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Improving Clinician Wellbeing in Mental Health Care

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Abstract

Mental health issues among children and youth have steadily been on the rise in Canada. One of the ways that the Provincial Government of British Columbia addresses this issue is by employing mental health clinicians (MHCs) on various community mental health teams across the province. It is well established in the literature that community MHCs experience considerably high levels of occupational stress (OS) in their therapeutic roles (O'Connor et al., 2018). Chronic exposure to OS makes MHCs vulnerable to the compassion fatigue and burnout, which are considered occupational hazards (OHs) of mental health care (Bride et al., 2007; O'Connor et al., 2018). This organizational improvement plan (OIP) addresses the problem that MHCs at Strong Communities (SC), are insufficiently practicing stress-reducing behaviours, proportionate to the OS-levels that are typical in the field. This problem, and the vision for change, were explored through the lenses of critical theory and servant leadership. Organizational change readiness was assessed, and the Wellbeing Workout (WW) (Hughes et al., 2019) was chosen as the solution to the Problem of Practice. A change implementation plan was created to operationalize the WW as a team-based change initiative. This OIP is influenced by my position as an informal leader and a front-line MHC. I utilize Kouzes and Posner's (2017) Five Practices of Exemplary Leadership, and manage change using Change Path Model (Deszca et al., 2020) and Prochaska and DiClemente's (2005) Stages of Change model. The change initiative is evaluated using three Plan, Do, Study, Act cycles (Deming, 1994/2018). Although the primary goal of this change initiative will be to reduce OS and OHs for MHCs, the long-term ambition of the plan is for SC to be re-conceptualized as a vicarious trauma-informed organization.

Keywords: mental health clinicians, occupational stress, occupational hazards, compassion fatigue, burnout

Executive Summary

Community mental health clinicians (MHCs) often experience high levels of occupational stress (OS), which can arise from various occupational and organizational issues. While OS can be related to variables such as administrative requirements and workloads (Acker, 2010), it also includes compassion stress, which stems from the practice of psychotherapy itself (Figley, 2002). If OS is not sufficiently managed, MHCs are vulnerable to experiencing burnout and compassion fatigue (CF), which are considered to be occupational hazards (OHs) of providing mental health counselling (Bride et al., 2007; O'Connor et al., 2018). Despite high-levels of OS, and MHCs vulnerability to OHs, many mental health teams do not implement comprehensive stress-reducing practices.

The primary objective of this organizational improvement plan (OIP) is to better understand, and resolve, a specific Problem of Practice (PoP). The PoP is that MHCs at the organization Strong Communities (SC) are not sufficiently addressing the occupational stressors of providing community mental health care. The organizational context of this PoP is a community mental health team, called the professional counselling group (PCG). The PCG is a part of a provincial government organization called SC, in British Columbia. Once the PoP is thoroughly established, a vision for change is presented. The PoP and the vision for change are both conceptualized from the perspective of a front-line MHC. This OIP is informed by the epistemological lens of critical theory (CT), as well as through the lens of servant leadership (SL). Critical theory and SL lenses are evident throughout this plan, in the themes of reducing suffering (for MHCs and their clients), empowering MHCs, fostering trust, reducing authoritative leadership, and prioritizing care for MHCs and their clients.

The theoretical leadership stance in this OIP is SL, and a leadership approach that is applied is the Five Practices of Exemplary Leadership (FPEL) (Kouzes & Posner, 2017). These leadership perspectives combine the academic insights and philosophical considerations of SL, with experiential knowledge and practical direction of the FPEL. Although these leadership perspectives are primarily reported in in chapter 2, their influence extends throughout the entire document. Organizational change readiness was assessed by considering the eight themes that inform the Organizational Capacity for Change (OCC) construct (Judge & Douglas, 2009). The change readiness assessment confirmed that SC is ready for change, however, there is currently much movement in upper leadership. Because there is considerable hierarchical distance between the movement in leadership and the PCG, there is little threat to this OIP being successfully implemented.

