented approach. These values are built into policy, staff development, and service delivery practices. Organizational leadership affirms that these values inform both client care and workforce support, promoting emotional safety, open communication, and opportunities for staff growth (BRX internal communications, 2024). These values extend to the organization's interactions with families, stakeholders, and community partners, ensuring that decision-making processes are grounded in transparency, accountability, and collaborative engagement (HHSC, 2024).

Governance and Structure

BRX operates under a dual governance model, with centralized oversight provided by a state agency responsible for policy direction, fiscal management, and regulatory compliance. Regional facilities maintain operational control over daily service delivery. Each site is led by an on-site director supported by interdisciplinary management teams responsible for clinical, behavioral, and administrative services. This governance model strikes a balance between statewide coordination and regional flexibility (State Agency Report, 2024; National Association of State Directors of Developmental Disabilities Services [NASDDDS], 2023). Leadership roles include directors, clinical supervisors, and behavioral health leads who collaborate to ensure that regulatory standards are met while tailoring services to the unique needs of local populations.

Figure 1

BRX Organizational Chart



Relationship to Parent Organization

BRX is embedded within the state’s Health and Specialty Care System, which oversees operation and coordination of several residential treatment facilities. This parent system supports strategic alignment, resource sharing, and policy consistency while enabling BRX to deliver responsive, locally tailored care (State Agency Report, 2024; NASDDDS, 2023). The relationship with the parent organization facilitates access to shared resources such as workforce development programs, statewide clinical guidelines, and infrastructure improvements, all of which strengthen BRX’s capacity to fulfill its mission effectively.

Relevance to Workforce Retention

Taken together, BRX's service structure, mission-driven focus, governance framework, and values-based culture form a critical foundation for strategic workforce retention efforts. Emphasizing trauma-informed care and client-centered values builds an emotionally sustainable environment for staff, while centralized governance supports coordinated retention initiatives and professional development strategies. This organizational profile directly supports this dissertation's aim of exploring how mental health professionals perceive their work environment, leadership presence, and organizational culture as they make decisions to stay or leave.

Organizational Background and Context

Need for the Study

BRX, a publicly funded behavioral health organization operating within a state-administered health and specialty care system, is experiencing persistent workforce instability, particularly among mental health professionals, nursing staff, and direct support workers. Turnover rates in residential behavioral health programs nationally remain high, with the behavioral health workforce experiencing a 27.5% annual turnover rate in 2023, reflecting systemic challenges across the sector (National Center for Health Workforce Analysis, 2024). Internally, BRX reports chronic vacancies in critical positions, difficulty retaining paraprofessional and clinical staff, and increasing burnout linked to the emotional intensity of providing 24-hour care for individuals with intellectual and developmental disabilities and co-occurring behavioral health conditions (State Agency Report, 2024). These workforce challenges threaten the organization's

ability to maintain service continuity, meet regulatory requirements, and fulfill its mission of delivering trauma-informed, person-centered care. This doctoral study is needed to examine how organizational culture, leadership practices, and workplace dynamics influence staff retention, generating actionable insights to stabilize the workforce and support the long-term sustainability of BRX's programs.

Institutional Context

The organization under study, referred to here as BRX (fictitious name), operates as part of a state-managed health and specialty care system that provides long-term residential and community-based behavioral health services for individuals with intellectual and developmental disabilities (IDD), serious mental illness, and co-occurring medical or behavioral conditions. Its service network spans multiple facilities within a metropolitan multi-county region, addressing the needs of a demographically and socioeconomically diverse population. These facilities serve individuals who require structured, 24-hour care beyond what is available in community-based settings, creating a complex institutional environment where clinical, behavioral, and social supports intersect (State Agency Report, 2024).

BRX functions within a dual governance model, where a centralized state authority provides policy direction, fiscal oversight, and regulatory compliance, while regional facilities retain operational control to adapt services to their local populations. This structure balances statewide alignment with the flexibility necessary for addressing unique community needs. Each regional program is managed by on-site leadership teams, including directors, clinical supervisors, and interdisciplinary management staff, who

collaborate to maintain quality standards and ensure programmatic responsiveness to residents' individualized care plans (National Association of State Directors of Developmental Disabilities Services [NASDDDS], 2023).

The mission of BRX emphasizes the provision of trauma-informed, person-centered care that promotes recovery, autonomy, and dignity for individuals with complex behavioral health and developmental needs. Its strategic vision reflects a commitment to fostering equitable, culturally responsive services that reduce systemic barriers to care while creating supportive environments for both clients and staff. These priorities are operationalized through organizational values that include safety, equity, respect for autonomy, and a recovery orientation, embedded into policies, staff training, and interdisciplinary care models (BRX internal documents, 2024).

Demographically, BRX's client population mirrors broader national trends, with individuals experiencing compounded challenges related to systemic inequities, social determinants of health, and limited access to integrated care. Internally, its workforce reflects the behavioral health sector's composition, consisting predominantly of women and racially and ethnically diverse direct support professionals, many of whom occupy paraprofessional roles with limited advancement opportunities. This demographic profile, combined with high-acuity client needs and persistent workforce shortages, underscores the urgency of stabilizing and supporting the behavioral health workforce as a critical organizational priority (Health Resources and Services Administration [HRSA], 2024; NASDDDS, 2023).

This institutional context situates the workforce retention challenge within a broader regulatory and strategic framework. BRX operates under state and federal behavioral health policies governing service delivery, licensure, and compliance, including oversight of staffing standards, care quality metrics, and fiscal accountability. As a publicly funded system, it engages in ongoing resource planning to balance operational demands with available state appropriations, federal funding streams, and targeted workforce development initiatives (State Agency Fiscal Report, 2024). These systemic pressures, paired with the organization's mission-driven service model, create an environment in which addressing workforce instability is both a clinical necessity and an organizational imperative.

Definitions of Organizationally Used Terms

To ensure clarity in interpreting organizational practices and operational processes relevant to this doctoral study, several key terms used internally by BRX are defined per Table 2 as follows.

Table 2*Key Terms Relevant to BRX and Behavioral Health Leadership*

Term	Acronym	Definition
BRX	BRX	The fictitious name of the publicly funded behavioral health organization under study, which provides residential and community-based services for individuals with intellectual and developmental disabilities (IDD) and behavioral health needs.
Direct Support Professional	DSP	Frontline staff responsible for assisting residents with activities of daily living (ADLs), behavioral support, and skill-building, forming the backbone of residential care delivery.
Psychiatric Nursing Assistant	PNA	Paraprofessional staff trained to support residents with complex behavioral and medical needs under the supervision of licensed nursing staff.
Licensed Vocational Nurse	LVN	Licensed nursing staff providing medical care, medication administration, and health monitoring under the supervision of registered nurses and physicians.
Registered Nurse	RN	Licensed nursing professional responsible for medication administration, health assessments, care coordination, and oversight of paraprofessional staff in residential settings.
Interdisciplinary Team	IDT	A collaborative care model in which nursing, behavioral health, social work, and habilitation professionals jointly develop and implement individualized care plans.
Trauma-Informed Care	TIC	An organizational framework that recognizes and responds to the impact of trauma on clients and staff through principles of safety, trust, empowerment, and cultural responsiveness.
Person-Centered Planning	PCP	A care planning process that emphasizes individual preferences, autonomy, and strengths in the development of service goals and interventions.
One-Way Caring	OWC	A dynamic describing the emotional load placed on staff who provide continuous care without reciprocal emotional support, contributing to compassion fatigue and burnout.
Workforce Retention	WR	The sustained employment of staff within an organization over time, particularly in high-stress or mission-driven roles such as behavioral health care.
Burnout	BO	A psychological state characterized by emotional exhaustion, depersonalization, and reduced sense of accomplishment among staff, often linked to turnover.
Organizational Culture	OC	The shared values, norms, and practices that shape behavior, decision-making, and staff engagement within an organization.
Leadership Presence	LP	The visibility, engagement, and accessibility of executive or supervisory leaders in supporting and guiding staff in behavioral health organizations.
Behavioral Analyst	BA	A professional specializing in applied behavior analysis (ABA), responsible for assessing behavioral patterns, designing interventions, and training staff to support individuals with challenging behaviors.
Mental Health Clinician	MHC	A licensed professional, such as a psychologist, licensed professional counselor (LPC), marriage and family therapist (LMFT), or licensed clinical social worker (LCSW), who provides therapeutic or psychiatric services to clients.
Psychological Safety	PS	A shared belief among staff that they can express concerns, share ideas, and admit mistakes without fear of punishment or reprisal, strongly linked to retention.

Fiscal Resource Planning, Management, and Compliance

BRX operates within a centralized fiscal planning and oversight framework coordinated by its parent health and specialty care system. Resource allocation is managed through a combination of state appropriations, Medicaid reimbursements, and federal funding streams that support residential and community-based behavioral health services (State Agency Report, 2024). The organization engages in multi-year budget planning to ensure alignment between operational needs and strategic priorities, with particular emphasis on workforce stabilization, infrastructure improvements, and programmatic expansion to meet growing service demands. Annual budgets are developed in collaboration with regional facility leadership, allowing for adjustments based on population needs, acuity levels, and emergent programmatic requirements (BRX internal planning documents, 2024).

Financial management practices include rigorous monitoring of expenditures, revenue forecasting, and compliance with state-mandated fiscal controls. Each facility maintains detailed cost reports, which are reviewed by the central fiscal office to ensure adherence to state guidelines and equitable resource distribution across campuses. BRX's fiscal policies are shaped by state-level performance improvement directives, emphasizing cost efficiency while safeguarding service quality for high-need populations. Compliance with behavioral health policy and law is a core component of BRX's fiscal and operational management. The organization adheres to federal and state regulations governing Medicaid funding, the Health Insurance Portability and Accountability Act

(HIPAA), and the Americans with Disabilities Act (ADA), ensuring both financial and clinical accountability (Centers for Medicare & Medicaid Services [CMS], 2022).

Additionally, the agency incorporates directives from statewide behavioral health initiatives and strategic frameworks, such as the 2023–2026 behavioral health strategic plan, which prioritizes equity, trauma-informed care, and workforce investment (State Strategic Plan, 2023). Regular audits by state oversight entities and internal compliance reviews are conducted to maintain fiscal transparency, operational integrity, and adherence to evolving behavioral health policies.

Broader Regulatory and Policy Context

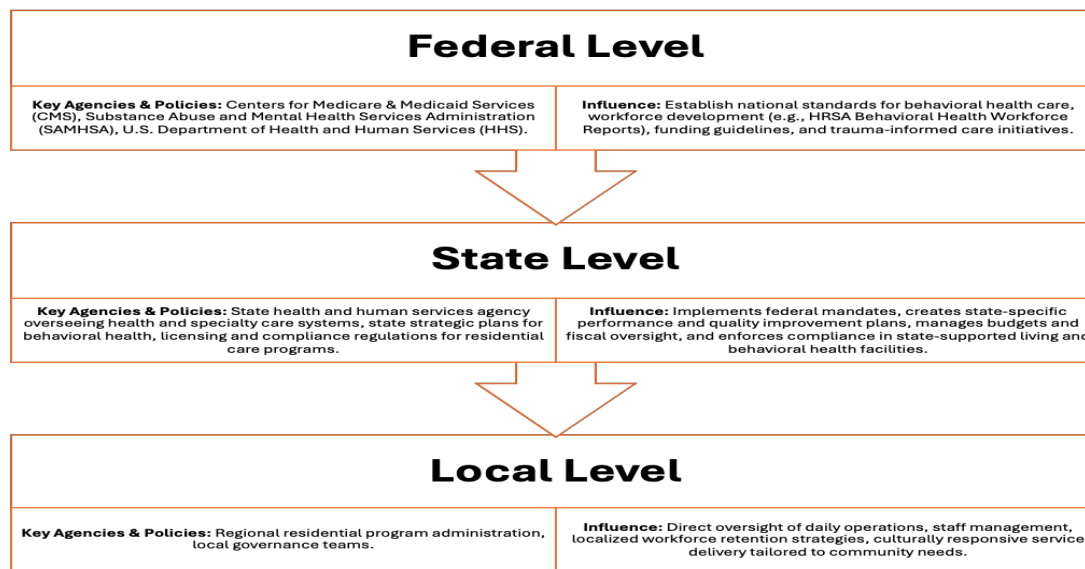
BRX operates within a multi-layered regulatory framework shaped by federal, state, and local policies governing behavioral health and disability services. At the federal level, compliance with the Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA), and Centers for Medicare & Medicaid Services (CMS) regulations ensures that BRX delivers care that meets national standards for accessibility, privacy, and reimbursement integrity (Centers for Medicare & Medicaid Services [CMS], 2022). The organization also aligns its practices with priorities outlined in national behavioral health initiatives, including the U.S. Department of Health and Human Services' 2023–2026 Strategic Plan, which emphasizes equity, person-centered care, and workforce sustainability in public health systems (U.S. Department of Health and Human Services [HHS], 2023).

At the state level, BRX operates under the oversight of its parent health and specialty care system, which establishes fiscal and operational policies for state-

supported facilities. These policies integrate state legislative mandates, appropriations directives, and performance improvement frameworks designed to maintain accessibility, trauma-informed practices, and cultural responsiveness in service delivery (State Agency Report, 2024).

At the local level, BRX serves a multi-county metropolitan region with significant socioeconomic diversity, where public health needs are shaped by poverty, systemic inequities, and limited access to integrated behavioral health care. Local public health priorities influence the organization's service delivery model by emphasizing community partnerships, population health management, and client transition pathways that support deinstitutionalization and greater inclusion in community-based settings (State Strategic Plan, 2023).

Collectively, these federal, state, and local influences create a complex operational environment in which BRX must balance compliance with external regulatory standards while addressing persistent workforce challenges, funding constraints, and the evolving behavioral health needs of its service population. Figure 2 summarizes this three-tiered regulatory framework and its implications for organizational operations.

Figure 2*Regulatory Framework Influences BRX Operations*

Note. This figure illustrates the three-tiered regulatory framework impacting BRX, including federal oversight (e.g., CMS, ADA, HIPAA), state-level governance (parent health and specialty care system policies, legislative mandates), and local influences (multi-county public health priorities and community integration strategies).

Summary

Section 1 provided the foundation for understanding BRX's organizational profile, including its mission-driven approach, institutional context, governance structure, service offerings, and the complex challenges it faces related to workforce retention. This section also articulated the need for the doctoral study, demonstrating how high turnover rates, systemic workforce shortages, and organizational culture dynamics threaten the sustainability of a publicly funded behavioral health organization serving individuals with intellectual and developmental disabilities and co-occurring conditions. Key operational

terms and fiscal management practices were defined to provide conceptual clarity, while the broader regulatory framework was discussed to situate BRX within its federal, state, and local policy environments.

In Section 2 that follows, the focus shifts to supporting literature and sources of evidence that contextualize the workforce retention problem within existing research and best practices. This section also explores the organization's leadership strategy and assessment processes, providing insight into how these influence employee experiences and workforce stability. Additionally, the clients and populations served are examined in greater depth to connect organizational goals with the needs of its service recipients. Finally, Section 2 introduces the analytical strategy that will guide the collection and interpretation of qualitative data, ensuring that the study's findings are grounded in both rigorous methodology and the lived experiences of behavioral health professionals.

Section 2: Background and Approach—Leadership Strategy and Assessment

Introduction

The problem identified in Section 1 is that BRX, a publicly funded behavioral health organization in Texas, is experiencing persistent difficulty retaining its mental health professionals. Employees in this system frequently report high levels of stress, heavy workloads, and inadequate organizational support, which contribute to burnout and turnover. These workforce challenges undermine service continuity and limit the organization's ability to provide trauma-informed, person-centered care for individuals with complex behavioral health and developmental needs.

The purpose of this qualitative case study is to explore how mental health professionals within BRX perceive organizational culture, workplace dynamics, and internal environmental factors that influence their decision to remain employed. By examining the lived experiences of staff who choose to stay, the study seeks to generate insights that may inform leadership strategies, workforce development, and organizational sustainability.

This section provides the background and approach for the study. It begins with a review of supporting literature, followed by a discussion of the sources of evidence that will be used in the case study. The section then addresses leadership strategy and assessment, the clients and populations served, workforce and operations, and finally, the analytical strategy that guides the study's methodological approach.

Supporting Literature

Behavioral health workforce retention has been consistently identified as one of the most pressing organizational and policy challenges in the United States. Persistent shortages of qualified professionals have placed considerable strain on healthcare systems, with annual turnover rates in behavioral health organizations routinely exceeding 25% (National Center for Health Workforce Analysis, 2024). High levels of attrition create a cycle of instability that undermines continuity of care, disrupts therapeutic relationships, increases organizational costs, and weakens the overall capacity of agencies to meet growing demand for mental health services. This challenge has prompted scholars to examine not only the prevalence of turnover but also the deeper structural, cultural, and systemic factors that shape professionals' decisions to remain employed or seek opportunities elsewhere.

The literature highlights that retention cannot be understood solely as an individual choice but is embedded within organizational and environmental contexts. Structural conditions such as competitive compensation, access to professional development opportunities, clear career pathways, and sufficient staffing are consistently associated with greater stability (Pettingell et al., 2022; Pathman et al., 2025). At the same time, cultural dimensions, including leadership presence, the quality of organizational climate, and perceptions of fairness or recognition, play a decisive role in shaping how employees experience their work environments. When workers perceive that their contributions are valued and that leadership is visible and responsive, their sense of commitment to the organization increases, even in the face of systemic

challenges. Conversely, environments characterized by neglect, limited growth opportunities, or weak communication often accelerate intentions to leave.

Theoretical models provide a critical lens for interpreting these dynamics. Maslach and Leiter's (2016) burnout framework is particularly influential, identifying the misalignment between organizational demands and available worker resources as a central mechanism driving turnover. According to this model, when workload consistently outpaces resources, whether in staffing, supervisory support, or emotional capacity, employees experience exhaustion, cynicism, and diminished professional efficacy, conditions that make long-term retention unlikely. Beyond burnout, recent scholarship emphasizes the need for systemic alignment, where organizational practices, leadership behaviors, and cultural expectations reinforce staff well-being, professional identity, and sense of purpose (Pulman & Fenge, 2024). This perspective moves beyond deficit-based models of attrition, underscoring the importance of proactive organizational strategies that sustain worker engagement.

Protective factors identified in recent studies offer further insight into pathways for retention. Values-based leadership, which integrates empathy, transparency, and inclusivity, has been associated with stronger employee loyalty and reduced turnover. Recognition, both formal and informal, has been shown to reinforce professional worth and reduce feelings of invisibility that often accompany burnout. Alignment between individual values and organizational mission also emerges as a particularly powerful factor, as employees who identify with the broader purpose of their organization are more likely to remain despite operational difficulties (Fogel et al., 2025). Collectively, these

protective elements demonstrate that retention is sustained not only through tangible resources but also through symbolic and relational dimensions of organizational life.

Taken together, these frameworks establish the foundation for analyzing workforce stability in behavioral health organizations. They suggest that the decision to remain employed is rarely the result of a single factor but is instead shaped by the complex interplay of organizational structures, cultural norms, leadership practices, and individual perceptions of purpose and recognition. For organizations such as BRX, understanding how these conditions are interpreted by professionals is essential for developing strategies that not only address turnover but also cultivate long-term commitment and resilience within the workforce. In this context, four areas of inquiry guide the present analysis: how professionals perceive organizational factors that influence their decision to remain employed; what aspects of organizational culture are identified as most influential in retention; how workplace dynamics and interpersonal relationships shape decisions to stay or consider leaving; and the ways in which environmental and contextual factors such as workload, support systems, and leadership contribute to organizational commitment and satisfaction.

Table 3*Databases and Keywords Used in the Literature Review*

Database	Search String
APA PsycInfo	“Mental Health Workforce” AND “Retention” AND “Behavioral Health Organization”
APA PsycArticles	“Behavioral Health Clinicians” AND “Staff Turnover”
CINAHL Plus with Full Text	“Mental Health Professionals” AND “Workforce Retention”
Academic Search Complete	“Job Satisfaction” AND “Behavioral Health Workers”
SocINDEX with Full Text	“Organizational Commitment” AND “Mental Health Staff”
ProQuest Dissertations & Theses Global	“Mental Health Workforce Retention” AND “Qualitative Study”
MEDLINE with Full Text	“Burnout” AND “Mental Health Workforce”
Social Work Abstracts	“Social Workers” AND “Retention in Behavioral Health Settings”
Mental Measurements Yearbook	“Retention Measurement Tools” AND “Mental Health Staff”
APA PsycBooks	“Organizational Culture” AND “Behavioral Health Organizations”
ERIC	“Professional Development” AND “Mental Health Workforce”
Business Source Complete	“Leadership Strategies” AND “Workforce Retention” AND “Behavioral Health”
Health and Psychosocial Instruments	“Burnout Scales” AND “Job Satisfaction” AND “Mental Health”
OpenDissertations	“Behavioral Health Workforce” AND “Retention Factors”
Gale Academic OneFile Select	“Employee Engagement” AND “Mental Health Services”

The scope of the review was limited to publications from 2020 through 2025 to ensure contemporary relevance. Only qualitative studies were included, with emphasis on research that explored staff experiences, perceptions, and meaning-making processes related to workforce retention in behavioral health organizations. This approach aligns directly with the qualitative design of the present study, which seeks to understand how mental health professionals interpret organizational culture, workplace dynamics, and leadership practices. In addition to peer-reviewed qualitative research, reports from national agencies such as the Health Resources and Services Administration (HRSA, 2024) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS, 2023) were reviewed to provide context for understanding workforce challenges at both the practice and policy levels.