Chapter 2 ends with a solution to the PoP being chosen. After considering the literature on the PoP, my agency as a front-line MHC, and the individual and team dynamics on the PCG, the Wellbeing Workout (WW) (Hughes et al., 2019) was chosen as the solution to the PoP. The WW is essentially a book on self-care that contains over 50 separate sessions. Each session focuses on a topic relating to wellbeing and fostering resiliency. The WW contains surveys, lessons, and activities. I plan to recruit a team of change implementers and a capable champion, to lead the implementation of the WW.

Even though the WW is anticipated to be effective, there is much more to this change initiative than reading the WW as a group. The change process is structured according to the Change Path Model (CPM) (Deszca et al., 2020), which outlines the four phases of this change initiative: awakening, mobilization, acceleration, and institutionalization. In addition to the organizational and team-based perspective of Deszca et al. (2020), the change plan will consider

the perspectives of individual MHCs, by utilizing Prochaska and DiClemente's (2005) SoC model. The SoC model identifies the pre-contemplative, contemplative, preparation, action, maintenance, and completion stages of change, and provides practical guidelines for change leaders to enhance the change process. This process is briefly reported on in chapter 2, before being thoroughly articulated in chapter 3.

The communication strategy and the monitoring and evaluation plans are presented in chapter 3. The larger communication strategy combines the CPM, the FPEL, and several smaller communication strategies that are identified by Lewis (2019). A monitoring plan was established to ensure that the change initiative is progressing as intended, and to ensure that MHCs are engaged in the change process. The Plan, Do, Study, Act (PDSA) cycle (Deming, 1994/2018) is the foundational evaluation framework for the change initiative. The change initiative will utilize three PDSA cycles, commensurate with the three sections of the WW. The *study* stage of the PDSA cycles will contain a Strengths, Needs, Opportunities, Threats (SWOT) analysis, to improve the change process and to consolidate learnings from the WW. The learnings from the SWOT analysis sessions will both enhance the change initiative, as well as inform the creation of an enhanced wellness resource. With the content and process knowledge gained through this change initiative, I will develop a wellness resource after the change initiative is complete. This will foster knowledge mobilization and help to more effectively address the PoP in the future.

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List of Acronyms

ACEs	(Adverse Childhood Experiences)
CF	(Compassion Fatigue)
CPM	(Change Path Model)
CT	(Critical Theory)
CYC	(Child and Youth Care)
EE	(Emotional Exhaustion)
FPEL	(Five Practices of Exemplary Leadership)
MHC	(Mental Health Clinician)
PCG	(Professional Counselling Group)
OH	(Occupational Hazard)
OIP	(Organizational Improvement Plan)
OS	(Occupational Stress)
PDSA	(Plan, Do, Study, Act)
PoP	(Problem of Practice)
SC	(Strong Communities)
SL	(Servant Leadership)
SoC	(Stages of Change)
STS	(Secondary Traumatic Stress)
SWOT	(Strengths, Weaknesses, Opportunities, Threats)
TIP	(Trauma-Informed Practice)
TTM	(Transtheoretical Model)
VT	(Vicarious Trauma)
WW	(The Wellbeing Workout)

Definitions

Burnout: A severe state of emotional exhaustion, often paired with high levels of cynicism and a reduced sense of personal accomplishment (O'Connor et al., 2018).

Compassion Fatigue (CF): A severe state of exhaustion and hopelessness that arises from the desire to relieve other people's suffering (Figley, 2002).

Compassion Stress (CS): Compassion stress is "the residue of emotional energy from the empathetic response to the client and is the on-going demand for action to relieve the suffering of a client" (Figley, 2002, p. 1437). Compassion stress is a form of occupational stress for mental health clinicians.

Emotional Exhaustion (EE): Continuously "feeling overburdened and depleted of emotional and physical resources" (O'Connor et al., 2018, p. 74). Emotional Exhaustion is a core attribute of burnout.

Languishing: A deficiency in mental health often characterized by mental illness (Keyes, 2002).

Flourishing: A state of mental health characterized by a positive emotional state and functioning (Keyes, 2002).

Occupational Hazard (OH): "Any workplace condition that causes a risk to employee health" (Shaw, 2023, n.p.), including their psychological health.

Occupational Stress (OS): Stress that a person experiences in relation to their occupational responsibilities. Occupational Stress is also known as workplace stress (Rees et al., 2015).

Wellbeing: A state of mental health and satisfaction in life, characterized by overcoming challenges and feelings of appreciation (Hughes et al., 2019).

Chapter 1: Problem Posing

Chapter 1 sets the stage for this organizational improvement plan (OIP) by providing necessary context. First, I situate myself and my unique role as a mental health clinician (MHC) who has been engaged in various front-line leadership opportunities for the past 10 years or so. Next, I provide a brief description of critical theory (CT), and I attempt to explicate its significance in my role as an informal leader and as an MHC. I then discuss my leadership approach. Subsequently, I describe my organizational context using pseudonyms for anonymity, and provide connections between CT, my leadership approach, and the organizational context. After the context is established, I identify the Problem of Practice (PoP) for this OIP and review the literature that is pertinent to the PoP through the theoretical and leadership lenses that have been established. Once the PoP is thoroughly described I identify several questions that will need to considered moving forward. This chapter concludes with a clearly outlined vision for organizational change.

Leadership positionality

As a MHC I am not in a formal leadership position. This is an important factor in contextualizing my leadership position and agency, as I do not have the responsibility and authority that is attached to a formal leadership position. I have, however, been granted informal leadership status in many ways—by multiple levels of formal leadership—which makes me an informal leader (Chiu et al., 2021). I have served as the acting team leader on a regular basis for approximately 5 years (including for 9 consecutive months in 2021), I have also been sponsored for a regional leadership succession program as well as an academic scholarship for leaders in Provincial government. In addition to these leadership roles, I am the co-chair of a committee, the only on-site supervisor for practicum students, the facilitator of clinical trainings at the

worksite, and the most experienced full-time MHC on the team by several years. These leadership roles give me influence in the workplace, which is "the true measure of leadership" (Maxwell, 1998, cited in Russel & Stone, 2002, p. 150).

I have a foundational leadership position that focuses on leading alongside people. My educational background is in Child and Youth Care (CYC), which has a strong focus on relationships compared to those who are trained in Psychology (Phelan, 2005). My experience has taught me to prioritize caring (Rogers, 1995) and relationships (Lafrance et al., 2020). Though this leadership experience may seem rudimentary, it has garnered follower trust, which is perhaps the most important aspect of leadership (Dirks & Ferrin, 2002; Kutsyuruba & Walker, 2015).

Theoretical Lens

This section is labeled theoretical "lens" because, similar to the lens on a microscope or a pair of glasses, a theoretical lens enables leaders to "see" themselves and their environments more clearly. Knowing one's theoretical lens is essential for leaders to accurately assess their present circumstances. My theoretical lens is CT, which is "attentive to power relations, aim[s] to raise consciousness, and, in doing so, seek[s] to emancipate those entangled in oppressive social dynamics" (Paradis, 2020, p. 843). In this subsection, I describe my adherence to CT in my work with clients, and in my role as a MHC and an informal leader.

Critical theory supports my work with children and youth in two key ways. First, it generates insight into their struggles by identifying the oppressive context in which they live. This can be helpful in understanding the reasons for behaviour. Zimić and Jukić (2012) provide a practical example of this, stating that "it is highly likely that a certain number of adolescents, whose early psychological development was rich in difficulties and frustrations, would try to