Relevance of Workforce Retention to Behavioral Health Practice

Workforce retention is consistently identified as a foundational determinant of stability in behavioral health organizations, with widespread implications for service delivery, organizational sustainability, and public health outcomes (National Wraparound Implementation Center & National Wraparound Initiative, 2024). National workforce analyses indicate that annual turnover in the behavioral health sector has remained persistently high, averaging between 25% and 30%, creating operational instability and placing long-term pressure on organizations tasked with serving high-acuity populations (National Center for Health Workforce Analysis, 2024). This instability is not only an administrative burden but also a direct threat to clinical outcomes, as continuity of care depends on stable relationships between staff and clients. When turnover disrupts these connections, therapeutic processes are interrupted, treatment adherence decreases, and trust between clients and providers weakens (Brabson et al., 2020).

At the practice level, workforce retention is closely tied to the ethical mandate of behavioral health care. Staff in state-operated and nonprofit systems frequently provide trauma-informed and person-centered services to individuals with complex needs, including co-occurring mental illness and developmental disabilities. These service models rely heavily on stable staffing to implement long-term treatment plans, interdisciplinary collaboration, and consistent crisis intervention strategies (Ballout, 2025). High turnover undermines these objectives, resulting in staff shortages, increased reliance on overtime, and a higher risk of error or neglect, all of which compromise the quality of care delivered (Hallett et al., 2024). From a practical standpoint, addressing

workforce retention is inseparable from safeguarding the safety and recovery of vulnerable populations.

A significant body of research attributes workforce instability to structural and cultural conditions (Wynendaele et al., 2025; Ballout, 2025). Maslach and Leiter's (2016) burnout framework highlights how mismatches between staff needs and organizational resources generate emotional exhaustion, depersonalization, and reduced professional efficacy. Although widely applied, more recent scholarship argues that burnout should be understood not simply as an individual syndrome but as a systemic signal of organizational misalignment (Pulman & Fenge, 2024). Scholars increasingly emphasize that retention hinges on the interplay between leadership practices, organizational culture, and professional development opportunities, rather than on staff resilience alone (Nyerges et al., 2024). This framing reinforces the practice relevance of retention as a systemic priority that extends beyond individual coping mechanisms.

The relevance of retention to behavioral health practice is also reinforced by national policy reports. The Health Resources and Services Administration (2024) has identified workforce stability as crucial to addressing unmet behavioral health needs, highlighting that shortages across psychiatric, psychological, and social work professions are exacerbated by retention issues. Similarly, the National Association of State Directors of Developmental Disabilities Services (2023) emphasizes that turnover among direct support professionals (DSPs) poses the most significant threat to the sustainability of services for individuals with intellectual and developmental disabilities. The Substance Abuse and Mental Health Services Administration's (2023) Strategic Plan likewise

prioritizes retention, linking workforce well-being to the effective implementation of trauma-informed and equity-driven care models. These policy perspectives underscore that retention is a practice-critical issue with systemic consequences for behavioral health leadership.

From an organizational practice standpoint, workforce retention influences multiple domains of performance. First, turnover generates financial strain by increasing recruitment and training costs, diverting resources away from program development and quality improvement (Wang et al., 2023). Second, instability contributes to cycles of disengagement, as remaining staff face heavier workloads and heightened stress, accelerating burnout and further attrition (Fukui et al., 2025). Finally, instability erodes organizational culture, weakening trust in leadership and reducing staff commitment to organizational mission (Choy-Brown et al., 2025). Together, these findings affirm that workforce retention is integral to practice, as it directly influences both the internal functioning of organizations and the outcomes they produce for clients.

Organizational Factors and Workforce Retention (RQ1)

Organizational factors form the foundation upon which behavioral health workforce stability rests. Leadership presence, communication practices, recognition structures, and concrete structural supports are consistently associated with retention outcomes. In a transnational qualitative study, Alhassan et al. (2025) reported that organizations retaining staff most effectively cultivated adaptive leadership that was visible, emotionally intelligent, and transparent about operational goals. The authors showed that visible leaders signaled psychological safety and conveyed that decision

making was responsive to frontline realities, which strengthened commitment. De Vries et al. (2023), synthesizing evidence across 32 peer-reviewed studies, reached a complementary conclusion through a systematic review. They found that empowerment, defined as staff perception of influence over decisions, and psychological safety were robust correlates of lower turnover intention. Taken together, these studies suggest that leadership is not simply a background condition. Rather, it shapes how professionals appraise fairness, voice, and security in their roles, all of which are central to retention.

Evidence from public systems in the United States underscores the consequences when these organizational features are absent (Hallett et al., 2024). Using qualitative interviews with behavioral health professionals across multiple state-funded agencies, Hallett et al. (2024) identified three recurring organizational drivers of turnover. Participants emphasized chronically low compensation, stagnant or undefined career pathways, and experiences of institutional neglect, including weak transparency and insufficient attention to staff well-being. While compensation is a structural lever, participants described the deeper problem as a deficit in recognition and organizational care. This interpretation aligns with Maslach and Leiter's burnout framework, which posits that attrition emerges when job demands exceed worker resources and when there are mismatches in areas such as workload, control, reward, community, fairness, and values (Maslach & Leiter, 2016). Where recognition and control are limited, exhaustion and cynicism become more likely, and retention falters.

The literature further indicates that specific structural supports buffer these risks. Pettingell et al. (2022) noted that retention programs which integrated professional

development, flexible scheduling where feasible, and clear progression pathways were more durable than programs that relied primarily on financial incentives. De Vries et al. (2023) found that empowerment mechanisms and authentic, accessible leadership amplified the effects of other structural investments, implying that design choices interact rather than operate in isolation. Recognition practices also appear salient. Fogel, Groton, and Gurdak (2025) observed that formal recognition and consistent acknowledgment by supervisors strengthened professional identity among frontline workers serving unhoused populations. Even in stressful contexts, the experience of being seen and valued mitigated intentions to exit.

There is also theoretical convergence on how organizational factors influence quality as well as retention. In a meta-analysis, Salyers et al. (2017) linked professional burnout to diminished quality and safety in care settings, suggesting that the same organizational mismatches that deplete staff also jeopardize client outcomes. Although Salyers et al. (2017) examined broader healthcare contexts, the mechanism is applicable to behavioral health where high caseloads and limited supervision are common. Organizational investments that reduce burnout are therefore consequential both for keeping staff and for safeguarding service outcomes.

Methodologically, these studies bring complementary strengths. Hallett et al. (2024) provide depth through qualitative narratives that illuminate how workers make sense of organizational neglect. Alhassan et al. (2025) contribute cross-national variation and programmatic detail about what leaders can do. De Vries et al. (2023) offer breadth and consistency across diverse settings via systematic review. Convergence across these

designs increases confidence that organizational design and leadership presence are primary determinants of workforce stability.

Gap identification for RQ1. Despite the convergent findings, several gaps persist. Most studies examine single levers rather than combined interventions, which limits understanding of how leadership accessibility, recognition, and compensation interact over time. Evidence from state-operated behavioral health organizations in the United States remains comparatively sparse relative to hospital or community-based contexts. There is also limited attention to middle management practices that translate high-level policy into daily workflow, and few studies examine how professionals interpret recognition and empowerment when formal resources are constrained.

Bridge to methods. A qualitative inquiry that elicits how staff in a state-operated system perceive leadership presence, recognition, communication, and structural supports is well-suited to address these gaps. Unlike quantitative surveys, qualitative methods can capture how professionals interpret organizational factors in context, revealing the meanings, tensions, and trade-offs that influence decisions to remain employed. This approach provides depth and nuance that are essential for understanding retention in complex, resource-constrained behavioral health environments.

Organizational Culture and Retention Decisions (RQ2)

Organizational culture shapes how structures are experienced in practice. Culture includes mission alignment, values-based leadership, and psychological safety, each of which influences whether employees view their organization as a place where they can thrive. Using interpretive phenomenological analysis with frontline social workers,

Pulman and Fenge (2024) showed that cultures marked by heavy caseloads, limited acknowledgment, and weak supervisory support were interpreted as toxic and unsustainable. In contrast, when values-based leadership was evident and staff felt psychologically safe to surface concerns, professionals described renewed engagement and a willingness to remain. Nyerges et al. (2024), studying residential treatment settings, reached similar conclusions. Staff intention to stay was higher in environments characterized by teamwork, fairness, and consistent supervision. The authors emphasized perceptions of organizational justice as a cultural mechanism. When decision processes were transparent and equitable, employees reported greater loyalty.

Mission alignment functions as a distinct cultural driver. In a grounded theory study of frontline workers serving unhoused populations, Fogel et al. (2025) found that alignment between personal values and organizational mission sustained commitment despite operational challenges. Participants described their organizations as communities of purpose where shared values created meaning during difficult stretches. These findings complement the psychological safety lens in De Vries et al. (2023), which identifies authentic leadership and inclusion as cultural features that enable staff voice. When voice is encouraged, employees are less likely to disengage even when workload pressures persist.

The burnout literature offers a theoretical bridge between culture and retention. Maslach and Leiter (2016) include fairness, community, reward, and values among the domains where mismatches produce burnout. Culture is the domain in which these mismatches are felt most acutely because it frames how resources and demands are

interpreted. If recognition and fairness are experienced as authentic, then even high demands may be perceived as meaningful rather than depleting. Conversely, when values and rewards are misaligned, the same demands are experienced as corrosive. Salyers et al. (2017) add that burnout is associated with poorer quality and safety, which suggests that cultural repair is not only a retention strategy but also a quality strategy.

Comparing methods helps clarify where the evidence is strongest. Pulman and Fenge (2024) provide depth on lived experience and the meanings staff ascribe to culture, while Nyerges et al. (2024) combine qualitative insights with quantitative measures of intention to stay, strengthening claims about associations. Fogel et al. (2025) bring a mission-specific context that tests culture under high stress. None of these designs alone can rule out unmeasured confounding, yet the triangulation across them yields a coherent picture. Cultures that are inclusive, mission-aligned, and psychologically safe are more likely to retain staff.

Gap identification for RQ2. The literature establishes that culture matters but leaves several questions unresolved. Measurement of psychological safety and justice varies across studies, which complicates cross-study comparisons. There is limited research isolating the unique contributions of mission alignment versus general climate, and few studies focus specifically on state-operated behavioral health agencies where bureaucratic and policy constraints may shape culture differently than in private or nonprofit settings.

Bridge to methods. A qualitative study that asks professionals to identify which cultural elements are most influential in their retention decisions, and how they discern

authenticity in values-based leadership, can address these gaps. By drawing on interpretive methodologies, such as those used by Fogel et al. (2025), this inquiry can capture the meanings professionals ascribe to fairness, safety, and mission alignment, offering insights not accessible through surveys or statistical models.

Workplace Dynamics and Interpersonal Relationships (RQ3)

Workplace dynamics and interpersonal relationships translate culture into daily experience. Team collaboration, trust, peer support, mentoring, and supervisory relationships are frequently identified as proximal determinants of whether employees choose to stay. Fogel et al. (2025) described how trauma-informed supervision and emotional solidarity among colleagues helped sustain frontline workers despite high exposure to stress. Participants framed collegial trust as a resource that made the work feel shared rather than isolating. Nyerges et al. (2024) observed that consistent supervision and collaborative teams in residential settings predicted higher intention to stay, whereas hierarchical decision making and siloed practice increased departure risk.

Crisis conditions make the relational stakes clear. Hendrickson et al. (2022) documented how the early phases of the COVID-19 pandemic were characterized by breakdowns in communication, inconsistent guidance, and insufficient emotional support. These relational failures amplified burnout and disillusionment. Pulman and Fenge (2024) similarly reported that acknowledgment of effort and opportunities to participate in decisions were decisive interpersonal factors. When employees felt unseen by peers or supervisors, their commitment eroded. Together, these studies suggest that workplace relationships function as mediators between organizational conditions and individual

outcomes. Where communication, mentoring, and recognition are strong, staff interpret demands as manageable. Where they are weak, even moderate demands can feel untenable.

Theoretical integration again points to burnout as the mechanism that links relational dynamics to retention. In the Maslach and Leiter (2016) model, community and fairness are central domains. Interpersonal dynamics are the terrain where community and fairness are most visible. When community is strong, trust and recognition buffer the emotional load of clinical work. When fairness and acknowledgment are weak, the sense of community frays, accelerating exhaustion and cynicism. Salyers et al. (2017) further remind us that the consequences are not limited to turnover. Deteriorating relationships correlate with declines in care quality and safety, implying that strengthening relationships is both a workforce and a service priority.

There are important methodological contrasts in this area. Hendrickson et al. (2022) captured relational strain in a crisis through observational data and reported outcomes, while Fogel et al. (2025) used qualitative methods to generate a grounded explanatory model. Nyerges et al. (2024) bridged the two with mixed evidence on climate and intention to stay. Across these approaches, the directional story is consistent. Nevertheless, longitudinal evidence tracking how specific relational interventions influence retention over time is limited.

Gap identification for RQ3. The literature demonstrates that relationships matter, but empirical work rarely isolates which specific relational practices are most consequential in public behavioral health systems. Mentoring receives comparatively less

attention than supervision, and there is limited longitudinal analysis of how team redesign or communication protocols alter retention trajectories.

Bridge to methods. A qualitative study that probes how employees experience collaboration, trust, peer support, and mentoring in a state-operated setting can clarify which interpersonal levers are most influential and why. By eliciting lived narratives, this design complements the quantitative evidence of Nyerges et al. (2024) and the crisis observations of Hendrickson et al. (2022), filling a gap in understanding about how relational ecosystems shape decisions to remain or leave.

Environmental and Contextual Influences (RQ4)

Retention is also shaped by environmental and contextual conditions that transcend any single organization. Workload, staffing ratios, policy environments, and broader systemic pressures create the context in which organizational and relational factors operate. In a global systematic review, Poon et al. (2022) reported that excessive workloads, fear of contagion, and perceived institutional disengagement during the pandemic were associated with higher turnover intention across health systems. Ibrahim, Gebril, Nasr, Samad, and Zaki (2023) conducted a comprehensive review and meta-analysis of professionals in emergency and critical care and found high prevalence of anxiety, depressive symptoms, and burnout, attributing these to structural inaction, ethical fatigue, and insufficient organizational supports. Although the settings vary, the mechanism is familiar. When macro-level stressors increase demands without corresponding resources, retention risks rise.

The role of compensation and organizational commitment within these contexts is illuminated by quantitative work. Using quantile regression, Nam, Wong, and Fong (2025) found that organizational commitment was a stronger predictor of turnover intention than salary across role and income strata, suggesting that contextual perceptions of belonging and support weigh at least as heavily as economic incentives. This finding resonates with the qualitative accounts of Hallett et al. (2024), where participants framed low pay as one strand in a broader tapestry of systemic neglect. In other words, compensation affects retention, but its influence is mediated by the broader environment of recognition, transparency, and support.

Theoretical perspectives again help integrate these results. Maslach and Leiter (2016) argue that burnout emerges from mismatches between demands and resources and from misalignment in values and fairness. Environmental drivers such as staff shortages and policy constraints intensify workload mismatches, while opaque decision making, and underinvestment create fairness and value misalignments. Salyers et al. (2017) show that the downstream effects include compromised quality and safety, which feeds back into staff distress, creating a self-reinforcing cycle. Choy-Brown et al. (2025) observed that systems that intentionally addressed work-life integration and tailored supports to local needs were more successful in retaining staff than systems relying on generic approaches. This suggests that environmental pressures are not immutable. They can be buffered when policy and organizational choices are aligned.

Methodologically, Poon et al. (2022) and Ibrahim et al. (2023) bring strong evidence through systematic review and meta-analysis, while Nam et al. (2025)

contribute a robust quantitative design that differentiates effects across the distribution of turnover intention. Hallett et al. (2024) provide qualitative specificity about how public behavioral health professionals interpret systemic conditions. The triangulation across designs strengthens the inference that environmental and contextual factors are decisive for retention outcomes.

Gap identification for RQ4. Despite substantial progress, there is limited research that links policy changes, staffing ratio adjustments, or workload redistribution to subsequent retention at the level of state-operated behavioral health systems. Measures of workload and staffing are often coarse, and the field lacks qualitative accounts that trace how professionals experience policy shifts and resource allocation decisions in real time.

Bridge to methods. A qualitative study that asks how employees interpret workload, support systems, leadership signaling, and policy context will help identify which environmental levers most strongly influence organizational commitment and satisfaction. Building on the global scope of Poon et al. (2022) and the quantitative insights of Nam et al. (2025), this approach will capture the nuanced ways state-operated behavioral health professionals navigate systemic pressures and resource gaps.

Literature Integration and Research Justification

The literature on behavioral health workforce retention demonstrates that stability is shaped by a constellation of organizational, cultural, relational, and contextual influences. Organizational factors such as leadership visibility, recognition, and structural supports provide the foundation upon which workforce sustainability is built (Alhassan et al., 2025; de Vries et al., 2023; Choy-Brown et al., 2025). Organizational culture adds an

interpretive layer, where mission alignment, values-based leadership, and psychological safety determine whether employees experience their work as meaningful and sustainable (Pulman & Fenge, 2024; Nyerges et al., 2024; Fogel et al., 2025). Workplace dynamics underscore the importance of daily interactions, where collaboration, trust, supervision, and peer support function as mediators of staff commitment (Hendrickson et al., 2022; Fogel et al., 2025). Finally, environmental and contextual conditions such as workload, staffing ratios, systemic pressures, and policy environments shape the broader realities of practice, often amplifying or mitigating organizational challenges (Poon et al., 2022; Ibrahim et al., 2023; Nam et al., 2025).

Theoretical perspectives such as the burnout framework (Maslach & Leiter, 2016) and evidence linking burnout to quality and safety outcomes (Salyers et al., 2017) reinforce the connection between workforce stability and organizational health. Despite this convergence, the literature leaves unresolved how these factors intersect and are experienced in state-operated behavioral health organizations. The collective gaps identified across organizational structures, culture, workplace dynamics, and systemic conditions underscore the need for qualitative inquiry that centers the perspectives of professionals within these settings. Such an approach is positioned to capture the nuanced ways employees interpret organizational conditions, cultural norms, workplace relationships, and systemic contexts in shaping their decisions to stay or leave.

Synthesis of Studies of Similar Organizations in Behavioral Health Leadership

Research across behavioral health leadership contexts demonstrates that the workforce retention challenges observed at BRX reflect broader patterns in both state-

operated and nonprofit systems. Comparative studies consistently identify high turnover, burnout, and organizational strain as systemic problems rather than isolated anomalies.

Alhassan et al. (2025) examined workforce dynamics in publicly funded behavioral health organizations and found that trauma-informed supervision, coupled with emotionally intelligent leadership, improved staff commitment and reduced turnover intent. Their findings underscore the protective role of leadership practices that prioritize staff well-being and recognition, themes echoed across multiple studies. In a study of residential behavioral health programs, Nyerges et al. (2024) reported that supportive workplace cultures, clear communication, and fairness in workload distribution were decisive in staff decisions to remain. Notably, compensation alone did not predict retention, suggesting that organizational climate and values alignment hold greater weight in staff engagement.

International perspectives provide additional comparative insight. Pulman and Fenge (2024) synthesized qualitative studies of behavioral health staff across European systems and concluded that leadership responsiveness and organizational justice were consistently associated with retention. Similarly, Alhassan et al. (2025) found that cross-national patterns of turnover were mitigated when organizations embedded equity-driven practices and participatory decision-making into supervision and governance structures. These findings suggest that workforce instability is not confined to the United States but is a global challenge with consistent organizational determinants.

The literature also highlights the impact of crisis events on retention. Armstrong (2025) reported that turnover rates in publicly funded behavioral health organizations

rose sharply during the COVID-19 pandemic, driven by heightened workloads, resource shortages, and increased emotional strain on staff. Comparative studies of state-operated residential systems documented that pandemic-related disruptions exacerbated longstanding structural challenges, including insufficient compensation and limited career advancement (Hallett et al., 2024). These findings suggest that organizations already struggling with retention are particularly vulnerable during periods of systemic crisis.

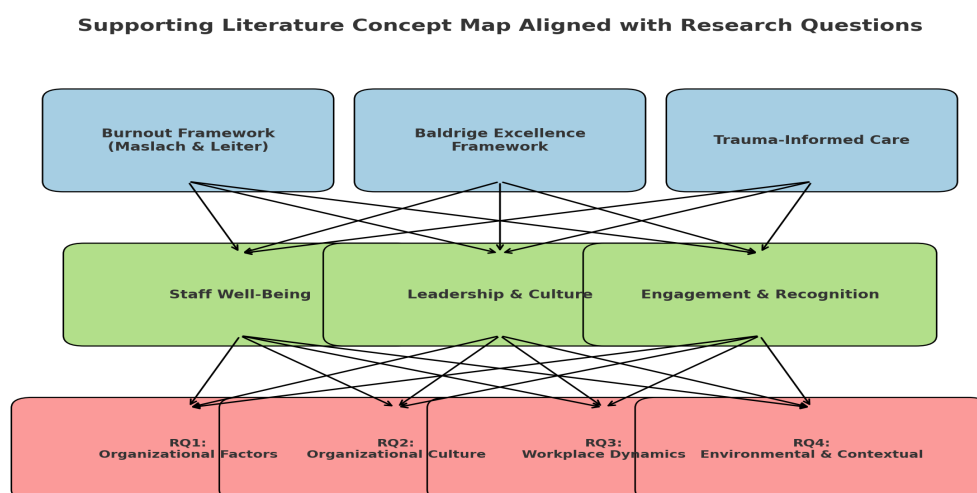
Studies of similar organizations consistently point to the importance of mission alignment and values-based leadership as protective factors. Fogel et al. (2025) found that emotional solidarity among staff and alignment with organizational mission served as buffers against attrition in high-acuity care environments. De Vries et al. (2023) further demonstrated that authentic leadership and psychological safety significantly predicted organizational commitment across health care teams, reinforcing that leadership style is a central determinant of retention. Taken together, these studies reveal that organizations that successfully integrate trauma-informed, values-driven, and participatory leadership practices are better positioned to sustain staff in demanding environments.

Despite these insights, the literature reveals an important gap. Much of the research on workforce retention remains quantitative, focused on turnover rates, predictors, and survey-based correlations (Hallett et al., 2024; Pathman et al., 2025). While valuable, these approaches omit the qualitative depth necessary to understand the lived experiences of staff who remain in challenging organizational environments. Few studies have explored how professionals interpret organizational culture, workplace

dynamics, and leadership presence in ways that support their retention. This gap underscores the contribution of the present study, which seeks to elevate staff voices and situate their experiences within the broader context of behavioral health leadership and organizational sustainability.

Figure 3

Concept Map (Retention Frameworks) – showing how Burnout, Baldrige, and Trauma-Informed Care frameworks connect to workforce retention.



Sources of Evidence

Evidence for this qualitative case study will be drawn from multiple sources to ensure methodological rigor and alignment with the study's purpose of exploring workforce retention among mental health professionals in a state-operated behavioral health organization. Drawing on Yin's (2018) guidance for case study methodology, the study adopts a multi-source evidence strategy to strengthen construct validity through triangulation. Data streams will include semistructured interviews, organizational documents, policy and workforce reports, and peer-reviewed literature, all of which

together provide a holistic basis for examining workforce retention in complex behavioral health systems.

The primary source of evidence will be semistructured interviews with clinical staff currently employed at BRX. These interviews will be structured around the Baldrige Excellence Framework for Health Care, Workforce Criteria (Baldrige Performance Excellence Program, 2021), which emphasizes workforce engagement, well-being, and capability as essential pillars of organizational performance. Aligning the interview protocol to these criteria ensures that participants' perspectives will be systematically elicited in relation to leadership visibility, recognition, communication, psychological safety, and structural supports, factors shown in the literature to directly shape retention (Alhassan et al., 2025; de Vries et al., 2023; Choy-Brown et al., 2025). Interviews will be digitally recorded, transcribed verbatim, and coded using NVivo software, which supports thematic analysis through systematic data organization, memoing, and coding queries (Bazeley & Jackson, 2019). Coding reliability will be strengthened through iterative cycles of open and axial coding, with emergent themes compared against theoretical constructs from burnout, trauma-informed care, and organizational excellence frameworks (Maslach & Leiter, 2016; Baldrige Program, 2021).

A second source of evidence will be internal organizational documents. These include employee handbooks, training and onboarding manuals, staff development materials, workforce survey results, strategic planning reports, and policy memos related to human resources and workforce engagement. Access to these materials will be requested formally through the organization's human resources office and executive

leadership team, following institutional approval protocols and confidentiality agreements. Such documents provide crucial insight into the organization's formal policies, workforce development strategies, leadership commitments, and stated retention priorities. They also serve as an essential point of comparison with employee narratives, allowing the study to assess whether staff experiences align with or diverge from stated policies (Yin, 2018; Bowen, 2009). Limitations must also be acknowledged: organizational records often represent aspirational ideals rather than lived practice, may be selectively curated for external consumption, and in some cases may be withheld due to legal or proprietary restrictions. For these reasons, the value of organizational documents lies not in treating them as neutral reflections of reality but in analyzing them critically, in juxtaposition with staff perspectives and external policy reports (Patton, 2015).

A third stream of evidence will include publicly available workforce and policy reports that situate BRX within broader state and national contexts. These reports provide systemic perspectives on workforce shortages, burnout, and retention challenges, offering benchmarks against which organizational dynamics can be interpreted. Key resources include the Health Resources and Services Administration's (HRSA, 2024) Behavioral Health Workforce Report to Congress, which documents national shortages and projects demand across disciplines, and the National Association of State Directors of Developmental Disabilities Services (NASDDDS, 2023) workforce report, which highlights challenges in direct care and support roles. These reports will be supplemented by recent umbrella reviews and meta-analyses that synthesize turnover trends across

healthcare and social service sectors (Wynendaele et al., 2025; Ibrahim et al., 2023; Poon et al., 2022). Such analyses will enable the study to locate organizational findings within broader systemic pressures, including staffing ratios, funding models, and policy mandates.

Finally, triangulation will be reinforced through peer-reviewed scholarly literature that has examined workforce retention, burnout, leadership, and organizational culture in behavioral health and healthcare systems. This body of evidence provides the theoretical scaffolding and comparative context for interpreting study findings. Key contributions include Alhassan et al. (2025) on adaptive leadership and retention, de Vries et al. (2023) on empowerment and structural supports, Breslin et al. (2022) on workplace stress and retention, and Pathman et al. (2025) on organizational climate and professional development. Theoretical integration will draw especially on Maslach and Leiter's (2016) burnout framework, Salyers et al.'s (2017) meta-analysis linking burnout to quality and safety outcomes, and Ballout's (2025) conceptual work on trauma, workforce shortages, and equity.

Data analysis will follow a convergent triangulation design, where interview transcripts, organizational documents, and policy reports are first analyzed within source type and then compared across sources to identify areas of convergence, complementarity, and dissonance (Creswell & Poth, 2018). NVivo software will support this analytic process by enabling coding comparisons, matrix queries, and visualization tools (e.g., word trees, thematic clusters), which will help identify where staff narratives align with or diverge from formal policy documents and system-level reports. These

analytic strategies will strengthen the credibility of findings, ensuring they reflect not only participants' lived experiences but also the organizational and systemic conditions that frame those experiences.

Collectively, these multiple forms of evidence provide a comprehensive and rigorous foundation for addressing the research questions. The integration of semistructured interviews, organizational records, and national workforce reports strengthens construct validity by ensuring that lived experiences of staff are contextualized alongside organizational policies and broader systemic patterns. Triangulation across diverse evidence sources enhances credibility and transferability, while explicit acknowledgment of document access procedures and limitations ensures transparency. By combining in-depth narrative accounts with organizational and policy-level documents, the study is positioned to generate insights applicable to both organizational practice and broader debates on behavioral health workforce sustainability (HRSA, 2024; NASDDDS, 2023; Yin, 2018).

Together, these evidence streams are deliberately structured to align with the four research questions guiding this study. Semistructured interviews with mental health professionals will directly illuminate perceptions of organizational factors such as leadership presence, recognition, and structural supports (RQ1), which prior research identifies as critical determinants of retention (Alhassan et al., 2025; de Vries et al., 2023; Choy-Brown et al., 2025). These interviews will also explore the cultural dimensions of mission alignment, fairness, and psychological safety that shape retention decisions (RQ2), extending insights from studies of values-based leadership and organizational

climate (Pulman & Fenge, 2024; Nyerges et al., 2024; Fogel et al., 2025). Internal organizational documents, including policies and workforce materials, will provide a complementary lens for assessing how official practices reflect or diverge from staff perceptions, thereby enriching analysis of both organizational factors and culture (Bowen, 2009; Yin, 2018).

Narratives from interviews will further capture the immediacy of workplace dynamics and interpersonal relationships, including collaboration, trust, peer support, and mentoring (RQ3), areas emphasized in relational studies of retention and crisis responses (Hendrickson et al., 2022; Fogel et al., 2025). Finally, state and national workforce reports will situate the findings within broader systemic realities, shedding light on environmental and contextual influences such as workload, staffing ratios, and policy pressures (RQ4) that have been documented as decisive for turnover intention (HRSA, 2024; NASDDDS, 2023; Poon et al., 2022; Ibrahim et al., 2023; Nam et al., 2025). By mapping each evidence source explicitly onto the research questions, the study ensures that triangulation is not only methodological but also conceptual, reinforcing the rigor, credibility, and practical utility of the analysis (Creswell & Poth, 2018; Yin, 2018).

Leadership Strategy and Assessment

Governance and Leadership

Leadership at BRX is guided by a dual governance model that reflects the broader state-operated system in which the organization functions. At the central level, the state agency establishes the policy framework, fiscal oversight mechanisms, and performance standards that govern all publicly funded behavioral health programs across Texas (State

Agency Report, 2024). This centralized oversight ensures that BRX operates in alignment with state-mandated requirements related to regulatory compliance, staffing ratios, and service delivery benchmarks. At the organizational level, BRX leadership is responsible for implementing these requirements in a way that addresses the unique needs of its client population and workforce.

Within BRX, governance is carried out by an on-site Director and a team of interdisciplinary leaders, including nursing supervisors, behavioral health leads, clinical directors, and administrative managers. This management team oversees day-to-day operations and works collaboratively to integrate medical, behavioral, and habilitative supports for individuals with complex needs (BRX, 2024). Leaders prioritize trauma-informed care, person-centered planning, and culturally responsive practices as guiding principles for both staff management and service delivery.

This governance structure is consistent with broader literature emphasizing that strong leadership in behavioral health systems must balance compliance with innovation. Alhassan et al. (2025) note that when leaders model organizational values, remain visible in clinical environments, and engage meaningfully with staff, they strengthen trust and reduce perceptions of organizational distance. Nyerges et al. (2024) similarly find that emotionally intelligent leadership and cultural responsiveness are central to workforce commitment. At BRX, these principles are demonstrated through visible leadership presence in residential units, responsiveness to staff concerns, and transparency in communication. Such practices align with trauma-informed supervision, which is

increasingly recognized as a protective factor against staff burnout in high-acuity environments (Pulman & Fenge, 2024).

Leaders also embed accountability through interdisciplinary committees and clinical rounds. These mechanisms ensure that decisions are not made in isolation but reflect collaborative professional judgment across nursing, behavioral health, psychology, and social work disciplines. This mirrors best practices in behavioral health governance, where interdisciplinary models improve decision quality and enhance staff engagement (Fogel et al., 2025). BRX's governance approach thus reflects both regulatory necessity and a leadership philosophy that centers the workforce as a critical element of organizational sustainability.

Strategy Development, Implementation, and Key Challenges

The implementation of strategy at BRX reflects both state directives and organizational priorities. At the state level, strategic plans emphasize workforce development, service accessibility, and the integration of trauma-informed practices across the behavioral health system (State Agency Report, 2024). BRX aligns with these directives by embedding strategic priorities into its internal policies, training programs, and quality assurance activities. For example, onboarding protocols are designed not only to ensure regulatory compliance but also to emphasize trauma-informed, person-centered care as the organizational norm (BRX, 2024).

Strategic development at BRX includes staff training and professional development initiatives, interdisciplinary behavior support committees, and continuous quality improvement systems. Leadership invests in competency-building through

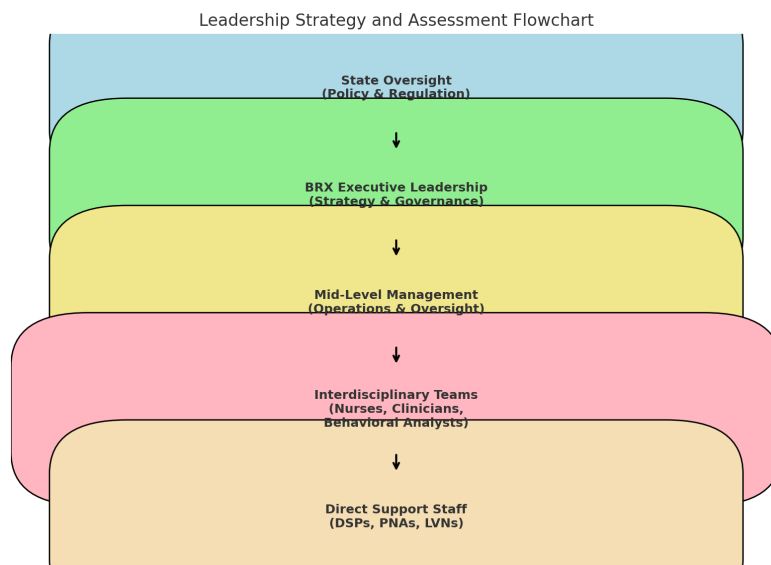
structured training, clinical supervision, and mentoring opportunities for staff. These align with national guidance from HRSA (2024), which underscores the importance of professional development in stabilizing the behavioral health workforce. Research also suggests that embedding professional growth opportunities into organizational strategy enhances both job satisfaction and retention (Pettingell et al., 2022; de Vries et al., 2023).

Despite these efforts, BRX continues to face significant strategic challenges that mirror statewide trends. Persistent workforce shortages and high turnover among direct support professionals, nursing staff, and clinical supervisors create ongoing instability that undermines service continuity and places added strain on existing staff (State Agency Report, 2024; BRX, 2024). Last and Crable (2024) highlight that such workforce instability is systemic in residential behavioral health environments, where high stress and low compensation exacerbate attrition. Hallett et al. (2024) further emphasize that burnout and compassion fatigue among staff are heightened in organizations that serve individuals with intellectual and developmental disabilities, precisely the population BRX supports.

Another strategic challenge lies in balancing statewide accountability with the need for local flexibility. While BRX must comply with centralized directives on fiscal accountability and regulatory performance, each facility serves populations with unique clinical and social needs that require adaptive leadership strategies (BRX website, 2024). This creates tension between adhering strictly to top-down mandates and tailoring strategies to reflect staff realities and client complexity.

A final challenge is resource scarcity. Leaders at BRX must manage limited budgets while addressing growing clinical demands and workforce shortages. This requires prioritization of initiatives that directly influence retention, such as enhancing recognition systems, strengthening supervisory support, and investing in staff wellness programs. As Fogel et al. (2025) argue, values-based leadership and the alignment of organizational mission with staff purpose are crucial strategies for mitigating turnover intent, often more so than financial incentives. Fukui et al. (2025) add that resilience-building practices, when institutionalized within organizations, improve long-term staff stability.

Moving forward, leadership at BRX recognizes the need to expand beyond compliance-driven governance toward resilience-focused strategies. This involves intentionally embedding staff voice into planning processes, implementing recognition systems that validate employee contributions, and developing culturally responsive retention initiatives. By aligning with state directives while also addressing the realities of frontline staff, BRX's strategic development seeks to create a sustainable balance between workforce well-being and the delivery of high-quality behavioral health services.

Figure 4*Leadership Strategy and Assessment Flowchart*

Note. Illustrating the hierarchy from State Oversight → BRX Executive Leadership → Mid-Level Management → Interdisciplinary Teams.

Clients/Population Served

Client Population and Information Sources

Over 40% of individuals with intellectual and developmental disabilities (IDD) also experience co-occurring psychiatric disorders such as anxiety, depression, and impulse-control conditions, which can increase the need for intensive residential care (Zablotsky et al., 2021). Adults with developmental disabilities continue to experience significant and persistent health disparities, including higher rates of chronic conditions and unmet health needs compared to adults without disabilities (McLean et al., 2025).

The clients served by BRX are individuals with IDD who require intensive, long-term care that exceeds the resources available in their home or community settings (BRX

website, 2024). These individuals often have complex medical, behavioral, or habilitative needs that necessitate 24-hour residential support, therapeutic interventions, and clinical oversight. Residents may present with co-occurring physical or psychiatric conditions, mobility limitations, or significant challenges with activities of daily living. A growing number of clients are older adults with lifelong IDD who also experience dementia, osteoporosis, or progressive mobility loss, highlighting the dual challenges of developmental disability and age-related decline (Di Giacomo et al., 2025).

The population profile is further illustrated by the distribution of BRX campuses, which serve diverse geographic regions across the state. For example, one BRX campus located on 200-acre site houses 242 residents and employs more than 1,100 full-time staff to provide habilitative and medical supports for individuals referred from 18 counties in its catchment area. In contrast, another BRX site supports 180 residents within a smaller 95-acre setting and covers a 28-county region, illustrating both the scale and reach of the organization's service delivery system. Larger campuses, such as the facility with 375 residents, provide comprehensive psychiatric, behavioral, and medical care for individuals referred from densely populated regions, while smaller campuses, such as the 70-resident location, address highly individualized needs within a narrower service catchment (State Agency Report, 2024).

Information about client needs is obtained through structured intake assessments and interdisciplinary team (IDT) processes. Upon admission, residents receive comprehensive evaluations led by physicians, psychologists, behavioral analysts, nurses, and habilitation specialists. These assessments guide the development of individualized

service plans that document medical, behavioral, and habilitative goals tailored to each resident. In addition, the organization obtains feedback from families and guardians, who are engaged as part of annual planning meetings and routine satisfaction surveys. This combination of clinical evaluations, family engagement, and periodic reassessment ensures that BRX maintains an accurate and evolving understanding of client needs and expectations (NASDDDS, 2023; CMS, 2022).

Client Engagement and Relationship Building

BRX provides on-campus housing, individualized care plans, and interdisciplinary services designed to promote safety, autonomy, and well-being. Clients are referred through coordinated entry systems and typically come from multi-county service areas defined by regional healthcare infrastructure and state placement protocols. The population includes both younger and older adults with lifelong disabilities who are aging in place and often experience multiple health risks associated with institutional living or chronic disease progression.

Across sites, the total number of residents ranges from approximately 70 to 375 individuals, depending on the geographic catchment area, facility capacity, and operational scale. For example, one BRX site in a 226-acre location serves 204 residents and draws referrals from over 50 counties, demonstrating the extensive regional responsibility entrusted to these facilities. Another BRX location employs more than 1,300 staff to serve 320 residents, underscoring the high level of engagement and staff-client interaction required to sustain person-centered care at scale (Texas Health and Human Services, 2024).

The organization engages clients through a combination of trauma-informed practices, consistent relationship-building, and habilitation programming. Direct support professionals (DSPs) and psychiatric nursing assistants, who provide day-to-day care, play a crucial role in building trust and reinforcing routines. Their continuity of presence allows clients to feel secure in environments where stability is critical to reducing behavioral crises and promoting therapeutic progress (Friedman, 2021). Research shows that consistent DSP staffing improves communication, reduces incident reports, and increases quality of life outcomes for individuals with IDD (National Center for Health Workforce Analysis, 2024).

In addition, clinical and therapeutic staff work with residents to teach daily living skills, enhance communication, and encourage participation in structured recreational and vocational activities. These services are designed to reduce social isolation, foster self-determination, and build long-term resilience (Fogel et al., 2025). Family involvement is another key element of engagement. BRX routinely invites family members and guardians to participate in care plan meetings, advisory councils, and feedback sessions. This practice strengthens client-family-staff relationships and ensures that care decisions remain grounded in the perspectives of those most familiar with residents' histories.

Further, BRX implements community integration activities such as supported employment, day habilitation, and recreational outings to foster broader social participation (Lanchak et al., 2024). These approaches align with national directives such as SAMHSA's recovery-oriented systems of care and CMS's requirements for person-centered planning, which emphasize dignity, choice, and autonomy for individuals

receiving behavioral health and disability services (SAMHSA, 2023; CMS, 2022). By combining clinical services with relational and community-focused approaches, BRX ensures that its clients are not only supported but also meaningfully engaged in their daily lives.

Workforce and Operations

Building the Workforce Environment

The workforce at BRX represents the most critical determinant of organizational success in serving individuals with intellectual and developmental disabilities (IDD) who require intensive residential and clinical support. BRX operates a network of large campuses, each serving between 70 and 375 residents with diverse behavioral, medical, and psychiatric needs (BRX website, 2024). This client base requires an expansive workforce consisting of direct support professionals (DSPs), nurses, physicians, behavioral analysts, mental health clinicians, and ancillary personnel who collectively sustain daily operations.

The organization's mission is to provide safety, dignity, and individualized rehabilitative and therapeutic care, yet fulfilling this mission depends heavily on the availability and stability of its workforce. Nearly 40 percent of residents present with co-occurring psychiatric conditions such as anxiety disorders, major depression, or impulse-control disorders, all of which exacerbate the complexity of care and heighten demands on staff capacity (Zablotsky et al., 2021). In this context, BRX cannot simply rely on baseline staffing ratios but must build layered systems of oversight, clinical response, and direct care coordination.

National workforce trends highlight the precariousness of this environment. The Health Resources and Services Administration (2024) and the National Association of State Directors of Developmental Disabilities Services (2023) report sustained shortages of direct support personnel and psychiatric staff in long-term residential care settings. These shortages pose daily challenges for BRX, where high-acuity populations amplify risks of behavioral crises, medical emergencies, and caregiver fatigue (Hallett et al., 2024). As a state-operated system, BRX faces the dual responsibility of complying with federal regulatory mandates while managing operational realities that mirror those of a large health system. This environment situates BRX at the intersection of public accountability and workforce sustainability.

The workforce environment at BRX extends beyond clinical and behavioral roles to include essential operational staff. Facilities span hundreds of acres with multiple residential cottages, clinics, dining halls, and therapeutic spaces that require continuous support from food service, custodial, maintenance, and transportation teams (State Agency Report, 2024). These roles, while not clinical, directly influence resident well-being and workforce morale by ensuring that living spaces remain safe, accessible, and responsive to resident needs. Consequently, BRX's workforce environment is best described as an ecosystem, one in which interdisciplinary collaboration and constant engagement across staff roles sustain the organization's capacity to serve high-acuity populations.