resolve an otherwise normal adolescent crisis by virtue of drug consumption" (p. 175). While a surface level analysis might recognize that a youth used drugs, an analysis through the lens of CT may consider the underlying casual factors. As Zimić and Jukić (2012) suggest, those who have experienced more "difficulties and frustrations", have worse outcomes. This is common knowledge in healthcare, where there is an abundance of literature on negative consequences of adverse childhood experiences (ACEs) (McDonald & Tough, 2014). A critical theorist would also attest to the macro perspective that these casual factors (e.g., childhood trauma) occur more frequently in the lives of marginalized individuals. The second way that CT supports my work with youth is that it validates their humanity instead of giving them a negative label. Validation is a key factor in building supportive relationship with clients, as well as supporting the development of emotional literacy and regulation (Lafrance et al., 2020). By validating clients through statements, such as, "of course you're exhausted, you're fighting against so many challenges", clients can feel connected and supported, which can increase their ability to make positive changes in their lives (Lafrance et al., 2020).

Capper (2019) notes that one of the assumptions of CT is that those working in organizations, such as many MHCs, are also suffering in some capacity. This is an accurate assumption, as Dr. Michael Kirby, from the Mental Health Commission of Canada, has stated that "it is clear that many providers of mental health service [in Canada] are themselves experiencing high levels of stress and other mental health problems" (Kirby, 2008, p.1321). While some MHCs may accept the status quo of suffering in their work, critical theorists insist on taking action to reduce suffering when possible (Churchill, 2008).

My foundational aim as a critical theorist is to reduce suffering for both MHCs and their clients. In order to reduce suffering in any sustainable way I must disrupt the systems that

perpetuate the respective suffering (Capper, 2019). Though this may seem like an abstract concept, it is often easy to recognize and act on, upon reflection. For example, I work with Indigenous clients on an unceded territory (specific details omitted for anonymization). I am also a government employee, and governments across Canada are still disproportionately removing Indigenous children from their homes compared to non-Indigenous children (Government of Canada, 2021). Although I cannot rectify this situation in any significant way, I have made small changes to show respect for Indigenous culture and to express my allyship. These include doing land acknowledgments when hosting meetings, changing my email signature to recognize the land that I am on, and offering to meet Indigenous clients in the community, as transit can be a barrier for people who live on Indigenous reserves. Through these actions, I hope to be supportive and possibly reduce suffering a little over time. I also adjust my therapeutic approach when working with Indigenous youth, knowing that most of the "evidence" that I have been trained to consider, came from psychological research involving adult white males studying other adult white males (Gitberg & Van Wyk, 2004).

Despite many people perceiving CT to be pessimistic and rigid (Thompson, 2017), proponents of CT actually see problems, even large systemic ones, as fluid and changeable (Brincat, 2012). This can foster encouragement and optimism for MHCs, by giving them hope that change is possible, particularly with the right leadership.

Leadership lens

I have a servant leadership (SL) approach to my work as a MHC, as well as in the various leadership roles that I have as an informal leader at my organization. The creator of SL, Robert Greenleaf, describes the sequence of becoming a servant leader, stating that it "begins with the natural feeling that one wants to serve, to serve *first*. Then the choice brings one to aspire to

lead…" (Greenleaf, 1970, cited in Northouse, 2019, p. 254). The prerequisite desire to serve is evident in my personal and professional experience, as well as my current title as a Public Servant for the people of British Columbia.

Eva et al. (2019) defined servant leadership as "(1) an action-oriented approach to leadership (2) manifested through one-on-one prioritizing of follower individual needs and interests, (3) and outward reorienting of their concern for self towards concern for others within the organization and the larger community" (p. 114). As I will describe, characteristics #1 and #3 of SL significantly overlap with CT, and characteristic #2 is somewhat synonymous with the role of being a MHC.

When characteristics #1 and #3 of SL are combined, they describe an action-oriented approach that is concerned with others and the community. Greenleaf (1977/2002) prompts leaders to do this by reflecting on how their actions impact others, particularly those who have less privilege. Capper (2019) takes this a step further, stating that if leaders are not moving others closer to equity, they are actually "uphold[ing] and perpetuat[ing] the status quo" (p.72). While both CT and SL focus on the importance of a leader's actions, they differ in what those actions, or lack of actions, imply about them as leaders. Servant leadership takes a softer approach, encouraging leaders to consider how their actions could support marginalized groups, whereas CT has a more binary approach, prompting leaders to help others to avoid being an oppressor.