Creating Workforce Capability and Capacity

Building capability and capacity within BRX's workforce requires deliberate strategy that balances recruitment, retention, and ongoing professional development. Nationally, the behavioral health sector faces turnover rates exceeding 40 percent annually among direct support professionals (NASDDDS, 2023). For BRX, which employs thousands of DSPs across multiple campuses, high turnover destabilizes resident continuity of care and compounds operational pressures. Capability and capacity are therefore framed not only as quantitative targets, ensuring sufficient staffing ratios, but also as qualitative imperatives that safeguard staff preparedness, competence, and resilience.

As a publicly operated organization, BRX confronts inherent structural limitations. State reimbursement rates often lag behind market wages, constraining salary competitiveness for both licensed professionals and paraprofessionals (HRSA, 2024). This structural challenge is compounded by geographic disparities, as rural campuses struggle to attract candidates due to limited local labor pools, while urban campuses face higher costs of living that outpace state pay scales (Pathman et al., 2025). Addressing capacity within this context requires workforce forecasting models that incorporate demographic trends, retirement projections, and anticipated clinical demand.

BRX has begun aligning its capacity strategies with state-level workforce development initiatives. Partnerships with nursing schools, social work programs, and applied behavior analysis certification pathways have been established to create direct pipelines into residential employment (BRX website, 2024). The organization also

collaborates with community colleges to expand access to training for DSPs, emphasizing person-centered care and trauma-informed practice as foundational competencies.

Capacity is also reinforced through technology-enabled workforce management. Digital scheduling systems monitor staff-to-resident ratios in real time, while training completion and competency assessments are tracked electronically to ensure regulatory compliance (CMS, 2022). These tools allow BRX to identify capacity risks, such as high overtime levels or gaps in specialized competencies, and to reallocate staff proactively. By embedding both forecasting and operational monitoring into workforce planning, BRX strengthens its ability to meet short- and long-term capacity requirements.

Fostering Relationships

A defining element of workforce sustainability at BRX lies in fostering strong relationships between leadership, supervisors, and frontline staff. Research consistently demonstrates that organizational culture and supervisory relationships are among the strongest predictors of turnover in behavioral health settings (Nyerges, Gonzales, & Smith, 2024). At BRX, leadership emphasizes relationship-building as both a retention strategy and an operational necessity.

Staff engagement begins at the unit level, where supervisors conduct daily shift huddles, review individualized resident needs, and communicate updates on safety and treatment priorities (BRX website, 2024). These practices orient staff not only to immediate tasks but also to the larger mission of dignity and inclusion. Relationship building continues through reflective supervision sessions, where staff are encouraged to discuss emotional challenges, behavioral incidents, and workplace stressors in a

structured environment. Evidence shows that such trauma-informed supervision reduces burnout and enhances staff resilience in high-stress care environments (Alhassan et al., 2025).

BRX also prioritizes peer support networks as a relationship-based strategy. Mentorship programs pair new hires with experienced staff, ensuring smoother onboarding while fostering a sense of community. Peer support groups create opportunities for shared problem solving and reduce feelings of isolation, which are common among staff managing challenging behaviors (Fukui, Wu, & Salyers, 2025). Relationship-centered practices not only enhance workforce morale but also promote organizational transparency, as staff trust that leadership will act on their feedback.

Hiring and Onboarding

Recruitment and onboarding at BRX reflect both state-level requirements and organizational adaptations to the realities of residential behavioral health care. Prospective employees undergo extensive pre-employment screening, including criminal background checks, credential verification, and health clearances such as tuberculosis testing and vaccination requirements (Texas Health and Human Services, 2024). These processes ensure compliance with federal and state mandates while safeguarding resident safety.

The onboarding process includes orientation sessions that introduce new hires to the organizational mission, trauma-informed care frameworks, and expectations for interdisciplinary collaboration. Documentation reviewed during onboarding typically includes the employee handbook, policies on resident rights, confidentiality agreements,

and emergency response procedures (State Agency Report, 2024). New hires also complete baseline training in CPR, first aid, and crisis prevention techniques such as nonviolent crisis intervention (CMS, 2022).

What distinguishes BRX's onboarding strategy is the integration of relationship building and mission alignment from the outset. Supervisors conduct structured check-ins during the first 90 days of employment, recognizing that the early period is the most vulnerable for turnover (Choy-Brown et al., 2025). Onboarding is therefore framed not only as compliance training but also as an opportunity to embed organizational culture, connect staff to peer mentors, and reinforce the value of their contributions.

Staff Training

Staff training at BRX is continuous, multi-tiered, and aligned with federal and state competency frameworks. All direct care staff complete mandatory training on trauma-informed care, person-centered planning, behavioral crisis de-escalation, and regulatory compliance (CMS, 2022). Annual refreshers ensure ongoing competency, while specialized workshops address emerging needs such as autism spectrum interventions, psychiatric medication management, and dual diagnosis care (Texas Health and Human Services Commission, 2024).

Licensed professionals receive targeted continuing education opportunities, supported by tuition reimbursement and access to professional conferences when budgets permit. For DSPs, training emphasizes core competencies in communication, ethical practice, and behavioral support (NASDDDS, 2023). Simulation-based training modules have recently been introduced, allowing staff to practice de-escalation techniques and

emergency response protocols in controlled environments. Research shows that simulation training enhances skill retention and reduces errors in high-stakes behavioral health settings (Elendu et al., 2024).

Training also reflects BRX's emphasis on staff well-being. Workshops on resilience, stress management, and self-care have been integrated into professional development programming. This aligns with evidence that workforce sustainability in high-stress behavioral health settings improves when staff are equipped with coping strategies and psychological support (Supan Unjai et al., 2024). By linking training to both technical competencies and workforce wellness, BRX strengthens not only staff performance but also retention.

Staffing Configurations

The staffing configurations at BRX reflect the complexity of serving a population with high-acuity intellectual and developmental disabilities. Each campus implements a tiered staffing structure designed to provide both individualized support and systemic coverage for residential and clinical needs. Direct Support Professionals (DSPs) form the largest segment of the workforce, delivering daily assistance with activities of daily living, personal hygiene, mobility, and habilitative training. Ratios are adjusted to meet individualized resident acuity levels, ranging from one-to-one coverage for residents with intensive behavioral or medical needs to broader ratios in less acute settings (BRX website, 2024).

Beyond DSPs, nursing personnel provide critical medical coverage. Registered nurses (RNs) and licensed vocational nurses (LVNs) manage chronic disease care,

administer medications, and coordinate acute care with physicians and psychiatric staff. Psychiatric nursing assistants and behavioral health technicians extend nursing capacity by implementing individualized treatment plans and reinforcing behavioral support protocols (CMS, 2022). Interdisciplinary teams, comprising psychiatrists, psychologists, behavioral analysts, and occupational and physical therapists, collaborate to develop and evaluate resident care plans, ensuring integration across medical and behavioral domains.

Non-clinical staff are equally essential to staffing configurations. Food service teams prepare individualized meals based on dietary restrictions, maintenance staff ensure the safety of physical environments, transportation staff support resident mobility across large campuses, and custodial staff maintain hygiene standards critical for infection control. This structure mirrors a small municipality, with staffing needs extending well beyond healthcare to encompass essential operational systems (State Agency Report, 2024).

Scheduling reflects both regulatory mandates and operational realities. Federal and state requirements stipulate minimum staff-to-resident ratios, but BRX frequently operates above these thresholds due to the intensity of care required. High turnover exacerbates scheduling pressures, often necessitating overtime and cross-coverage arrangements. National workforce data suggest that overtime reliance contributes to burnout and higher attrition rates, underscoring the need for sustainable staffing models (Pettingell et al., 2022).

Establishing Workforce Climate and Engagement

Promoting Safety

Safety is the cornerstone of workforce climate at BRX. Employees are required to undergo extensive health screenings, drug testing, and safety training prior to employment, with ongoing refresher training mandated by state oversight bodies (Texas Health and Human Services Commission, 2024). Safety protocols extend to both staff and residents, encompassing CPR/AED certification, first aid, bloodborne pathogen prevention, and crisis de-escalation training (CMS, 2022).

Supervisors conduct periodic environmental safety checks, ensuring residential spaces meet accessibility and infection-control standards. Regular drills for fire, weather emergencies, and behavioral crises further reinforce preparedness. This emphasis aligns with findings that robust safety climates improve staff confidence, reduce turnover intentions, and enhance resident outcomes (Fukui, Wu, & Salyers, 2025).

Enhancing Workplace Culture

BRX recognizes that a supportive workplace culture is directly linked to retention. Research highlights that job satisfaction among direct care workers increases when organizational cultures emphasize teamwork, transparent communication, and recognition of contributions (Gao et al., 2025; Nyerges et al., 2024). At BRX, culture is reinforced through daily shift meetings, open-door supervisory policies, and regular listening sessions where staff share concerns directly with leadership.

Peer recognition programs further cultivate positive culture. Staff appreciation events, spotlight awards, and wellness initiatives are designed to acknowledge the emotionally demanding nature of the work. These practices reflect national evidence that

recognition and involvement in decision-making reduce disengagement and foster organizational loyalty (Jo & Shin, 2025).

Challenges in Recruitment and Retention

Recruitment and retention remain among the most pressing challenges for BRX, reflecting national workforce crises in behavioral health and long-term care. National data show turnover rates exceeding 40 percent annually for DSPs, with average tenure often less than one year (NASDDDS, 2023). BRX experiences similar patterns, with vacancies concentrated in DSP and nursing roles, both of which are essential for day-to-day operations.

Recruitment challenges stem from multiple factors. Compensation disparities remain a central issue, as private sector employers often offer comparable wages with less emotional and physical demand (Last & Crable, 2024). Geographic disparities exacerbate recruitment difficulties in rural counties, where limited housing, fewer professional opportunities, and smaller labor pools hinder workforce stability (Pathman et al., 2025). Urban campuses, while benefitting from larger applicant pools, contend with high cost-of-living pressures that outpace state salary scales.

Retention challenges are equally acute. Exposure to trauma, resident aggression, and demanding schedules elevate risks of burnout, compassion fatigue, and moral distress among staff (Maslach & Leiter, 2016; Hallett et al., 2024). Research confirms that behavioral health workers in institutional settings face higher burnout risks than those in community-based environments, owing to constant vigilance and dual responsibility for safety and habilitation (Pulman & Fenge, 2024).

BRX counters these challenges with multi-pronged strategies:

- Structured onboarding with mentorship programs to reduce early attrition.
- Trauma-informed supervision and reflective practice groups that provide emotional support (Alhassan et al., 2025).
- Stay interviews and climate surveys to identify retention drivers and guide policy adjustments (Bass et al., 2025).

Despite these initiatives, retention remains fragile, underscoring the need for sustained investment in workforce infrastructure.

Career Progression and Advancement

Career progression is critical for workforce retention in high-demand behavioral health settings. Evidence suggests that staff who perceive opportunities for advancement are more likely to remain committed to their organizations (Kennedy et al., 2021). At BRX, career pathways are emphasized for both licensed and paraprofessional staff. DSPs, for example, are encouraged to pursue certifications in applied behavior analysis or psychiatric nursing assistance, with tuition assistance and mentoring provided. Nursing staff have opportunities for specialization in psychiatric care, geriatrics, or leadership roles. Licensed professionals are supported in pursuing continuing education credits and leadership development programs.

BRX's partnerships with universities and community colleges facilitate career advancement pipelines. Internship and residency programs allow psychology, nursing, and social work students to gain experience in IDD residential settings, with many transitioning into full-time roles post-graduation (Texas Health and Human Services,

2024). Such pipelines both strengthen workforce supply and create visible progression routes for staff already within the organization. Research confirms that career ladders are particularly effective in mitigating turnover among younger workers, who often leave behavioral health roles due to limited advancement opportunities (Fukui, Wu, & Salyers, 2025). By embedding structured pathways into organizational culture, BRX promotes both retention and professionalization of the workforce.

In addition to internal mentoring and advancement opportunities, BRX has developed partnerships with regional nursing schools, universities, and community colleges to establish direct pipelines for career advancement. These collaborations provide tuition assistance, clinical training placements, and priority hiring pathways for graduates who commit to working in state-operated facilities. For direct support professionals, tuition reimbursement and continuing education credits are offered to encourage credential attainment, including certified medication aide and psychiatric technician certifications (BRX website, 2024). By embedding these opportunities into workforce planning, BRX demonstrates commitment to transforming entry-level positions into long-term careers, thereby improving retention and reducing turnover.

Rewards and Recognition

BRX uses both formal and informal recognition systems to engage and retain staff. Annual awards, employee appreciation events, and recognition ceremonies acknowledge contributions across clinical and non-clinical roles. Supervisors also use letters of appreciation, small incentives, and peer-recognition platforms to highlight exemplary performance (BRX, 2024). However, structural financial constraints limit

BRX's ability to provide competitive compensation or robust benefits. Research consistently links low wages with high turnover in direct support roles (HRSA, 2024; Last & Crable, 2024). State funding models often fail to account for the true cost of care, leaving BRX with limited flexibility to increase pay or expand benefits such as health insurance.

Policy environments further shape rewards and recognition capacity. Federal initiatives, such as the Centers for Medicare & Medicaid Services' Behavioral Health Strategy and SAMHSA's workforce stabilization goals, highlight the need for investment in compensation, training, and retention infrastructure (CMS, 2022; SAMHSA, 2023). Yet implementation at the state level is constrained by budgetary limitations and competing priorities. BRX's leadership continues to advocate for policy reforms that would strengthen workforce sustainability, including:

- Government-subsidized training programs to expand entry pipelines.
- Wage subsidies to align compensation with the intensity of care provided.
- Grants for resilience and wellness programming to support staff retention.

Until such reforms are realized, BRX leverages non-monetary recognition and organizational culture as its primary retention tools. Although these efforts improve morale, research indicates that without systemic policy changes, workforce instability will remain a persistent challenge across IDD residential systems (Hoge et al., 2021).

Recognition at BRX is also tied to state-level policy constraints that shape what types of rewards can be offered. For example, state funding structures often limit the flexibility of on-site administrators to provide bonuses or non-standard benefits, requiring

recognition programs to operate within tight fiscal guidelines (State Agency Report, 2024). Despite these restrictions, BRX has piloted innovative recognition strategies such as expanded wellness stipends, “Employee of the Quarter” celebrations that include input from residents, and leadership-nominated professional development scholarships. These initiatives signal to staff that their contributions are valued, even within the boundaries of state regulations, and align with literature emphasizing the role of meaningful recognition in workforce retention (Nyerges et al., 2024; Choy-Brown et al., 2025).

Analytical Strategy

This section outlines the design of the study, my role in conducting the research, the participants, the data collection strategy, and the methods I will use to ensure the quality, credibility, and trustworthiness of the findings.

Research Design

This doctoral study employs a qualitative, single case study research design to investigate workforce retention challenges and strategies within BRX, a publicly funded behavioral health organization located in a metropolitan area in Texas that provides residential and community-based services for individuals with behavioral health and developmental support needs. Yin (2018) argues that a case study design is most appropriate when the objective is to gain an in-depth understanding of a contemporary phenomenon within its real-life organizational context. In contrast to quantitative designs that seek to isolate and measure variables under controlled conditions, the qualitative case study approach facilitates holistic exploration of workforce retention as it manifests in a complex, multi-layered system. This study is exploratory and descriptive in nature,

designed to integrate multiple data sources to address the professional practice problem of high turnover within BRX, a publicly funded behavioral health organization located in a metropolitan area in Texas. As Ravitch and Carl (2016) explain, qualitative research often serves exploratory and descriptive purposes by generating rich, contextualized understanding without imposing prior assumptions.

Triangulation

Triangulation is a cornerstone of methodological rigor in qualitative inquiry, strengthening the credibility and validity of findings. As Yin (2018) and Farquhar et al. (2020) explain, triangulation allows for cross-verification of data across multiple sources, reducing the risk of bias or misinterpretation. In this study, triangulation will occur at three levels: primary data from semistructured interviews with BRX clinical staff, secondary data from organizational and archival documents, and tertiary confirmation through publicly available reports on the behavioral health workforce. This layered approach ensures that interpretations are substantiated by convergent evidence rather than dependent on a single source.

At the primary level, semistructured interviews will provide first-hand accounts of how staff experience organizational leadership, communication, and recognition practices within a state-operated behavioral health setting. These narratives will be coded for emergent themes and then cross-checked against documentary evidence. At the secondary level, organizational documents such as employee handbooks, training manuals, retention policies, and strategic planning reports will serve as comparators, making it possible to examine whether formally stated workforce strategies align with or

diverge from the lived experiences of staff (Bowen, 2009; Yin, 2018). At the tertiary level, triangulation will extend outward by drawing on workforce reports, including the HRSA Behavioral Health Workforce Report to Congress (2024), the NASDDDS report on direct support workforce challenges (2023), and state-level planning documents from Texas Health and Human Services (2024). These sources provide systemic context and benchmarks that situate BRX's organizational practices within broader national and state workforce challenges.

This three-tier strategy incorporates methodological, data source, and theoretical triangulation (Denzin & Lincoln, 2013). The approach is further reinforced through relevant scholarship: Alhassan et al. (2025) highlight adaptive leadership as a retention factor, de Vries et al. (2023) emphasize empowerment and structural supports, and Hallett et al. (2024) document attrition drivers in public systems. Foundational studies on burnout and quality of care (Maslach & Leiter, 2016; Salyers et al., 2017) ground these findings in established theoretical frameworks. Together, these sources ensure analytic generalization while maintaining alignment with the study's design.

Explicitly articulating triangulation adds credibility by showing how findings will be corroborated across distinct yet interrelated data streams. For instance, if interviews reveal staff concerns about limited recognition, organizational manuals may indicate whether recognition policies exist, while national workforce reports can show whether such concerns reflect broader systemic trends. To support transparency and dependability, NVivo software will be used to code and compare all data sources, enabling structured analysis across interviews, documents, and policy benchmarks

(Bazeley & Jackson, 2019; QSR International, 2020). This rigor enhances confirmability, ensuring that conclusions about workforce retention are trustworthy, well-documented, and transferable. The following section details the step-by-step analytic process through which triangulation will be operationalized to address the research questions:

- **Data Analysis Plan.** The analytic process will follow a structured, multi-stage workflow consistent with qualitative case study analysis and the triangulation design described above, ensuring rigor, transparency, and direct alignment with the research questions for BRX (Yin, 2018; Denzin & Lincoln, 2013). NVivo will be used for data management, coding, memoing, and cross-source comparison to maintain a coherent chain of evidence (Bazeley & Jackson, 2019; QSR International, 2020).
- **Data Preparation and Organization.** Interview recordings will be transcribed verbatim, verified for accuracy, and de-identified. Transcripts and organizational documents will then be imported into NVivo, assigned source classifications and participant attributes, and logged in an audit trail to document analytic decisions and preserve dependability and traceability (Yin, 2018; Bazeley & Jackson, 2019).
- **Initial Coding.** Open coding will be conducted across interview transcripts and organizational documents to capture descriptive categories in participants' language and organizational policy text. Brief analytic and reflexive memos will be recorded to document emerging ideas and links to the research questions (Bazeley & Jackson, 2019; Bowen, 2009).

- **Code Refinement and Codebook Development.** Initial codes will be iteratively reviewed to merge redundancies, clarify conceptual boundaries, and establish inclusion and exclusion criteria. A structured codebook will be developed with operational definitions and exemplar excerpts to ensure consistent application across sources (Bowen, 2009).
- **Full Coding.** The refined codebook will be systematically applied to all interviews and documents in NVivo. Analytic memos will be maintained at the code level to capture patterns related to organizational culture, leadership, recognition, workload, and staff support.
- **Theme Development.** Related codes will be grouped into higher-order themes through constant comparison, pattern matching, and explanation building to assess coherence and distinctiveness. Themes will be examined against theoretical perspectives on retention and burnout to support theoretical triangulation where appropriate (Maslach & Leiter, 2016; Salyers et al., 2017; Yin, 2018).
- **Triangulated Comparison.** Themes derived from interviews will be compared with organizational documents and, where relevant, the workforce reports identified in the Triangulation section to determine convergence, divergence, and complementarity. NVivo queries and matrix coding will be used to structure cross-source analyses and to document corroboration or discrepancy across data streams (Bazeley & Jackson, 2019; QSR International, 2020).

- Synthesis Aligned to Research Questions. Final themes will be mapped directly to the study's research questions. For each theme, defining statements, representative quotations, corroborating document excerpts, and evidence of triangulation will be presented. Integrated findings across interviews, documents, and workforce benchmarks will be used to address each research question, thereby supporting credibility, confirmability, and transferability (Denzin & Lincoln, 2013; Yin, 2018).

Researcher Reflexivity and Ethics

Researcher reflexivity is essential to acknowledge and manage potential biases that may influence data interpretation. Ravitch and Carl (2016) define reflexivity as the researcher's ongoing awareness of personal perspectives and the impact of positionality on the study. As the sole researcher, I bring both professional knowledge of behavioral health systems and personal awareness of the challenges inherent in workforce instability. To mitigate the risk of bias, I will employ bracketing, journaling, and regular peer debriefing to reflect critically on assumptions and interpretations. Ethical standards will be upheld by safeguarding participant anonymity, ensuring informed consent, and maintaining strict confidentiality of sensitive organizational information. These measures align with established qualitative research ethics and support trustworthiness (Lincoln & Guba, 1985).

Nature of Data Collected and Respondents

Primary data collection will consist of semistructured interviews with a purposive sample of BRX clinical staff and leaders who oversee direct care operations, workforce

development, and clinical administration. Participants will include executive leadership, campus-level supervisors, and clinical directors with direct responsibility for staffing and retention. This selection is intentional, as clinical staff and leaders at these levels are positioned to provide insights into both systemic and day-to-day workforce challenges. Secondary data sources will include internal workforce reports, policy documents, training manuals, and state regulatory performance reviews. These documents will contextualize interview responses and allow for comparison between policy intent and operational practice.

Primary Data Collection

Semistructured interviews will be guided by a protocol derived from both the research questions (RQs) and relevant theoretical frameworks, ensuring full coverage of the study's aims. While the Baldrige Excellence Framework emphasizes systems thinking, workforce engagement, and strategic leadership as determinants of organizational performance (Baldrige Performance Excellence Program, 2021), the interview questions will primarily be aligned with the study's four research questions:

RQ1: How do mental health professionals in a state-operated behavioral health organization perceive organizational factors that influence their decision to remain employed?

RQ2: What aspects of the organizational culture do mental health professionals identify as most influential in their retention decisions?

RQ3: How do workplace dynamics and interpersonal relationships shape employees' decisions to stay or consider leaving?

RQ4: In what ways do environmental and contextual factors (e.g., workload, support systems, leadership) contribute to employees' sense of organizational commitment or satisfaction?

The Baldrige framework will serve as a supplementary guide, helping to ensure that interview questions systematically address domains such as leadership visibility, recognition, communication, workforce capability, and alignment with organizational mission. However, the ultimate structure of the interview protocol will be driven by the RQs, so that data collection remains focused on answering the central inquiry of the study (Yin, 2018).

Open-ended questions will be used to elicit participant perspectives, allowing respondents to expand on their lived experiences while still providing consistency across interviews (Creswell & Poth, 2018; Patton, 2015). Probes will be included to capture depth around specific areas, such as recognition practices, team collaboration, and workload pressures, that the literature identifies as central to retention (Choy-Brown et al., 2025; Breslin et al., 2022). This alignment ensures that interview data will not only reflect participants' experiences but will also directly map to established research findings on workforce stability, creating analytic bridges between theory, prior evidence, and the study's central questions (Maslach & Leiter, 2016; Salyers et al., 2017).

Relevance of Data Collected to the BRX Practice Problem

The data collected are directly relevant to the workforce retention problem identified at BRX. By combining clinical staff and leader perspectives with archival documentation and state-level workforce reports, the study will generate a comprehensive

analysis of the structural, cultural, and policy-based factors influencing retention. This approach aligns with contemporary calls for systems-level evaluation of the behavioral health workforce (HRSA, 2024). Findings are expected to illuminate not only the organizational dynamics of BRX but also broader implications for state-operated behavioral health systems nationwide.

Archival and Operational Data

Archival and operational data are essential secondary sources in this study, as they provide contextual evidence that complements the semistructured interviews with clinical staff and leaders. These data represent documents and records that were created by the organization in the course of normal operations, not specifically for research purposes. Their use strengthens triangulation by validating or challenging themes identified in the interview process and by grounding interpretations in documented organizational practices (Yin, 2018).

Nature of the Information and Sources

The types of archival and operational data relevant to this study include organizational charts, policy and procedure manuals, employee handbooks, staff training records, job descriptions, onboarding protocols, and strategic workforce development plans. In addition, performance management tools, safety compliance reports, and redacted summaries of employee satisfaction surveys or exit interviews may be used where available. These documents are produced by various contributors within the organization, such as human resources staff, clinical administrators, and workforce development teams.

Because these materials were originally designed to support regulatory compliance, guide daily operations, and provide orientation to employees, they serve as credible reflections of organizational practice. Potential examples of archival and operational documents expected for review in this study include, but are not limited to:

- Job applications, onboarding checklists, and professional reference forms
- Mandatory training records, competency verification forms, and safety compliance logs
- Employee handbook, code of conduct, confidentiality agreements, and HR policies
- Exit interview summaries, climate surveys, and staff development plans
- Position descriptions, supervision agreements, and redacted care coordination forms

The final set of documents analyzed may vary depending on organizational availability and permissions, and not all listed sources may be used. This flexible approach ensures that the study maintains methodological integrity by relying only on data that can be accessed ethically and that align with IRB and organizational confidentiality protocols. As Yin (2018) emphasizes, case study research depends on multiple forms of evidence that may differ in accessibility, and Lincoln and Guba (1985) note that trustworthiness in qualitative inquiry is strengthened when researchers adapt data collection strategies to ethical and contextual realities.

Relevance to the Practice Problem

The relevance of these archival data to the practice problem lies in their direct connection to workforce recruitment, retention, and professional development within the organization. For example, job descriptions and staffing protocols reveal expectations placed on employees and help identify whether role clarity or scope of duties align with staff perceptions of workload and burnout (Maslach & Leiter, 2016; Pulman & Fenge, 2024). Similarly, onboarding materials and training curricula demonstrate the organization's investment in professional preparation, which has been shown to influence retention and workforce sustainability in behavioral health settings (Pettingell et al., 2022). Policies addressing safety, trauma-informed care, and person-centered practices provide further evidence of how organizational culture is formally articulated and whether it supports or undermines staff well-being. By connecting these documents to interview data, the study evaluates congruence between written standards and lived experiences of employees.

Collection and Validity of the Data

These documents were collected by the organization in alignment with federal and state regulatory requirements for publicly funded behavioral health providers. For instance, employee handbooks and policy manuals are standardized across the system to ensure compliance with the Centers for Medicare & Medicaid Services (2022) and state-level behavioral health guidelines (Texas Health and Human Services Commission, 2024). Training and competency records are maintained to validate licensure compliance, while workforce surveys are periodically administered by human resources as part of

routine staff engagement processes. Because the data are generated and maintained in the course of regulatory oversight and operational necessity, they represent valid and credible sources of organizational evidence. Nonetheless, limitations exist. Some documents may reflect policy intent rather than actual implementation, while others may provide only a snapshot at a given time rather than capturing dynamic workforce conditions (National Center for Health Workforce Analysis, 2024).

Procedures for Gaining Access

Access to these archival and operational data will occur following Institutional Review Board (IRB) approval and with written permission from organizational leadership. The process involves submitting formal requests to the designated research liaison within the organization, who will determine which documents may be shared under confidentiality agreements. All identifying information, such as personal employee records, will be excluded or redacted to protect privacy. To safeguard confidentiality, only de-identified and organizationally approved data will be used for analysis, and no individual staff member will be linked to a specific document or policy. Consistent with masking protocols, the name of the agency and specific facilities will not be disclosed in the dissertation, and references will instead describe the organization as a state-operated behavioral health organization in Texas.

Reputability and Limitations of Historical and Legal Documents

Publicly available historical and legal documents also contribute to triangulation. Examples include state legislative reports on behavioral health workforce shortages, federal workforce strategies published by the Health Resources and Services

Administration (2024), and policy directives issued by the Substance Abuse and Mental Health Services Administration (2023). These sources are reputable because they originate from governmental and regulatory authorities with statutory oversight responsibilities. While they may not capture the lived experience of organizational staff, they situate the practice problem in broader policy and workforce contexts, enabling comparison between local implementation and systemic mandates. The limitations of these sources primarily involve their broad scope, which may not fully reflect the unique challenges experienced at the organizational level.

Integration into the Study

By combining internal organizational documents with state and federal reports, this study establishes layered evidence base that links individual narratives to systemic policies and operational practices. This integration not only supports triangulation but also enhances the trustworthiness of findings by demonstrating consistency, or lack thereof, across multiple data sources (Farquhar et al., 2020). Importantly, archival and operational data will be mapped against the Baldrige Excellence Framework Workforce Criteria (Category 5), ensuring alignment between documented policies, leadership practices, and the systems-level factors influencing workforce retention. Ultimately, these archival and operational data will provide the necessary contextual framework to analyze how organizational culture, structural policies, and workforce management practices influence retention within publicly funded behavioral health organizations.

Evidence Generated for the Doctoral Study

The evidence generated for this doctoral study will consist of semistructured interviews with clinical staff and leaders at BRX, a publicly funded behavioral health organization located in a metropolitan area in Texas that provides residential and community-based services for individuals with behavioral health and developmental support needs. Unlike archival and operational data that are part of the organization's normal operations, the interviews are designed specifically for this research and represent primary data created for the purpose of examining workforce retention.

Prior to beginning the study, I obtained Institutional Review Board (IRB) approval, and secured a completed Partner Organization Agreement Form signed by the designated organizational liaison. This document conveyed formal site approval, confirmed that strict ethical standards will be upheld, and ensured that the organization's anonymity is protected in all reports and publications. Participants will also receive a written informed consent form explaining the study's purpose, voluntary nature, potential risks, and protections for confidentiality.

Step-by-step, the evidence will be generated as follows:

1. **Site Approval and Permissions:** A signed Partner Organization Agreement Form will be secured prior to recruitment. This document will confirm organizational approval and delineate the procedures for safeguarding both the organization and participants.
2. **Recruitment of Participants:** Using purposive sampling, I will invite clinical staff and leaders with supervisory, clinical, or workforce-related

responsibilities to participate. Recruitment will occur through organizational communication channels and will be coordinated with the research liaison.

3. **Distribution of Informed Consent:** Participants will receive the informed consent form in advance of the interview. The form will outline their rights, describe the research questions guiding the study, and affirm that participation is voluntary and confidential. Participants will have the opportunity to review, ask questions, and provide written consent before scheduling the interview.
4. **Scheduling and Conducting Interviews:** Interviews will be scheduled at times that minimize disruption to the organization's operations. Each interview will be conducted virtually or in a private location identified by the organization to ensure confidentiality. Interviews will follow a semistructured protocol derived from the Baldrige Excellence Framework and aligned with the four research questions.
5. **Recording and Documentation:** With participant consent, interviews will be audio recorded to ensure accuracy. Field notes will also be taken during each session to capture contextual observations and nonverbal cues.
6. **Protection of Confidentiality:** All identifying information will be removed during transcription, and pseudonyms will be assigned to each participant. Transcriptions will be stored on a password-protected device accessible only to me as the researcher. The organization will be referenced only as a

state-operated behavioral health organization in Texas, consistent with masking requirements.

7. Ethical Oversight and Reflexivity: Throughout data collection, I will engage in reflexivity by journaling impressions and reflecting on potential biases. This process ensures that my subjective perspectives do not compromise the trustworthiness of the evidence generated.

The combination of signed site approval, participant consent, and strict confidentiality safeguards ensures that the evidence generated for this study adheres to ethical research standards. By producing new, original data directly related to the professional practice problem, the study generates insights that cannot be captured solely from archival or operational records.

Participants

The participants in this study will include clinical staff and leaders at BRX who are directly responsible for service delivery, workforce supervision, and clinical oversight. The expected sample size is approximately 15 to 20 participants, which aligns with qualitative case study traditions where the goal is to achieve depth of inquiry and thematic saturation rather than statistical generalization (Yin, 2018; Ravitch & Carl, 2016). Participants will be selected through purposive sampling in collaboration with the organizational liaison to ensure representation from both clinical roles and leadership roles.

These participants are directly relevant to the practice-focused research questions, as they can speak to organizational culture, workforce dynamics, retention challenges,

and contextual factors shaping decisions to remain employed or leave the organization. By including both frontline clinical staff and leaders, the study captures perspectives across levels of the organization that influence workforce sustainability.

Procedures

The techniques used to collect evidence will consist of semistructured interviews guided by an interview protocol aligned with the Baldrige Excellence Framework and the four research questions. Open-ended questions will be used to allow participants to describe their lived experiences, while maintaining consistency across interviews.

In alignment with Walden requirements, the interview protocol that guided this study is identified in the table of contents, referenced in the body of this manuscript, and presented in full in Appendix A. The protocol includes an introduction script, open-ended interview questions aligned with the four research questions, and closing prompts to ensure completeness and consistency across interviews.

Tentative Timeline for Primary Data Collection:

- Month 1: IRB approval and site agreement finalized.
- Month 2: Participant recruitment and informed consent distribution.
- Month 3: Semistructured interviews conducted; recordings and field notes collected.
- Month 4: Transcriptions completed; data prepared for coding and analysis.

This timeline ensures a structured and ethical process for generating primary evidence while allowing flexibility to accommodate organizational operations.

Summary

In Section 2, the background and approach for this study were presented, including leadership strategy and assessment, the client population served, workforce and operations, supporting literature, and the analytical strategy. The supporting literature established that workforce shortages and retention challenges in behavioral health organizations have been persistent issues nationally. Maslach and Leiter (2016) argued that burnout results from the interaction between workload, limited resources, and organizational culture, while Alhassan et al. (2025) emphasized the importance of trauma-informed supervision in sustaining the workforce. These studies provided a foundation for understanding the complexity of the workforce environment at BRX, a publicly funded behavioral health organization located in a metropolitan area in Texas that provides residential and community-based services for individuals with behavioral health and developmental support needs.

The leadership strategy and assessment subsection outlined how clinical staff and leaders shape workforce capacity and organizational culture. As Pulman and Fenge (2024) contended, organizational culture plays a central role in retention by influencing staff perceptions of support and alignment with professional values. The section also described the characteristics of the client population, emphasizing that individuals with intellectual, developmental, and behavioral health needs require high-acuity services. This complexity increases demands on staff and amplifies the importance of retention for continuity of care.

The workforce and operations discussion examined the organization's staffing structures, training systems, and operational practices, highlighting the challenges associated with turnover, limited compensation, and the reliance on interdisciplinary teams to provide integrated care. National reports, such as the Health Resources and Services Administration (2024) and the National Center for Health Workforce Analysis (2024), documented similar workforce pressures across the sector, reinforcing the relevance of BRX's experiences to broader policy and practice concerns.

The analytical strategy was described, including the rationale for a qualitative single case study design. Yin (2018) argued that case study methodology is particularly effective in examining organizational processes within their real-life context, while Farquhar et al. (2020) explained that triangulation strengthens the validity of findings. The section outlined the use of archival and operational documents as secondary sources of evidence and semistructured interviews with clinical staff and leaders as primary evidence, supported by reflexivity and ethical safeguards described by Lincoln and Guba (1985).

By integrating these elements, Section 2 provided a comprehensive foundation for investigating the practice-focused problem of workforce retention in a publicly funded behavioral health organization. Section 3 will build upon this foundation by examining how BRX measures, analyzes, and manages knowledge to strengthen workforce sustainability. Specifically, Section 3 will address organizational processes for evaluating performance, strategies for improving workforce engagement, and the use of knowledge assets and information systems to enhance recruitment and retention outcomes.

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

Introduction

BRX, a publicly funded behavioral health organization in Texas, is experiencing persistent difficulty retaining its mental health professionals. Employees frequently report high stress, heavy workloads, and inadequate organizational support, which contribute to burnout and turnover. These workforce challenges disrupt service continuity and impede the delivery of trauma-informed, person-centered care to individuals with complex behavioral health and developmental needs. The practice-focused question guiding this qualitative case study is the following: How do mental health professionals within BRX perceive organizational culture, workplace dynamics, and internal environmental factors that influence their decision to remain employed? Understanding these perceptions is crucial to developing evidence-informed strategies that enhance workforce retention, promote organizational sustainability, and ensure the continuity of behavioral health services.

Sources of Evidence and How They Were Obtained

Evidence for this qualitative case study was collected from four distinct data streams to ensure methodological rigor and triangulation (Yin, 2018). First, semistructured interviews will be conducted with clinical staff currently employed at BRX, using the Baldrige Performance Excellence Program (2021) Workforce Criteria to structure questions on engagement, well-being, leadership visibility, recognition, communication, psychological safety, and structural supports (Alhassan et al., 2025; de

Vries et al., 2023; Choy-Brown et al., 2025). Interviews were audio-recorded, transcribed verbatim, and coded in NVivo to support thematic analysis and iterative coding cycles (Bazeley & Jackson, 2019).

Second, internal organizational documents, including employee handbooks, training and onboarding manuals, staff development resources, workforce survey results, strategic planning reports, and policy memos, were requested from the human resources office and executive leadership team, following institutional review and confidentiality protocols. These documents offered insight into BRX's formal workforce policies, development strategies, and retention priorities, and were critically analyzed in relation to staff accounts (Bowen, 2009; Yin, 2018; Patton, 2015).

Third, publicly available workforce and policy reports, including the Health Resources and Services Administration (HRSA, 2024) Behavioral Health Workforce Report to Congress and the National Association of State Directors of Developmental Disabilities Services (NASDDDS, 2023) workforce report, provided contextual benchmarks for understanding statewide and national retention trends. These were supplemented by umbrella reviews and meta-analyses documenting turnover and burnout patterns in health and social care systems (Wynendaele et al., 2025; Ibrahim et al., 2023; Poon et al., 2022).

Finally, peer-reviewed scholarly literature on burnout, leadership, organizational culture, and workforce retention (Maslach & Leiter, 2016; Salyers et al., 2017; Pathman et al., 2025) supplied the theoretical scaffolding for interpreting findings. Data from all sources were integrated through a convergent triangulation design (Creswell & Poth,

2018) to identify convergence, complementarity, and dissonance, thereby ensuring that results reflect both lived experiences and the organizational and policy contexts shaping workforce retention at BRX.

Analysis of the Organization

Building an Effective, Supportive Workforce Environment

BRX builds a supportive workforce environment through a comprehensive framework that prioritizes trauma-informed care, equity-driven supervision, and continuous staff development. Guided by the Baldrige Performance Excellence Program (2021) Workforce Criteria, BRX integrates staff well-being, psychological safety, and clinical capability as core pillars of service quality. The organization provides trauma-informed care training that emphasizes understanding the impact of trauma on both clients and staff, creating emotionally safe environments, and fostering empathy in daily practice. These trainings are supported by modules in culturally responsive care, positive behavior support, and crisis prevention, ensuring that all staff maintain the competencies necessary to serve individuals with complex intellectual and developmental disabilities and co-occurring behavioral health conditions (Friedman, 2021; Centers for Medicare & Medicaid Services, 2022).

BRX embeds equity-centered supervision by structuring reflective supervision sessions, psychological safety rounds, and cross-disciplinary case reviews that allow staff to discuss challenges without fear of reprisal. Supervisors are trained to monitor secondary traumatic stress and risk of burnout, using workload assessments and wellness check-ins as early interventions (Pulman & Fenge, 2024). New employees complete a

structured onboarding that combines classroom training with shadowing, peer mentoring, and competency evaluations. Career progression is supported through tiered advancement pathways and professional development stipends that incentivize ongoing learning (Fukui et al., 2025).

Interdisciplinary clinical teams, including nurses, psychologists, behavioral health clinicians, and social workers, provide consistent guidance and oversight. They participate in regular Behavior Support Committee meetings, interdisciplinary service planning, and joint treatment reviews to ensure the alignment of care. BRX also offers access to employee assistance programs, wellness workshops, and resilience coaching to address staff emotional health. These strategies reflect the real workforce framework used by THHS, which emphasizes staff retention, emotional support, and structured career development as essential to sustaining quality behavioral health services (BRX website, 2024). BRX also incorporates culturally and linguistically appropriate services (CLAS) training and health equity action plans to ensure that workforce development aligns with the cultural and linguistic diversity of the populations served. By integrating these practices into daily operations, BRX has created a workforce environment designed to reduce burnout, enhance engagement, and improve retention (de Vries et al., 2023; Hallett et al., 2024).

Engaging Staff to Achieve a High-Performance Work Environment

BRX fosters staff engagement and high performance through transparent governance structures, participatory decision-making, and recognition systems that align employee efforts with organizational goals. Staff engagement is supported by standing

workforce councils, behavioral support committees, and interdisciplinary leadership forums that give frontline employees a voice in shaping policy, practice, and program design. This approach aligns with research indicating that employee engagement increases when leadership is perceived as trustworthy, emotionally available, and responsive (Alhassan et al., 2025; Choy-Brown et al., 2025).

The organization conducts workforce climate surveys, stay interviews, and exit interviews, using results to identify gaps in supervision, workload distribution, and recognition. Data from these assessments are reviewed quarterly and incorporated into performance improvement plans that follow Baldrige feedback cycles (Baldrige Performance Excellence Program, 2021). Supervisors embed engagement practices into daily routines by providing consistent feedback, goal-setting sessions, and peer recognition opportunities. These practices are reinforced by leadership's emphasis on equity, inclusion, and emotional solidarity, which are known to reduce turnover intention and improve team cohesion (Fogel et al., 2025; de Vries et al., 2023).

BRX also supports engagement by providing structured professional development plans tied to performance milestones. Employees can pursue certifications in crisis intervention, applied behavior analysis, or trauma-informed care, which are linked to advancement opportunities. These initiatives align with BRX's workforce engagement strategies, which prioritize continuous feedback, employee growth, and recognition as essential to workforce retention (BRX website, 2024). BRX's engagement strategies are supported by the organization's commitment to equity-focused workforce planning, which includes tracking demographic data and ensuring representation across leadership

levels. By embedding engagement practices at every organizational level, BRX maintains a workforce climate rooted in psychological safety, shared accountability, and consistent performance excellence (Hallett et al., 2024).

Designing, Managing, and Improving Key Services and Work Processes

BRX manages its services through a centralized quality management framework that emphasizes regulatory compliance, fidelity to evidence-based practices, and responsiveness to local needs. The organization delivers 24/7 interdisciplinary behavioral health, medical, and habilitative services to individuals with complex needs. These services are anchored in person-centered planning principles, which ensure that each individual's goals, preferences, and cultural values are incorporated into their care plans (National Association of State Directors of Developmental Disabilities Services, 2023).