Not only do CT and SL both have a focus on caring for others, particularly the marginalized members of society, but they also contain a skepticism of those in power. Capper (1998) describes people in power as blocking marginalized groups from advancing at work, and Graham (1991) suggests that servant leaders believe that both people and corporations can be inherently fallible, "capable of dangerous mistakes…, [and] encourag[ing] narcissism" (p. 111).

Servant leadership seems to describe power hierarchies as having flaws that could negatively affect marginalized groups. Critical theorists, according to Capper (2019) would take this one step further by claiming that those in power have oppressive intentions. While I agree with the focus on reducing the suffering of marginalized individuals through leadership action, I find Capper (2019) to be too condemning of leaders who fall short of this goal. I have a longer-term perspective that seeks to reduce suffering, without labeling leaders that fail to emancipate others at times.

There is considerable overlap between SL and psychotherapy. For example, Northouse (2022) states that "servant leadership emphasizes that leaders be attentive to the concerns of their followers, empathize with them, nurture them…., put followers first, empower them, and help them develop their full personal capacities" (p. 253). This description of SL is somewhat synonymous with the clinician-client dynamic in psychotherapy. Another consistency between SL and certain psychotherapeutic modalities is the concern that people in positions of power can harm people in the general population (Graham, 1991; Madigan, 2011; Rogers & Skinner, 1956). As noted above, these concerns are also evident in CT as well.

To summarize, there is much alignment with my theoretical lens, my leadership lens, and my informal leadership role as a MHC. Critical theory, SL, and psychotherapy all have a systems focus, in that they consider the implications that a person's environment has on their life (Madigan, 2011; Rogers & Skinner, 1956; Sensoy & DiAngelo, 2017; Spears, 1998). Servant leadership's beginnings may have been predominantly value-based (Greenleaf, 1977/2002); however, it has come a long way to become scientifically validated as well (Eva et al., 2019). Formal leadership at my organization has granted me the task authority to implement this OIP.

Though I am an informal leader, I was able to garner support for this OIP by communicating how it will help the PCG meet the directives of the organization's strategic plan.

Organizational Context

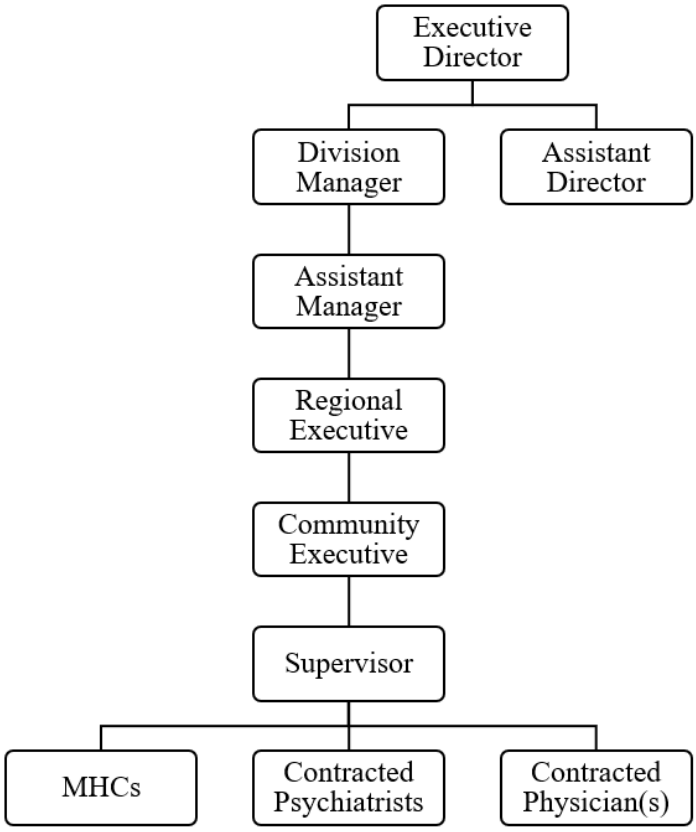
I now briefly describe the organizational context for this OIP. The organization that I work for is named Strong Communities (SC), and the program that I work in is the Professional Counselling Group (PCG) (both pseudonyms for anonymity). Strong Communities is a governmental organization with over 5000 staff, 5000 contractors, and an operating budget of more than 1.5 billion dollars annually (Strong Communities, 2022a). Strong Communities was created to protect children and youth in British Columbia (BC), under the mandate of the Adoptions Act (1996), the Child, Family and Community Service Act (1996), and the Infants Act (1996). Strong Communities has a variety of programs that target different aspects of protecting and supporting children and youth. The PCG is mandated support the mental health needs of those under the age of 19.