BRX integrates a wide array of evidence-based behavioral health programs that are central to its service delivery. These include coordinated specialty care for individuals experiencing first-episode psychosis, which combines psychotherapy, medication management, and family education; home- and community-based behavioral health services that allow individuals to receive intensive support in less restrictive environments; structured peer support programs that embed lived experience into recovery planning; and permanent supportive housing initiatives that provide stable housing with wraparound behavioral supports (BRX website, 2024). Each program is delivered through interdisciplinary care teams, utilizing individualized service plans (ISPs) and behavior support plans that are aligned with positive behavior support practices.

BRX applies continuous quality improvement (CQI) cycles, root cause analysis, and performance dashboards to monitor service outcomes, behavioral progress, and quality-of-life indicators (Health Resources and Services Administration, 2024). Clinical leadership teams conduct routine fidelity audits and policy reviews to ensure services adhere to evidence-based guidelines and regulatory standards (Substance Abuse and Mental Health Services Administration, 2023). BRX also aligns its practices with federal and state regulatory frameworks, including Medicaid HCBS waiver standards and CMS quality assurance requirements, to ensure compliance and maintain funding eligibility. These quality systems reflect Baldrige principles of organizational learning, data-driven decision-making, and systematic process evaluation (Wang et al., 2023). By integrating person-centered planning, interdisciplinary coordination, and CQI methodologies, BRX maintains a service delivery system that is consistent, responsive, and adaptable to shifting population needs.

Ensuring Effective Management of Operations

BRX ensures operational effectiveness through a dual governance structure that combines centralized oversight with decentralized operational authority. Central administration sets policy, directs strategic planning, oversees regulatory compliance, and manages workforce strategy, while local program leaders oversee daily operations including staffing, scheduling, and service workflows. This structure allows BRX to maintain uniform quality standards while tailoring operations to regional needs (BRX website, 2024).

The organization uses integrated workforce and financial management systems to align staffing levels with service demand, reduce overtime reliance, and ensure fiscal sustainability (Ballout, 2025). Key performance indicators (KPIs) track workforce stability, service timeliness, incident rates, and regulatory adherence, and are reviewed quarterly by executive leadership (Hallett et al., 2024). Data from these reviews inform workforce forecasting, resource allocation, and risk mitigation planning. BRX's operational teams are trained in crisis response and supported by centralized emergency coordination units that ensure service continuity during critical incidents (Fukui et al., 2025; Brabson et al., 2020).

BRX integrates electronic health records (EHRs), incident reporting systems, and performance analytics dashboards to track real-time outcomes and support data-informed decision-making at both the administrative and program levels (BRX website, 2024). This approach reflects Baldrige operational criteria by embedding systems thinking, proactive planning, and continuous monitoring into day-to-day management. Through these operational strategies, BRX sustains workforce confidence, financial accountability, and reliable delivery of trauma-informed behavioral health services while ensuring regulatory compliance and long-term organizational stability.

Knowledge Management

Improving Organizational Performance

BRX uses an integrated, data-driven performance management framework to measure, analyze, and continuously improve its organizational outcomes. Drawing on the Baldrige Performance Excellence Program (2021) measurement and analysis criteria, the

organization aggregates data from multiple operational domains, including workforce stability, behavioral outcomes, service timeliness, incident reporting, and quality-of-life measures for individuals served. These data are collected through interoperable electronic health record (EHR) systems, incident reporting portals, and workforce management platforms, which feed into centralized dashboards monitored by administrative leadership.

Performance indicators are reviewed quarterly by executive leadership and cross-functional quality councils. These teams conduct root cause analysis, process mapping, and control chart trend analysis to identify performance gaps and system inefficiencies. Findings from these reviews inform targeted process redesign, corrective action plans, and policy revisions, which are implemented at the program level through structured Plan-Do-Study-Act (PDSA) cycles. BRX requires each program to submit continuous quality improvement (CQI) reports detailing performance trends, interventions implemented, and post-intervention outcomes. This approach mirrors the real performance improvement system within BRX's Health and Specialty Care System, which emphasizes iterative learning cycles and outcome-driven decision-making (BRX website, 2024).

To reinforce the integrity of its performance data, BRX aligns its measurement and reporting practices with external oversight frameworks from Centers for Medicare & Medicaid Services (CMS), The Joint Commission, and the Texas Department of State Health Services (DSHS). This ensures that its CQI processes meet state and federal standards for quality, safety, and accountability. This rigorous structure ensures that

operational and clinical decisions are evidence-based and informed by real-time performance data. Leadership uses results from these analyses to allocate resources, develop workforce retention strategies, and improve client outcomes. Embedding performance data into governance processes allows BRX to link strategic planning with frontline practice, creating a continuous feedback loop that drives system-wide learning and improvement (Hallett et al., 2024; de Vries et al., 2023; Health Resources and Services Administration, 2024). As a result, the organization maintains regulatory compliance while fostering a culture of accountability, transparency, and continuous performance excellence.

Managing Organizational Knowledge

Alongside its performance systems, BRX manages its organizational knowledge assets, information, and technology infrastructure through a coordinated knowledge management framework (BRX website, 2024). Core organizational knowledge, including policies, procedures, treatment guidelines, training modules, and administrative protocols, is stored in secure digital repositories accessible via an internal learning management system (LMS) and document control platform. These materials are version-controlled and reviewed regularly by quality assurance teams to ensure alignment with state and federal regulatory frameworks, including CMS quality standards and Medicaid Home- and Community-Based Services (HCBS) waiver requirements (BRX website, 2024).

The organization's enterprise health information technology (HIT) infrastructure includes interoperable EHR systems, secure data exchange interfaces, and embedded

clinical decision support tools. These systems enable interdisciplinary teams to coordinate care, track treatment plans, and document services across geographically dispersed sites. BRX enforces data governance policies that define data access permissions, quality standards, and security audits to ensure confidentiality and integrity of sensitive health information. In addition, the LMS platform is integrated with workforce competency tracking tools, allowing leadership to identify skills gaps, assign targeted training, and align professional development plans with organizational priorities. This linkage of knowledge systems to staff development reflects THHS's emphasis on strengthening workforce capability through structured knowledge use (BRX website, 2024).

BRX also employs predictive analytics and data visualization platforms to forecast workforce needs, monitor service utilization trends, and track behavioral health outcomes (Ballout, 2025; Fukui et al., 2025). Cybersecurity safeguards, including HIPAA compliance audits, multi-factor authentication, and data loss prevention systems, are embedded throughout the HIT infrastructure to protect organizational knowledge from unauthorized access or breaches. BRX promotes organizational learning by convening interdisciplinary learning forums, performance collaboratives, and communities of practice where staff share lessons from CQI projects and innovation pilots (BRX website, 2024). These structures reflect BRX's emphasis on embedding organizational learning within its Health and Specialty Care System as a strategy to improve care quality and workforce retention. By integrating centralized knowledge repositories, robust health IT systems, and collaborative knowledge-sharing mechanisms, BRX ensures that

institutional knowledge is preserved, secure, accessible, and actively used to enhance decision-making, improve performance, and sustain high-quality behavioral health services (de Vries et al., 2023).

Summary

In Section 3, I conducted an analysis of BRX in terms of how its behavioral health leaders build an effective and supportive workforce environment and engage staff to achieve a high-performance work setting. I also described how they design, manage, and improve key organizational services and work processes, and how they ensure effective management of operations through centralized oversight, interdisciplinary collaboration, and continuous quality improvement structures. Lastly, I examined how organizational performance data are measured and analyzed to guide process improvements, and how BRX manages its knowledge assets and technology systems to support decision-making, workforce development, and service quality.

Based on the evidence collected in this study, Section 4 will analyze the results from the standpoint of their implications for BRX. This will include a discussion of the strengths and limitations of the findings and how they address the practice-focused problem of workforce retention in the behavioral health setting. The transition from Section 3 to Section 4 marks a shift from designing the study and planning its methods to presenting and interpreting the data that emerge from its implementation.

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

Introduction

This research study examines the problem of workforce retention among mental health professionals employed at BRX, a publicly funded behavioral health organization located in a metropolitan area in Texas. The organization provides residential and community-based services for individuals with behavioral health and developmental support needs. The practice-focused research questions explore how mental health professionals perceive organizational culture, workplace dynamics, and environmental factors that influence their decision to remain employed within the organization. Understanding how these factors affect retention represents a critical gap in the academic and practical literature concerning workforce stability in publicly funded behavioral health systems.

In Section 4, I use the evidence collected through this study to address the four research questions deemed important to BRX, which are as follows:

RQ1: How do mental health professionals in a state-operated behavioral health organization perceive organizational factors that influence their decision to remain employed?

RQ2: What aspects of the organizational culture do mental health professionals identify as most influential in their retention decisions?

RQ3: How do workplace dynamics and interpersonal relationships shape employees' decisions to stay or consider leaving?

RQ4: In what ways do environmental and contextual factors (e.g., workload, support systems, leadership) contribute to employees' sense of organizational commitment or satisfaction?

The results are based upon multiple sources of evidence, a series of semistructured primary interviews with 20 employees representing diverse organizational roles, a review of secondary internal documents, and an examination of publicly available workforce and policy data. Of the 20 participants, six (30%) were directors, three (15%) served as supervisors, and 11 (55%) were clinical direct care staff. This distribution ensured representation across multiple organizational levels, providing perspectives from leadership, supervisory, and frontline positions.

Primary data were collected through semistructured interviews aligned with the Baldrige Excellence Framework for Health Care, specifically the Workforce Criteria, which emphasize workforce engagement, capability, and well-being as central to organizational performance. Each interview was transcribed and analyzed using NVivo qualitative data analysis software following established procedures outlined by Saldaña (2021), Miles and Huberman (2014), and Merriam and Tisdell (2015). The analytic process incorporated iterative open and pattern coding consistent with Brinkmann and Kvale (2015), Creswell and Poth (2016), Finfgeld-Connett (2018), Simula (2018), and Thornberg and Charmaz (2014), ensuring methodological rigor and alignment with qualitative standards for validity and reliability in data analysis.

Secondary data included internal organizational materials such as workforce development manuals, employee handbooks, human resources policies, staff survey

results, and strategic planning documents. These materials provided additional context for understanding the organization's retention challenges and policies. External data sources included national workforce studies, such as those from the Health Resources and Services Administration (2024) and the National Center for Health Workforce Analysis (2024), which identified similar staffing pressures and retention concerns across behavioral health systems nationwide. Analysis of these findings provides a foundation for the study recommendations presented later in Section 5. Finally, the study strengths and limitations are described in Section 4.

Analysis, Results, and Implications

Qualitative Coding

The qualitative data analysis for this study was conducted using NVivo (QSR International) to organize, manage, and analyze the interview data from twenty mental health professionals employed at BRX, a state-operated behavioral health organization in Texas. NVivo was selected for its robust capability to support qualitative data analysis through systematic coding, categorization, and thematic synthesis (Saldaña, 2021; Miles et al., 2014). The analytic process was structured through multiple iterative cycles of coding to identify recurring themes and patterns aligned with the study's four research questions.

Open and Descriptive Coding

The first cycle of coding began immediately after transcription and familiarization with the twenty interviews. Open coding was used to identify distinct units of meaning within participants' narratives. Each transcript was examined line by line to capture

participants' direct expressions regarding organizational culture, leadership, workload, and retention-related perceptions (Brinkmann & Kvale, 2015; Merriam & Tisdell, 2015).

Initial open coding generated approximately one hundred thematic codes, representing a wide spectrum of ideas, including communication transparency, safety concerns, burnout, team support, leadership responsiveness, recognition gaps, and workload inequities. NVivo's text search and word frequency query tools were applied to ensure data saturation and consistency across participant responses. This initial phase enabled me to catalog all possible meanings without imposing theoretical bias, aligning with Creswell and Poth's (2016) emphasis on emergent, inductive analysis.

Pattern and Thematic Development

Following the open coding phase, the second cycle involved pattern coding and axial integration to cluster related codes into higher-order categories. Through iterative comparison, 100 thematic codes were refined into 24 recurring themes that captured the most salient organizational, interpersonal, and systemic factors influencing workforce retention. NVivo's hierarchical node structure facilitated the construction of parent and child codes, allowing me to examine relationships among subthemes such as leadership trust, fairness, and emotional support. Constant comparison ensured that each theme was grounded in multiple participant accounts and supported by verbatim excerpts, enhancing validity through triangulation (Finfgeld-Connett, 2018; Thornberg & Charmaz, 2014).

Recurring Themes

- Leadership Responsiveness and Emotional Presence
- Communication and Transparency

- Accountability and Fairness
- Recognition and Value
- Structural Inefficiency and Bureaucracy
- Innovation and Collaboration in Care
- Staffing Shortages and Turnover
- Workload Overload and Role Creep
- Training and Onboarding Gaps
- Professional Growth and Advancement Opportunities
- Work–Life Balance and Flexibility
- Safety and Security Concerns
- Organizational Culture and Climate
- Team Cohesion and Peer Support
- Equity, Inclusion, and Respect
- Trust and Psychological Safety
- Accountability Culture (Double Standards)
- Morale and Emotional Climate
- Burnout and Compassion Fatigue
- Emotional Resilience and Coping
- Motivation and Retention Drivers
- Commitment to Client Care and Mission Alignment
- Pay and Compensation Inequity
- External and Environmental Pressures

Each of these themes reflected patterns that emerged consistently across multiple participant narratives, underscoring the complexity of workforce retention in state-operated behavioral health systems. Themes such as leadership responsiveness, recognition and value, and communication and transparency appeared in nearly all interviews, revealing a shared perception of leadership visibility and organizational accountability as critical to staff retention. Conversely, themes such as workload overload, staffing shortages, and burnout highlighted the structural and systemic pressures undermining workforce stability.

Research Question Alignment

The 24 themes were organized according to the study's four research questions. Themes related to organizational structure, workload, and leadership responsiveness (Themes 1, 5, 7, 8, 9, 23) directly addressed RQ1, examining how organizational factors shape employees' decisions to remain employed. Cultural and relational aspects, including team cohesion, trust, and equity (Themes 13–16), aligned with RQ2. Workplace dynamics and interpersonal relationships, central to RQ3, were reflected in peer support, morale, and burnout (Themes 14, 18, 19). Finally, work–life balance, external pressures, and commitment to client care (Themes 11, 22, 24) were particularly relevant to RQ4, highlighting contextual factors influencing satisfaction and commitment.

Findings Organized by Research Question

RQ1 Findings

Theme 1: Leadership Responsiveness and Emotional Presence

Participants consistently described leadership responsiveness as a central organizational factor shaping their decision to stay. Several noted that leadership often “listens but does not act,” creating a sense that staff concerns are acknowledged but not addressed. Others explained that leadership support varies widely across departments, with some supervisors being “present and responsive” while others were “hard to reach when issues come up.” These differences influenced staff perceptions of whether they could rely on leadership during difficult situations, directly affecting their willingness to remain in the organization.

Theme 2: Structural Inefficiency and Bureaucracy

Employees described structural inefficiencies as a daily barrier that influenced their decisions about retention. Some participants stated that processes felt “disorganized” or “inconsistent,” making routine tasks more difficult than necessary. Others described a bureaucratic environment where changes were “rolled out without clear direction,” requiring staff to adapt with little guidance. These inefficiencies contributed to frustration and affected participants’ sense of stability and predictability within the organization.

Theme 3: Staffing Shortages and Turnover

Staffing shortages were one of the most frequently cited organizational factors influencing retention. Participants reported that units were “often short two or three people,” forcing remaining staff to “take on twice the workload.” Some explained that shortages felt constant and created a cycle where “people burn out and leave before

things improve.” These accounts demonstrate how persistent turnover increases strain and makes long-term employment feel unsustainable for many staff.

Theme 4: Workload Overload and Role Creep

Participants described workload overload as a major factor affecting their desire to remain in their positions. Many shared that their caseloads were “too heavy” or that responsibilities expanded regularly without additional support. One participant stated that staff are “pulled in too many directions,” while another explained that workload pressures made it “hard to imagine staying long term.” These experiences highlight how heavy workloads reduce organizational commitment by contributing to fatigue and emotional depletion.

Theme 5: Training and Onboarding Gaps

Training quality and onboarding effectiveness also shaped retention decisions. Several participants reported that training was “minimal” or “not enough to feel prepared” for the realities of the job. Others described inconsistent training practices across units, with some staff receiving “thorough instruction” while others were “expected to figure things out on their own.” These gaps left many feeling unsupported during critical early stages of employment, weakening confidence and long-term commitment.

Theme 6: Pay and Compensation Inequity

Compensation emerged as a clear organizational factor influencing retention. Participants frequently noted that pay “does not match the work we do,” especially given the high-risk and high-stress nature of their roles. Others described situations in which

new hires were paid more than long-term staff, which they felt created inequity and reduced motivation to stay. These perceptions of compensation misalignment made employees question whether remaining with the organization was financially or professionally worthwhile.

RQ2 Findings

Theme 1: Communication and Transparency

Participants frequently described leadership communication as a defining component of organizational culture. Several explained that communication at the organizational level was “often unclear or inconsistent,” leaving staff uncertain about expectations and priorities. One participant shared those updates “usually come after the change already happens,” which made them feel disconnected from decision-making. Another described communication as “moderately ineffective,” noting that information “gets lost” between departments. These perceptions shaped how employees interpreted cultural openness and influenced their sense of belonging within the organization.

Theme 2: Recognition and Value

Feeling valued emerged as an important cultural factor affecting retention. Some participants stated they felt “rarely recognized” for their work, while others explained that appreciation was “inconsistent” and depended largely on individual supervisors. One staff member shared that leadership “says thank you sometimes, but it feels routine,” suggesting that recognition efforts lacked authenticity. Another participant described feeling “unseen,” explaining that significant efforts often go unnoticed. These

experiences contributed to a cultural climate where many employees questioned whether their work was genuinely valued.

Theme 3: Organizational Culture and Climate

Participants described the culture as mixed, mission-driven yet emotionally taxing. Some noted that the organization fosters “compassion for clients,” which they identified as a cultural strength. However, others described the climate as “high stress” and “emotionally draining,” shaped by frequent crises and limited support. Another participant described the culture as “hierarchical and disconnected,” explaining that staff often feel removed from broader organizational decisions. These accounts show how cultural norms, both positive and negative, shape employees’ emotional connection to the workplace.

Theme 4: Equity, Inclusion, and Respect

Concerns about fairness and inclusion also influenced participants’ views of organizational culture. Several employees expressed frustration with practices they perceived as inequitable, such as promotions “not based on merit” or inconsistent enforcement of policies. One participant explained that certain staff “get away with more,” which created a sense of double standards. Others noted that they did not always feel respected when raising concerns, with one explaining that staff are “heard but not always taken seriously.” These experiences contributed to a cultural environment where fairness and respect affected employees’ decisions to remain.

Theme 5: Trust and Psychological Safety

Participants emphasized that trust and psychological safety were uneven across the organization. Some described feeling comfortable sharing concerns with their supervisors, noting that their immediate teams were supportive and communicative. However, others reported that raising issues sometimes led to “nothing happening,” which reduced trust in leadership follow-through. One participant said they were “cautious about what to say” due to fear of being judged or ignored. These mixed experiences demonstrate how trust and psychological safety influence staff comfort, engagement, and retention.

Theme 6: Team Cohesion and Peer Support

Many participants described peer relationships as a positive and stabilizing cultural force. One staff member noted that coworkers “support each other every day,” especially during stressful shifts. Another described their team as “the reason I’m still here,” highlighting the role of interpersonal support in fostering cultural connection. However, participants also acknowledged that cohesion varies between units, with some teams being “very divided.” These differences show how team culture directly shapes employees’ sense of community and influences their decision to stay or leave.

RQ3 Findings***Theme 1: Team Cohesion and Peer Support***

Participants consistently described peer relationships as one of the most stabilizing dynamics influencing their decision to remain employed. Several emphasized that coworkers “help each other get through the day,” especially during difficult shifts.

One participant explained that their team “is the only reason I haven’t left yet,” highlighting the significance of mutual support in an otherwise stressful environment. These accounts illustrate that strong interpersonal bonds can offset organizational challenges and encourage retention.

Theme 2: Morale and Emotional Climate

Workplace morale played a substantial role in shaping employees’ stay-or-leave decisions. Some participants described morale as “low” due to ongoing challenges and limited recognition, while others stated that the emotional climate “changes day to day” depending on staffing levels and unit conditions. One participant reported feeling “drained before the day even starts,” reflecting how chronic stress affects interpersonal interactions and overall workplace atmosphere. These experiences show how emotional climate directly influences job satisfaction and retention.

Theme 3: Burnout and Compassion Fatigue

Burnout emerged as a common interpersonal dynamic that undermines long-term commitment. Participants described feeling “exhausted,” “overwhelmed,” or “emotionally worn down” by repeated crises and demanding workloads. One staff member noted that burnout “makes you snap quicker,” affecting interactions with both coworkers and supervisors. Another explained that constant stress “changes how people talk to each other,” demonstrating how burnout disrupts team harmony and contributes to thoughts of leaving.

Theme 4: Safety and Security Concerns

Safety issues affected relationships and workplace dynamics by increasing tension among staff. Participants described incidents where coworkers were “assaulted” or “threatened,” explaining that these events created fear and anxiety within teams. One participant shared feeling that “nobody checks on you after something happens,” which weakened trust and emotional support among coworkers. These perceptions reveal how safety concerns strain interpersonal relationships and contribute to decisions about staying or leaving.