Organizational Structure

The PCG works alongside various social work teams and a youth justice team. Each of these teams have a supervisor who reports to the community executive. The community executive is highest level of leadership that is located onsite. Strong Communities operates with a structural functional organizational hierarchy (Capper, 2019), consisting of different levels of elected officials and public servants. The bottom 3 layers of the hierarchy are all public servants who work in the community they serve. The next level of leadership is a regional executive who oversees multiple communities. The regional executive reports to the assistant manager and the division manager, who have been elected by the people of British Columbia. The executive director is at the top of the hierarchy at SC (see Figure 1).

Figure 1

Strong Communities's Hierarchical Map – PCG Stream



Note. All of the leadership positions are pseudonyms for anonymity. The second tier of the hierarchy, to the top of the hierarchy, are all leadership positions.

Organizational Context and Leadership Approaches

Strong Communities has very clear legislative mandates, which they implement through policies and strategic plans. Though implementing a strategic plan is a top-down process, the content of the current strategic plan is broadly aligned with my SL and CT informed values and aspirations, which are to reduce suffering and provide equitable support to our clients, with a focus on marginalized groups (Strong Communities, 2022b). Capper (2019) puts critical theory and structural functionalism on opposite sides of a continuum, however, in many ways they are not binary opposites. Capper (2019) states that "bureaucracy, top-down leadership, positivism,

and quantitative methods not oriented toward equity reflect a structural functional epistemology" (p. 4). Strong Communities is a structural functional organization that meets all but one of these descriptors. According to the goals in their strategic plan, SC is oriented toward equity in many ways. Strong Communities's vision is therefore aligned with my theoretical and leadership lenses, which focuses on increasing equity and reducing suffering.

Though there are benefits to the structural functional framework at SC, there are problems associated with it as well, particularly in a long-term context. Fowler (2018) summarizes the pros and cons of structural functionalism, stating:

> An argument can be made that command and control leadership might be warranted when time is of the essence and risks are high (Blanchard, Zigarmi, & Nelson, 1993). However, in general and over time, this leadership style has been shown ineffective for developing people (Bass & Bass, 2008), generating long-term or sustainable high performance (Gagne & Panaccio, 2014), or promoting people's health and well-being. (p. 184)

This statement is evident at SC in many ways. There are a number of regulations and top-down directives that MHCs are expected to adhere to, and prompts and warnings for when they do not. Although this may reduce errors, it also increases occupational stress (OS). For example, giving employees smart phones with their work email on them, could improve organizational communication, but it could also interfere with MHCs separating their personal and professional lives. This may fail as a long-term strategy, and cause a positive feedback loop, as higher OS is likely to increase the number of treatment errors that MHCs make (Figley, 2002), which may increase their workload and OS levels. Similarly, the number of correspondences and administrative duties is increasing for MHCs at SC, and the amount of administrative support

seems to be decreasing, as MHCs have taken on more administrative tasks. Though aspects of these organizational practices may seem rational and produce efficiency, their long-term impacts are likely negative overall.