Theme 5: Accountability and Fairness

Participants reported that perceived inequities in accountability influenced how teams interacted and collaborated. Some explained that certain staff “get away with more than others,” while others described discipline practices as “inconsistent.” One participant noted that unfair treatment “makes people resent each other,” affecting team cohesion. These accounts highlight that fairness, and consistent expectations are central interpersonal dynamics that shape workplace relationships and influence retention.

Theme 6: Double Standards and Unequal Treatment

Several participants described double standards in leadership behavior or policy enforcement, which affected interpersonal trust. One staff member shared that “rules apply differently depending on who you are,” while another stated that some employees “can do whatever they want without consequences.” These experiences created interpersonal tension, eroded trust, and contributed to an environment where staff questioned whether remaining with the organization was worthwhile.

RQ4 Findings

Theme 1: Work–Life Balance and Flexibility

Participants described work–life balance as a significant contextual factor shaping their satisfaction. Several noted that long shifts and unpredictable demands made it difficult to maintain balance, explaining that the job “takes a lot out of you.” One participant shared feeling that work follows them home because the emotional strain “does not stop when the shift ends.” These experiences show how limited balance reduces commitment and increases burnout.

Theme 2: External and Environmental Pressures

Environmental pressures such as high acuity clients, crisis frequency, and the emotional toll of incidents influenced organizational commitment. One participant described the environment as “constantly stressful,” while another stated that the intensity of incidents makes staff “feel on edge most days.” These stressors affected overall satisfaction by making the work environment feel unpredictable and emotionally draining.

Theme 3: Commitment to Client Care and Mission Alignment

Despite challenges, many participants reported that their commitment to clients remains a strong motivator to stay. Several described the clients as “the reason we keep going,” and one participant explained that “the mission is what keeps most of us here.” These statements demonstrate how alignment with client-centered values can sustain organizational commitment, even when contextual conditions are difficult.

Theme 4: Staffing Shortages and Organizational Response

Participants consistently identified staffing shortages as a major environmental factor affecting satisfaction. Some reported that units were “short two or three people almost every day,” and others explained that shortages lead to “constant stress” and an inability to complete tasks safely. When staff felt unsupported during shortages, their overall commitment weakened, as they believed leadership “did not respond quickly enough” to address the issue.

Theme 5: Workload Intensity and Stress Levels

Workload intensity was repeatedly described as overwhelming. Participants shared that they often managed “more responsibilities than one person should,” creating chronic stress. One participant explained that the workload “makes it hard to imagine staying long term,” connecting high demands directly to reduced organizational satisfaction. These accounts show how heavy workloads undermine stability and long-term commitment.

Theme 6: Structural Inefficiency and Resource Limitations

Structural inefficiencies also shaped staff perceptions of their work environment. Participants described systems as “disorganized” or lacking clear processes, which increased frustration and slowed daily tasks. One participant stated that new initiatives “start but never follow through,” reducing confidence in organizational consistency. These resource limitations influenced satisfaction by making the environment feel unstable and difficult to navigate.

Analytic Validation and Reflexivity

Throughout the analysis, NVivo's memoing and query functions supported reflexive documentation of analytic decisions, ensuring transparency and traceability. Analytic memos captured researcher reflections on evolving interpretations and emerging relationships among themes, consistent with Finfgeld-Connett's (2018) guidance on maintaining analytic rigor through self-reflexivity. Peer debriefing and thematic cross-validation further ensured the internal consistency of coding categories and minimized researcher bias.

The methodological rigor was further reinforced through alignment with Creswell and Poth's (2016) validation strategies: triangulation across interviews, rich description to enhance transferability, and an audit trail documenting coding decision. The resulting 24 recurring themes provided a comprehensive interpretive framework for understanding how organizational, cultural, and environmental dimensions intersect to influence workforce retention.

Organizational Results

Organization's Client Programs, Services, and New Initiatives Effectiveness Results

Based on the collected evidence, the organization's client programs demonstrate a sustained commitment to serving vulnerable populations with behavioral and developmental support needs; however, the effectiveness of these services is uneven due to workforce shortages, inconsistent communication systems, and limited structural resources. Participants repeatedly emphasized that client care delivery often depends on "how many people we have on shift that day" rather than an established, predictable

model of service delivery. This inconsistency has led to variability in treatment continuity and the timeliness of interventions. Employees expressed pride in the organization's mission and alignment with public health goals, with one clinician noting that "the clients are why most of us stay." However, this dedication is often undermined by administrative constraints and limited follow-through on new initiatives aimed at improving service coordination. Staff reported that some pilot wellness and trauma-informed care programs "never went anywhere" due to funding delays and leadership turnover, reflecting systemic instability that impedes sustainable improvement (Creswell & Poth, 2016; Merriam & Tisdell, 2015).

Participants also described how client safety protocols and service quality are directly affected by gaps in violence prevention, coordination with Adult Protective Services (APS), and crisis management systems. Several direct care professionals shared that they have experienced or witnessed workplace aggression from clients with acute behavioral challenges. "You just hope the shift goes by without something happening," one respondent said, describing the fear and unpredictability of certain units. When violent incidents occurred, employees felt that the organization's response was reactive rather than preventive. Some noted that "management only steps in after it's already escalated." These findings indicate that while client-centered programs are conceptually aligned with safety and trauma-informed frameworks, the implementation remains incomplete. Literature supports that underdeveloped safety protocols and inadequate debriefing structures can negatively influence both client outcomes and workforce stability (HRSA, 2024; Finfgeld-Connett, 2018).

The interaction with APS emerged as a critical area influencing both service outcomes and staff stress. Many employees described APS reporting as a necessary but emotionally taxing process. They felt that “APS involvement is supposed to protect the client, but sometimes it feels like we’re being investigated instead of supported.” This tension points to systemic fragmentation between the organization and state oversight entities, creating duplicative burdens that reduce service efficiency and morale. Strengthening coordination with APS and developing clearer internal procedures for incident documentation and follow-up could improve client outcomes while supporting staff accountability without punitive overtones. As participants emphasized, the organization’s mission-driven approach remains strong, but its true effectiveness will depend on creating safer, better-coordinated, and ethically grounded systems that align with trauma-informed best practices and staff input (Miles & Huberman, 2014; Saldaña, 2021).

Organization’s Client-Focused Results

Based on the evidence collected from interviews with directors, supervisors, and direct care staff, the organization’s client-focused results reveal both significant strengths and systemic challenges in meeting the behavioral and developmental needs of its clients. Many participants described the organization as a “lifeline” for clients who would otherwise lack access to consistent, compassionate care. Staff demonstrated deep commitment to client well-being and a strong sense of personal responsibility, often “staying late or working through breaks” to ensure clients were stabilized and safe. This sense of purpose reflects alignment with the organization’s mission to serve underserved

populations. Although Merriam and Tisdell (2015) do not examine employee retention directly, their work demonstrates how intrinsic motivation and humanistic meaning-making shape individuals' lived experiences in organizational settings.

This literature supports the idea that many staff remain committed because their personal values align with the mission and the meaningful nature of their work. However, despite strong staff commitment, the quality and continuity of client care were reported to fluctuate due to understaffing, inconsistent communication between departments, and limited availability of evidence-based resources. Participants indicated that “clients get the best care when the unit is fully staffed, but that’s not the reality most days.” These accounts suggest that client outcomes are dependent not only on program design but on organizational capacity to support staff and maintain operational stability (HRSA, 2024).

Several participants described positive client outcomes resulting from individualized treatment plans, community reintegration programs, and crisis stabilization efforts. For instance, one clinician stated that “seeing clients transition back into independent living is what makes it worth it.” Such outcomes demonstrate the effectiveness of person-centered interventions when resources and staffing align with treatment goals. Yet, staff also acknowledged that successes often occur “in spite of the system rather than because of it.” Gaps in follow-up care, turnover among clinical teams, and limited multidisciplinary collaboration sometimes result in fragmented support. Participants emphasized the need for more holistic approaches integrating mental health, medical, and social support, consistent with the literature on wraparound and trauma-

informed care (Finfgeld-Connett, 2018; Saldaña, 2021). Moreover, some reported that new initiatives, such as family engagement workshops and peer support models, had potential to enhance client trust and continuity but lacked sustained administrative backing to achieve measurable impact.

A major barrier to consistent client-focused success involves the handling of safety incidents and the organization's interactions with Adult Protective Services (APS). Direct care staff recounted that APS interventions are often triggered by systemic failures, such as communication breakdowns or delayed incident responses, rather than individual neglect. One supervisor reflected, "APS calls don't always mean abuse, they mean something in the system isn't working." Employees noted that while APS oversight aims to protect clients, the process can also create distress among staff who fear blame rather than collaborative problem-solving. This observation aligns with findings in qualitative organizational research that systems accountability, when overly punitive, can erode trust and impede learning (Miles & Huberman, 2014; Thornberg & Charmaz, 2014). Despite these tensions, participants overwhelmingly emphasized their dedication to client dignity, safety, and empowerment. Several staff members described creating informal peer systems to ensure that "no client slips through the cracks," reflecting a culture of compassion and ethical responsibility even amid structural strain. The findings indicate that while the organization's client-centered philosophy remains intact, its realization requires stronger cross-departmental collaboration, improved APS coordination, and a sustainable staffing model to achieve consistent and measurable client outcomes.

Organization's Workforce-Focused Results

The analysis of workforce-focused results reveals a staff population that demonstrates remarkable dedication to client care despite chronic organizational stressors, limited resources, and a culture of emotional exhaustion. Across interviews, participants emphasized that the workforce's commitment to the mission is often the main factor sustaining service delivery under challenging conditions. As one clinician remarked, "We stay because we care about the clients, not because it's easy." This intrinsic motivation aligns with research showing that a strong sense of professional purpose and compassion satisfaction are primary buffers against turnover in behavioral health organizations (Creswell & Poth, 2016; Merriam & Tisdell, 2015). However, the data also indicate that structural inefficiencies, unclear communication channels, and minimal recognition contribute to a cycle of burnout and disengagement. Staff repeatedly reported feeling "unseen" or "unsupported" by leadership, particularly during crises. One employee stated, "You can report something serious, and it feels like it goes into a black hole." This perception reflects a gap between organizational rhetoric around staff support and the lived experience of workers, consistent with findings from Miles and Huberman (2014) that organizational inconsistency in reinforcement mechanisms undermines morale and psychological safety.

Workforce instability remains a significant concern, driven by turnover, safety fears, and insufficient professional development opportunities. Employees described an environment where "good people burn out and leave before real change happens." Participants linked burnout to high caseloads, unpredictable scheduling, and exposure to

client aggression without sufficient institutional response or protective measures. Many noted that while the organization provides basic training, “there’s no preparation for when a client becomes violent.” Several recounted experiences of being physically or verbally assaulted, with one staff member saying, “It’s not just the incident, it’s how alone you feel afterward.” These narratives align with HRSA (2024) findings that behavioral health workers experience elevated rates of occupational violence and trauma-related stress, often exacerbated by organizational silence or blame. Staff also expressed concern that workplace violence reports are inconsistently managed, and debriefings are rare. The absence of structured psychological support after such incidents leaves employees vulnerable to compassion fatigue and emotional disengagement (Finfgeld-Connett, 2018; Saldaña, 2021).

Despite these challenges, many staff members identified opportunities for improvement rooted in internal collaboration and leadership accountability. Some participants praised specific supervisors who “listen and actually show up when something goes wrong,” underscoring the role of relational trust in workforce resilience. However, they also noted disparities between supportive individual leaders and the broader organizational culture, which was described as “hierarchical and disconnected.” This dissonance contributes to inconsistent implementation of retention initiatives such as mentorship programs, wellness activities, and recognition systems. Employees emphasized that workforce empowerment and engagement require consistent follow-through, not symbolic gestures. As one respondent put it, “You can’t send an appreciation email and ignore safety reports, it doesn’t work that way.” Literature supports that visible

leadership presence, participatory decision-making, and transparent feedback loops are critical to workforce stability in human services organizations (Thornberg & Charmaz, 2014; HRSA, 2024). Overall, the workforce-focused findings highlight an organization rich in human compassion but constrained by systemic fatigue, uneven communication, and insufficient safety infrastructure. Addressing these deficits is essential not only for staff retention but also for the quality and ethical integrity of client care.

Organization's Leadership and Governance Results

The findings reveal a leadership structure characterized by both strong mission orientation and fragmented execution. Participants consistently expressed respect for the organization's overarching mission to serve individuals with behavioral health and developmental needs, yet they described a leadership culture that often fails to translate this mission into consistent operational support. Several participants remarked that "the mission is clear, but leadership doesn't always practice what they preach." This gap between strategic intent and daily practice reflects what Creswell and Poth (2016) describe as a "disconnect between espoused values and enacted values" common in organizations under chronic systemic strain. Employees reported that decisions are often made without staff consultation, resulting in feelings of disempowerment and disconnection. Supervisors and direct care staff noted that leadership visibility in the workplace was limited, and communication from upper management was frequently delayed or unclear. As one employee observed, "We usually find out about changes after they've already started." These perceptions suggest deficiencies in governance

transparency and communication flow that weaken organizational trust and reduce staff engagement (Miles & Huberman, 2014; Merriam & Tisdell, 2015).

Leadership responsiveness emerged as a defining theme across interviews. While some participants acknowledged supportive individual supervisors, the broader leadership system was perceived as reactive rather than proactive. For example, several staff members mentioned that leadership interventions typically occurred “after an incident” rather than through preventative planning. This reactive culture was particularly evident in how leadership managed crises involving client aggression or Adult Protective Services (APS) investigations. Employees described these situations as “chaotic” and “handled differently every time,” with one participant stating, “When APS is called, leadership disappears until it’s over.” Such accounts highlight inconsistent governance practices that foster uncertainty and emotional fatigue among staff. In behavioral health systems, this inconsistency can erode psychological safety and impede open communication, both of which are essential for workforce stability and client protection (Fingfeld-Connett, 2018; HRSA, 2024). Moreover, the lack of structured debriefing or follow-up after critical incidents contributes to a perception of leadership detachment from the realities of frontline care.

Despite these challenges, participants also identified leadership potential and emerging efforts toward improvement. Several directors and supervisors reported recent attempts to strengthen cross-departmental collaboration and accountability through team meetings, feedback sessions, and quality improvement initiatives. However, staff emphasized that such initiatives “start strong and then fade away,” suggesting a need for

sustained governance mechanisms rather than short-term responses. This pattern aligns with the findings of Thornberg and Charmaz (2014), who note that sustainable organizational change in qualitative systems requires consistent reinforcement of learning structures and leadership modeling. Employees expressed a desire for more participatory governance models, where decision-making includes input from staff who work directly with clients. One direct care worker summarized, “If leadership actually listened to what happens on the floor, we could fix half these problems.” This observation underscores that effective governance in behavioral health organizations is not only a matter of authority but of relational accountability and shared trust (Saldaña, 2021). Strengthening these connections could transform the organization’s leadership from a hierarchical command system into a collaborative learning network capable of adapting to workforce and client needs in real time.

Organization’s Financial and Marketplace Performance Results

The financial and marketplace evaluation reveals that while the organization fulfills a critical public mission in behavioral health, its financial constraints and limited operational resources significantly affect both workforce stability and service delivery. Participants repeatedly cited inadequate compensation, lack of wage progression, and insufficient resources as barriers to recruitment and retention. One direct care employee noted, “People can make more at fast food than working here, and we’re dealing with life-and-death situations.” This perception of inequitable compensation reflects systemic trends identified by the Health Resources and Services Administration (2024), which reports that behavioral health professionals in publicly funded settings consistently earn

less than their counterparts in private systems despite performing comparably complex work. Participants linked these financial challenges to staffing shortages that, in turn, compromise client outcomes and increase workplace stress. As one supervisor explained, “When there aren’t enough of us, the quality-of-care drops, and everyone pays the price, the clients and the staff.” These findings suggest that financial instability not only undermines competitiveness in the labor market but also reinforces a cycle of burnout and attrition that limits long-term organizational growth (Miles & Huberman, 2014; Merriam & Tisdell, 2015).

Participants also emphasized how the organization’s dependence on state contracts and public reimbursement mechanisms constrains flexibility in financial planning. Leadership staff noted that delays in state payments and shifting regulatory requirements often create budget uncertainty. A director explained, “We can’t plan six months ahead because we don’t know what the funding will look like.” This uncertainty affects the organization’s ability to invest in workforce development, safety infrastructure, and program innovation. Employees described new initiatives, such as wellness programs and staff recognition efforts, that were launched but quickly halted due to funding interruptions. One clinician stated, “They start programs with good intentions, but the money always runs out before anything sticks.” This inconsistency undermines employee confidence in leadership’s ability to sustain improvements and weakens the organization’s reputation in the behavioral health marketplace.

Despite fiscal limitations, participants acknowledged that the organization maintains strong community recognition as a vital provider of behavioral health services

in an underserved region. Several staff members described pride in working for “the only place some clients can go and feel understood.” This reputation contributes to a modest but meaningful competitive advantage in community trust, even as the organization struggles to offer competitive pay. However, staff also noted that financial strain forces trade-offs that compromise care quality, such as limiting professional training or reducing shift coverage. These trade-offs were viewed by employees as both pragmatic and ethically troubling. One participant summarized, “We do the best with what we have, but sometimes it feels like we’re being asked to choose between our safety and the client’s needs.” The literature supports that sustainable financial and marketplace performance in public behavioral health systems requires alignment between funding models, staff compensation, and organizational mission (Thornberg & Charmaz, 2014; HRSA, 2024). To ensure viability, the organization must strengthen its advocacy efforts for equitable reimbursement, implement transparent financial communication, and pursue strategic partnerships to expand its fiscal resilience and marketplace standing without compromising service equity or staff well-being.

Findings in Terms of Individuals, Organizations, Communities, and Systems

The findings from this qualitative study reveal a deeply interdependent relationship between individual staff experiences, organizational culture, and the larger behavioral health system. At the individual level, participants described both pride and strain in their roles. Many expressed a profound emotional commitment to serving vulnerable clients, explaining that “even when it’s hard, you don’t just walk away.” However, this commitment was frequently tested by emotional fatigue, safety concerns,

and inconsistent organizational support. Workers shared experiences of client violence, threats, and the psychological aftermath of those events, with one participant stating, “You’re scared to say something because you don’t want to seem weak or dramatic.” These emotional burdens have significant implications for individual well-being, reinforcing national findings from the Health Resources and Services Administration (2024), which identify burnout, compassion fatigue, and trauma exposure as major drivers of workforce attrition in behavioral health. Without structured debriefing, supervision, or counseling mechanisms, individuals face elevated risk of long-term stress and emotional disengagement, conditions that undermine both personal and professional sustainability (Finfgeld-Connett, 2018).

At the organizational level, the implications of the findings are equally significant. The data reveal that leadership practices, communication breakdowns, and insufficient safety infrastructure directly shape retention and performance outcomes. When staff reported not being heard or supported after incidents, it weakened their sense of belonging and professional identity. As one clinician reflected, “It’s not the violence itself, it’s how leadership ignores it.” This disconnects highlights how governance failures at the organizational level cascade into morale and retention crises. Literature supports that organizations that neglect workforce voice and safety compromise not only job satisfaction but also the quality of care delivered to clients (Merriam & Tisdell, 2015; Thornberg & Charmaz, 2014). Furthermore, limited financial resources restrict the organization’s ability to invest in professional development and recognition systems, leading to diminished internal advancement pathways. Participants noted that “there’s

nowhere to move up to,” illustrating structural stagnation that constrains growth. These findings underscore the urgent need for systemic workforce stabilization strategies, including trauma-informed supervision, equitable pay reform, and participatory leadership development programs that link employee input to organizational decision-making.

The community and systems-level implications extend beyond the organization itself. As a public behavioral health entity serving clients with complex needs, this organization occupies a crucial position within a broader care ecosystem that depends on continuity and trust. Participants described how staff turnover and burnout lead to disruptions in client relationships, sometimes resulting in repeated crises or re-hospitalizations. One employee explained, “When clients lose another trusted staff member, they spiral, it affects their whole treatment plan.” Such disruptions undermine community confidence in service reliability, particularly for families already navigating poverty, trauma, and limited access to care. These systemic patterns reflect national behavioral health workforce trends identified by HRSA (2024), where understaffing and high attrition threaten service continuity in underserved populations. On a larger scale, these findings call for policy and funding reforms that link reimbursement rates to workforce well-being and retention outcomes. Strengthening coordination among behavioral health agencies, public health departments, and community organizations could foster shared accountability for outcomes and improve resilience across systems. As Creswell and Poth (2016) emphasize, sustainable social systems depend on

continuous learning structures that integrate individual insight with institutional adaptation, a principle that must guide behavioral health governance moving forward.

Potential Implications to Positive Social Change

The findings of this qualitative study hold significant potential for positive social change by illuminating how structural, cultural, and leadership conditions within state-operated behavioral health organizations shape both workforce sustainability and client well-being. At the individual level, the results underscore the urgent need to establish trauma-informed, psychologically safe environments for employees who routinely encounter violence, emotional distress, and moral injury. Participants' accounts of fear, exhaustion, and isolation following critical incidents highlight the need for systems of care that extend to caregivers themselves. Implementing structured debriefing sessions, peer support programs, and access to behavioral health counseling for employees could help prevent the chronic stress and secondary trauma that often drive turnover in this field. As one staff member shared, "We tell clients to take care of their mental health, but no one checks on ours." By modeling organizational empathy and proactive support, the agency can serve as an exemplar of workforce-centered healing practices, aligning directly with national calls from the Health Resources and Services Administration (2024) for behavioral health systems that treat provider well-being as a public health priority.