Regarding employee job satisfaction, SC recently published the findings from their work environment surveys, and the results showed significantly low levels of job satisfaction (Strong Communities, 2022c). Regarding clients, there continues to be significant disparities between Indigenous and non-Indigenous children and youth, with Indigenous children and youth experiencing much higher rates of child poverty and being placed in government care. (Government of Canada, 2021). Child (2015) suggests that the impact of hierarchy is to support the status quo rather than support new ways of adapting. This is particularly concerning given how bleak the current status quo is for Indigenous people, and how vital the ability to adapt has proven to be over the past few years. For instance, many MHCs have left SC in the past several years, so SC has needed to be adaptive to prevent overloading the MHCs who have remained.

The structural functional system at SC, with its bureaucracy and focus on fiscal efficiency, often leads to sub-optimal working conditions for MHCs. The PCG is a relatively small team, and there are several vacant positions due to stress leaves, retirements, and resignations. When MHCs leave SC, they transfer their clients with the most challenging mental health issues to other MHCs, who often have full caseloads. With a focus on efficiency, MHCs at SC have adapted to staffing issues by running psychotherapy groups with one facilitator, instead of the standard of practice, which is having two. These trends are particularly concerning since the current norm in the field is MHCs working in isolation, which may limit their ability to learn from dialogue with their peers (Chow, 2017). Also, in mental health groups, clients often need individual support, which is difficult to give with one facilitator. The structural functional system

may serve more clients, but because there is less value placed on preparing for sessions and reflecting on them afterward, it may mean that MHCs are less effectively supporting clients. This may result in longer psychotherapeutic treatment and a higher likelihood of re-referral, which would translate into serving less clients over time.

Such conditions create stress for MHCs and also negatively affect client outcomes (Glisson & Schoenwalk, 2005). von Hippel et al. (2019) report that when MHCs perceive that "a large percentage of their client caseload [is] not improving, [they] experienced client-related burnout, which in turn was associated with lower job satisfaction, decreased job engagement, poorer workplace wellbeing, decreased organizational and professional commitment, and increased intentions to leave" (p. 9). Burnout is a severe state of emotional exhaustion (EE), often paired with high levels of cynicism and a reduced sense of personal accomplishment (O'Connor et al., 2018). Burnout is associated with a number of performance issues that could negatively impact the clients that MHCs have been entrusted to support (O'Connor et al., 2018). This is particularly concerning as MHCs at SC work with many clients who have severe mental health issues, and engage in life-threatening behaviours.

Strong Communities's current strategic plan (described in general terms for anonymity) focuses on family preservation and aims to equitably support marginalized groups (Strong Communities, 2022b). Strong Communities utilizes a top-down chain of command to ensure that the strategic plan goals are being pursued. As the current strategic plan is focused on benefiting marginalized populations, the organizational context is well aligned with SL and CT (Capper, 2019; Northouse, 2022). Though Fowler (2018) offers many criticisms of structural functional systems, Bolman and Deal (2021) attest to the potential benefits, stating that "structure provides the architecture for pursuing an organization's strategic goals" (p. 53). Though there are

limitations to having a highly structured organization, there are also benefits. The explicit hierarchy, policies, and structural practices at SC, provide an organizational stability that I can rely on with a measure of confidence as I pursue a change initiative.

The Problem of Practice

Mental health clinicians at SC are front-line professionals who provide psychotherapy, and other mental health services, to children, youth, and families with mental health issues. The process of psychotherapy often involves MHCs being compassionate and empathetic with people who are suffering, which makes MHCs vulnerable to compassion fatigue (CF) (Figley, 2002). Bride et al. (2007) elaborates on this issue, stating that:

> The indirect exposure to trauma involves an inherent risk of significant emotional, cognitive, and behavioural changes in the clinician. This phenomenon… is now viewed as an occupational hazard of clinical work that addresses psychological trauma; a view supported by a growing body of empirical research. (p. 155)

In addition to MHC's vulnerability to experiencing CF, they are also vulnerable to experiencing burnout. A meta analysis of MHC's reported that approximately 40% participants met the criteria for burnout (O'Connor et al., 2018). Because burnout is correlated with physical and mental health issues (Dreison et al., 2018), and because burnout compromises MHC's ability to practice psychotherapy (Puig et al., 2012), burnout will also be considered an occupational hazard (OH) for MHCs.