At the organizational level, the study's findings suggest that embedding transparency, participatory decision-making, and equitable recognition practices can create a cultural shift toward inclusivity and trust. When employees perceive fairness,

responsiveness, and visible leadership commitment, they are more likely to invest emotionally in the organization's mission and deliver consistent, high-quality care. Participants described wanting leaders "who listen, not just manage," emphasizing the transformative power of relational governance. Structural reforms that include staff representation on safety and quality committees, as well as accessible reporting channels for workplace concerns, could strengthen both accountability and morale. According to Merriam and Tisdell (2015), such participatory approaches bridge the gap between formal leadership and lived workforce realities, fostering an environment where social change begins within the organization itself. Moreover, linking workforce stability to improved client continuity of care demonstrates how internal organizational equity can produce broader social benefits, reducing crisis events, improving service reliability, and fostering public trust in behavioral health systems.

At the systemic level, the implications of this research extend to public policy, workforce development, and community engagement. The recurring themes of underfunding, staffing shortages, and safety concerns mirror national workforce crises documented by HRSA (2024) and other federal agencies. This study reinforces the necessity of policy reforms that link funding to measurable workforce well-being outcomes, such as retention rates, safety climate indicators, and training participation. Investing in equitable pay structures, professional growth pipelines, and interagency collaboration models would not only improve recruitment and retention but also enhance care continuity for vulnerable populations. Several participants spoke passionately about wanting to see "a system that values people as much as paperwork," signaling a broader

desire for moral and cultural transformation in public behavioral health. The study's implications align with Creswell and Poth's (2016) assertion that positive social change in human service systems emerges from integrating individual voices into institutional and policy-level redesign. By amplifying the lived experiences of behavioral health professionals, this study provides a framework for translating frontline insight into systemic reform, helping to build a more just, resilient, and compassionate behavioral health infrastructure.

Strengths and Limitations of the Study

The primary strength of this qualitative study lies in its depth of inquiry and the richness of the data collected from frontline behavioral health professionals who directly experience the organizational dynamics influencing workforce retention. Through the use of semistructured interviews, the study captured complex, nuanced narratives from behavioral health clinical staff, supervisors, and directors across multiple service units. Their firsthand perspectives provided valuable insight into the intersection of leadership responsiveness, workload demands, communication practices, and emotional safety within a state-operated behavioral health organization. Thematic saturation was achieved after repeated patterns and convergent perspectives emerged from the data, reinforcing the validity and trustworthiness of the findings (Creswell & Poth, 2016; Miles et al., 2014). By focusing on diverse professional roles within the behavioral health system, the study illuminated how structural constraints and leadership practices jointly shape organizational commitment, employee resilience, and the perceived quality of client care.

Another major strength of this research was its use of rigorous qualitative analysis guided by grounded theory principles. Coding and theme development were conducted using NVivo software to ensure systematic categorization of data and cross-case comparisons, which enhanced the reliability and credibility of findings (Thornberg & Charmaz, 2014). The inclusion of multiple layers of participants, clinical staff, supervisors, and directors, allowed for triangulation across hierarchical levels, strengthening the analytical rigor and depth of interpretation. Additionally, the study's alignment with post-2022 behavioral health workforce literature and its grounding in empirical evidence from federal and state sources such as the Health Resources and Services Administration (2024) and the Texas Health and Human Services (2024) provided an evidence-informed context for interpreting results. This methodological and theoretical alignment supports the study's contribution to both organizational research and practical workforce development strategies within state-operated systems.

Despite its contributions, the study faced several notable limitations. Recruitment challenges emerged as an initial barrier to data collection. During the first call for participants, few staff volunteered, likely due to competing job demands, limited trust in research processes, and ongoing stressors related to staffing shortages. However, after a second call for participation and additional communication with department leadership, a broader range of behavioral health clinical staff, supervisors, and directors agreed to participate. This delay slightly extended the data collection timeline but ultimately enriched the dataset by including more diverse experiences across service divisions. The study was limited to behavioral health staff and did not include nurses, physicians, or

social workers, as their participation was restricted by the organization's internal policy. While this decision maintained ethical compliance and institutional boundaries, it also narrowed the scope of perspectives and limited the cross-disciplinary applicability of the findings.

An unanticipated limitation of the study was the emotional intensity of participant narratives, particularly concerning workplace violence, burnout, and systemic inequities. Several participants described distressing incidents that revealed deeper organizational and cultural challenges than initially anticipated. While these disclosures provided powerful insights into the psychological burden of behavioral health work, they also highlighted the need for continued ethical sensitivity in qualitative research involving emotionally vulnerable participants (Finfgeld-Connett, 2018). Additionally, as with most qualitative studies, findings are context-bound and may not be generalizable to all state-operated behavioral health systems. Nevertheless, the transferability of insights remains strong due to the study's detailed contextualization, transparent methodological process, and alignment with national behavioral health workforce trends (HRSA, 2024; Merriam & Tisdell, 2015). Overall, while recruitment limitations and participant scope constrained the breadth of the sample, the study's methodological rigor, data saturation, and rich thematic depth ensured that the findings provide credible, actionable understanding of workforce retention dynamics in state-operated behavioral health settings.

Section 5: Recommendations and Conclusions

Recommendations

The findings from this qualitative study revealed systemic, structural, and cultural factors shaping workforce retention within the behavioral health organization. Analysis of the 20 participant interviews and 24 coded themes suggested that workforce stability depends on the integration of trauma-informed supervision, psychological safety, equitable recognition systems, and transparent communication across all operational levels. Employees consistently emphasized that the organization's mission, to deliver high-quality behavioral health care to vulnerable populations, is deeply meaningful but undermined by insufficient support structures, unclear accountability, and inconsistent leadership responsiveness. The data point to the need for multilevel interventions addressing both organizational climate and leadership capacity.

Behavioral Health Workforce Retention Framework

The first recommendation involves implementing a comprehensive Behavioral Health Workforce Retention Framework anchored in organizational psychology and trauma-informed leadership principles (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). This framework aligns with national workforce priorities that emphasize career development, leadership pipelines, and wellness integration (Health Resources and Services Administration [HRSA], 2024). Participants frequently reported emotional exhaustion, moral distress, and limited advancement opportunities, which collectively reduced engagement and organizational commitment.

Addressing these issues requires formalizing professional development plans, leadership mentoring, and reflective supervision for clinical and non-clinical staff.

Leadership Communication and Feedback Accountability Plan

To strengthen trust and transparency, the organization should establish a Leadership Communication and Feedback Accountability Plan modeled on workforce competency guidance that promotes participatory communication, equitable recognition, and performance feedback cycles (National Association of State Directors of Developmental Disabilities Services [NASDDDS], 2023). Participants described inconsistent communication between administrators and direct-care employees, with several noting that “leadership doesn’t always hear us until a crisis occurs.” Instituting quarterly town halls, structured listening sessions, and shared governance committees would provide bidirectional communication channels, reinforcing inclusivity and employee agency. Transparent communication also ensures alignment between leadership and frontline staff in decision-making, improving morale and organizational trust (Texas Health and Human Services, 2024).

Wellness and Resilience Strategy

A third recommendation is the development of a wellness and resilience strategy to mitigate burnout and compassion fatigue. Several participants recounted episodes of workplace violence and inadequate responses from leadership, revealing gaps in safety culture and trauma-informed crisis management. This strategy should include de-escalation training, employee assistance programs, and critical incident response teams to safeguard psychological health. SAMHSA (2020) emphasizes that employee resilience

and wellness directly influence client outcomes and retention, underscoring the importance of addressing workforce trauma as part of an organization's sustainability efforts. Implementing ongoing peer support and restorative circles would also align with trauma-informed care principles that promote safety, empowerment, and collaboration (Texas Health and Human Services, 2024).

Evaluation and Synthesis of Findings

The evidence collected through 20 in-depth interviews revealed that the behavioral health organization's primary challenge in workforce retention stems from systemic barriers in communication, leadership accountability, and the absence of structured support systems that sustain staff well-being. Employees repeatedly emphasized their deep commitment to serving vulnerable clients while struggling under inconsistent leadership, workload imbalances, and feelings of professional invisibility. Several participants voiced that "leadership does not communicate until there's a crisis," and others described emotional exhaustion from working short-staffed, with one noting, "we are committed to the clients, but we are breaking inside." These expressions reflected widespread burnout and limited psychological safety, issues consistent with the current literature, which identifies emotional fatigue and insufficient recognition as key predictors of turnover in behavioral health settings (HRSA, 2024; NASDDDS, 2023).

From the analysis of coded data, themes such as leadership responsiveness and emotional presence, communication and transparency, recognition and value, burnout and compassion fatigue, and commitment to client care emerged as interdependent variables influencing retention. The organization's strength lies in its mission-driven culture and

employee loyalty to the client population; however, its limitation is the lack of formalized systems to reinforce that culture through policy, mentorship, and trauma-informed supervision. This dissonance highlights the importance of leadership development and the integration of trauma-informed management practices that promote psychological safety, fairness, and consistent communication (Centers for Medicare & Medicaid Services [CMS], 2022).

Recommended Solutions

Based on the findings, four interrelated recommendations are proposed to address workforce instability and strengthen organizational culture.

Behavioral Health Workforce Retention Framework

First, the behavioral health organization should develop a Behavioral Health Workforce Retention Framework that integrates trauma-informed supervision, professional development pathways, and structured recognition programs. Each element should align with the Core Competencies for Direct Service Workers (CMS, 2022) and HRSA's (2024) workforce sustainability priorities. Participants indicated that professional growth and emotional validation were essential to retention, with one noting, "We stay when we feel seen and when there's room to grow." Therefore, the framework should incorporate a transparent performance evaluation process, mentorship for early-career staff, and targeted leadership training emphasizing equity, accountability, and resilience.

Communication and Feedback Accountability Plan

Second, the organization should implement a communication and feedback accountability plan. Consistent with the literature on high-performing behavioral health organizations (NASDDDS, 2023), leadership should establish formal communication channels, hold monthly listening sessions, implement anonymous feedback systems, and conduct shared governance meetings. Several participants expressed that communication breakdowns heightened stress and mistrust, while others described an “open door policy” that was not always accessible. Establishing structured dialogue mechanisms would ensure that staff feedback informs organizational policies, fostering transparency and trust across all levels.

Safety, Wellness, and Violence Prevention Strategy

Third, the organization should create a comprehensive safety, wellness, and violence prevention strategy. Participant narratives revealed significant emotional strain related to workplace violence, client aggression, and inadequate administrative follow-up. Employees recounted reporting violent incidents to leadership without timely resolution, which reinforced feelings of vulnerability. In response, the organization should establish a cross-departmental workplace safety and well-being program that incorporates de-escalation training, post-incident debriefing, and partnerships with local safety response teams. Trauma-informed leadership models emphasize that restoring trust after exposure to violence is critical for workforce resilience (Texas Health and Human Services, 2024).

Data-Driven Evaluation and Continuous Improvement Measures

Fourth, the organization should adopt data-driven evaluation and continuous improvement measures. Implementation must be monitored using mixed-method evaluation, retention metrics, employee climate surveys, and focus group feedback cycles. These outcomes should be reviewed quarterly by leadership teams to assess progress toward reducing turnover, improving communication, and strengthening psychological safety. Embedding continuous improvement aligns with evidence-based performance frameworks emphasizing adaptability and system learning (HRSA, 2024).

Implementation and Evaluation Procedures

Implementation of these recommendations should follow a structured, phased model to ensure feasibility and accountability. Decision-makers not involved in development can assign and supervise these actions without further planning, as each phase includes clear timeframes and measurable objectives.

Table 4

Implementation Plan for Behavioral Health Workforce Retention and Leadership Reform

Phases	Description	Timeframe
Phase 1	Leadership alignment and communication of study findings to executive and HR teams.	Months 1–2
Phase 2	Development of Workforce Retention Framework, including trauma-informed leadership curriculum and policy updates.	Months 3–6
Phase 3	Implementation of Communication and Safety Initiatives, including town halls and wellness training.	Months 7–12
Phase 4	Data collection and evaluation through climate surveys, retention metrics, and staff feedback groups.	Months 13–18
Phase 5	Continuous improvement cycle and policy revision based on evaluation outcomes.	Month 19 and ongoing

Note. Adapted from Core Competencies for Direct Service Workers (Centers for Medicare & Medicaid Services, 2022) and Behavioral Health Workforce Report to Congress (Health Resources and Services Administration, 2024).

The evaluation phase should utilize both quantitative and qualitative measures to monitor progress. Quantitative indicators include turnover rates, staff satisfaction scores, and absenteeism metrics. Qualitative feedback should be gathered through focus groups and reflective supervision sessions to evaluate perceived leadership responsiveness and workplace safety. Continuous monitoring of these data points allows for the identification of trends and early intervention in areas of decline. Leaders should communicate outcomes to all staff in quarterly reports, reinforcing accountability and transparency. As Creswell and Poth (2016) emphasize, cyclical evaluation in qualitative inquiry promotes reflexivity and organizational learning, ensuring that implemented interventions remain adaptive and relevant.

Recommendations for Future Studies

The results of this study provide a foundation for further exploration of workforce retention challenges and organizational behavior within public behavioral health systems. Future research should expand on these findings by incorporating additional professional groups such as nurses, social workers, psychiatrists, and medical support staff, whose perspectives were excluded due to organizational guidance during participant recruitment. Including these disciplines in future qualitative or mixed-methods research could help illuminate interprofessional dynamics and role-specific factors that influence retention. As noted by Creswell and Poth (2016), triangulation across diverse participant roles enhances the credibility and transferability of findings, leading to a more holistic understanding of workforce phenomena.

Longitudinal research should also be conducted to evaluate the effectiveness of the recommended Behavioral Health Workforce Retention Framework over time. Tracking key indicators, such as turnover rates, employee satisfaction, and psychological safety, over multiple years would help determine whether trauma-informed leadership practices produce sustained improvements in staff morale and retention. The literature on workforce sustainability emphasizes that consistent follow-up and data collection are critical to capturing the long-term impact of organizational interventions (Miles et al., 2014).

Future studies could also examine the intersection of demographic variables, such as gender, race, ethnicity, tenure, and educational background, with workforce retention experiences. The behavioral health workforce is disproportionately composed of women and people of color, populations that often encounter structural inequities in pay, promotion, and recognition (NASDDDS, 2023). By focusing on intersectionality, researchers can identify patterns of inequitable treatment that may influence organizational commitment and turnover intentions. These studies would not only contribute to the behavioral health literature but also support ongoing national discussions on diversity, equity, and inclusion (HRSA, 2024).

Finally, comparative studies across state-operated and community-based behavioral health agencies could reveal contextual variations in leadership practices, safety culture, and employee engagement. Conducting cross-site analyses using similar methodologies would enable policymakers and administrators to identify best practices that are adaptable across settings. Future research should therefore integrate multi-site

designs and participatory action methods to ensure that findings directly inform policy reform and leadership training models.

Dissemination Plan

The dissemination of findings from this doctoral study is essential to ensuring that the behavioral health organization and other stakeholders can use the results to inform practice improvement, leadership development, and workforce sustainability. The dissemination plan comprises two options, tailored to both internal and external audiences.

Option 1: Internal Dissemination

Internally, the findings will be presented to executive leadership, human resources administrators, and program directors within the behavioral health organization. This will be presented through a structured PowerPoint presentation and a written briefing that summarizes the methodology, major findings, and actionable recommendations. The presentation will highlight key retention drivers, including communication, psychological safety, and leadership consistency, supported by data visualizations such as coded theme frequencies and trend graphs.

I will facilitate a discussion following the presentation to ensure that decision-makers can ask questions, clarify findings, and prioritize implementation strategies. The briefing will include an executive summary that outlines the phased implementation plan (see Table 1 in Section 1) and assigns proposed roles and timeframes to ensure accountability. This dissemination approach follows guidelines for evidence translation

into organizational practice, emphasizing interactive engagement and participatory decision-making (SAMHSA, 2020).

Option 2: External Dissemination

For external dissemination, a “scrubbed” version of this doctoral study will be prepared to remove identifying information related to the behavioral health organization or study participants. This version will be submitted for presentation at professional conferences, including the Texas Behavioral Health Leadership Summit and the National Association of State Mental Health Program Directors Annual Conference. Additionally, the study will be considered for publication in peer-reviewed journals such as the Journal of Behavioral Health Services & Research and Administration and Policy in Mental Health.

External dissemination facilitates broader knowledge sharing among behavioral health professionals, policymakers, and researchers. Presenting the study’s findings at the state and national levels aligns with the HRSA (2024) workforce development priorities, which emphasize data-driven strategies to stabilize the behavioral health workforce. Dissemination will also promote dialogue about evidence-based leadership practices, trauma-informed organizational culture, and strategies to improve retention in high-stress care environments.

Executive Summary for Organizational Leadership and Committee Chair

The purpose of this qualitative study was to explore workforce retention in a state-operated behavioral health organization and to understand how leadership, organizational culture, and communication influence staff commitment, burnout, and

turnover. Data were collected through semistructured interviews with 20 behavioral health professionals, including clinicians, supervisors, and directors, and analyzed using inductive coding and thematic synthesis (Saldaña, 2021). Twenty-four themes emerged, grouped into five domains: workforce retention, leadership and governance, communication, safety and wellness, and social impact.

The study revealed that while employees of the behavioral health organization are strongly motivated by its mission to serve vulnerable populations, many experience emotional fatigue, unclear communication, and inconsistent leadership support. These challenges contribute to burnout, diminished engagement, and attrition. Despite these challenges, staff demonstrated resilience and expressed a shared desire to contribute to organizational improvement.

The study's key recommendations address the systemic and interpersonal factors affecting retention. They include developing a Behavioral Health Workforce Retention Framework, implementing trauma-informed supervision, creating structured recognition and reward systems, enhancing leadership communication, and promoting a culture of safety and wellness. Additionally, the study calls for greater data-driven accountability through regular evaluation of workforce metrics and employee engagement outcomes (HRSA, 2024).

The implementation plan includes a five-phase process: (1) leadership alignment, (2) development of the retention framework, (3) implementation of communication and safety initiatives, (4) data collection and evaluation, and (5) continuous improvement.

Each phase emphasizes transparency, collaboration, and employee empowerment, ensuring that leadership remains accountable for progress (CMS, 2022).

The implications of this study extend beyond the behavioral health organization. It contributes to the growing body of evidence that workforce retention is not solely dependent on compensation but is deeply connected to organizational empathy, fairness, and psychological safety. By incorporating trauma-informed leadership principles and participatory communication, behavioral health systems can cultivate environments that prioritize employee well-being as a vital component of service quality and public trust.

Conclusion

This qualitative study demonstrated that workforce retention within the behavioral health organization is shaped by the interaction between leadership behaviors, organizational culture, and systemic conditions. The findings revealed that communication breakdowns, lack of recognition, and limited psychological safety contribute to burnout and turnover, while mission alignment and commitment to client care remain powerful sources of motivation.

The recommendations presented in this study translate those findings into a practical roadmap for organizational reform. Implementing the proposed retention framework, safety and wellness strategies, and leadership accountability measures can foster a culture of trust, inclusion, and resilience. As emphasized by Miles et al. (2014), sustained organizational change requires continuous reflection, stakeholder engagement, and evidence-based evaluation to ensure that interventions remain responsive to evolving workforce needs.

The essential message of this study is that retaining behavioral health professionals requires more than financial incentives; it demands an ethical commitment to transparency, psychological safety, and equitable leadership. By addressing these systemic factors, the behavioral health organization can cultivate a stable, mission-driven workforce dedicated to delivering compassionate, high-quality care to the populations it serves. These findings also contribute to the broader field of behavioral health leadership, providing a foundation for future studies aimed at strengthening workforce sustainability across similar organizations.

Finally, a “scrubbed” copy of this doctoral study will be prepared for public presentation and publication. This version will preserve the academic rigor and integrity of the research while removing identifying details to protect confidentiality. The dissemination of this work is intended not only to inform local organizational reform but also to advance knowledge that supports national efforts to improve behavioral health workforce retention and well-being.

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Appendix: Semistructured Interview Questions

RQ1

How do mental health professionals in a state-operated behavioral health organization perceive organizational factors that influence their decision to remain employed?

Interview Questions

- How does the overall work environment in your current role influence your decision to stay or consider leaving?
- How do organizational supports for your health, safety, and well-being affect your decision to remain employed here?
- How does the organization's approach to managing workload and stress influence your decision to stay long term?

RQ2

What aspects of the organizational culture do mental health professionals identify as most influential in their retention decisions?

Interview Questions

- Which organizational values or norms most influence your loyalty and commitment to this organization?
- How does the communication style and transparency of leadership affect your decision to remain employed?
- How does leadership's responsiveness to staff concerns, including burnout or stress, influence your decision to stay?

RQ3

How do workplace dynamics and interpersonal relationships shape employees' decisions to stay or consider leaving?

Interview Questions

- How do your relationships with coworkers and supervisors influence your decision to stay or consider leaving?
- How do trust, collaboration, and support within your team affect your commitment to the organization?
- How have workplace conflicts or lack of recognition influenced your thoughts about staying or leaving?

RQ4

In what ways do environmental and contextual factors (e.g., workload, support systems, leadership) contribute to employees' sense of organizational commitment or satisfaction?

Interview Questions

- How does your current workload or caseload impact your satisfaction and commitment to the organization?
- How do staffing levels and the organization's response to shortages affect your decision to remain employed here?
- How do available support systems (such as wellness resources, training, or mentorship) influence your commitment to stay?