Compassion fatigue and burnout develop overtime, predominantly from unaddressed OS (Acker, 2010a, Dreison et al., 2018; Figley, 2002). Prior to experiencing CF, MHCs typically experience prolonged compassion stress (CS), which is a form of OS for MHCs. Figley (2002) defines CS as "the residue of emotional energy from the empathetic response to the client and is

the on-going demand for action to relieve the suffering of a client" (p. 1437). Burnout is also caused by MHCs experiencing prolonged OS; however, other occupational stressors, such as: workload, co-worker conflict, lack of professional autonomy, and lack of supervisor support, are typically identified as contributing factors (Dreison et al., 2018; Rees et al., 2015). The PoP is that MHCs at SC are not sufficiently addressing the OS that comes from providing community mental health care. As MHCs are not sufficiently addressing their OS, they are at a heightened risk for experiencing the OHs of burnout and CF.

Occupational hazards do not only compromise the mental health of MHCs, but they also compromise their clients' health, and may create problems for the organizations that they work for as well (Acker, 2010b; Bardhoshi et al., 2019; Demerouti et al., 2014; Figley, 2002; Puig et al., 2012; Rees et al., 2015). For instance, Acker (2010a) summarized several studies that found that EE, a key feature in burnout, "is linked to serious inadequacies in workers' job performance which include cynicism of clients, job dissatisfaction, lack of professional efficacy, and turnover…." (p.177). Cynicism is also a key feature in burnout, and when MHCs have high levels of cynicism they are often cynical towards their clients (Yang & Hayes, 2020), which may impair treatment (Acker, 2010b). The problem of MHC experiencing burnout happens more frequently in community mental health services (O'Connor et al., 2018), as well as with clients who have severe and persistent mental illnesses (Acker, 2010b). These issues are particularly relevant in the PCG at SC, which is a community mental health program that serves many clients with severe and persistent mental illnesses.

To mitigate OS, SC supports employee wellness in many ways. For example, their website has information about wellness practices, and it contains links to mental health supports, such as counselling services for employees (Strong Communities, 2022d). Staff at SC are also

given one hour per month to spend on a wellness activity of their choosing. The local SC office has a wellness committee. The community executive has sent emails to the entire building, expressing gratitude to the wellness committee members, and acknowledging the positive impact that they are making. At a team level, the supervisor has enacted a number of strategies in an attempt to reduce clinical and non-clinical challenges. They have reduced the number of compulsory weekly meetings that MHCs have, they have created specific roles to build specialized competencies, and they have committed to keeping MHC's caseloads under 20 clients. King (2009) recommends that MHCs have 20 clients maximum, and found that "there are human costs and service delivery costs when caseloads get higher" (p.457). While these strategies may slow the speed at which MHCs accumulate OS, more is needed. In addition to the low job satisfaction scores that were previously referred to, the impact of OS is evident in other ways at SC. For instance, several staff on the PCG have resigned over the past 2 years, explicitly stating high OS levels at work, two MHCs are currently on employment leaves due to issues pertaining to OS, and many of the MHCs who remain, regularly express high OS and engaging in maladaptive coping strategies. Thus, the question at the heart of this PoP is how can I, as an informal leader, disrupt the status quo of high OS that is inherent on the front-line of mental health service provision at SC.

Framing the Problem of Practice

I will begin framing the PoP by clarifying some of the major topics and terms that will be used in this section, as there are international variations in how these terms are used. Perhaps the most common term that I came across in the literature, relevant to this PoP, is burnout (Kim et al., 2018; O'Connor et al., 2018; Salyers et al., 2015). Burnout is most commonly measured by the Maslach Burnout Inventor (MBI) (Maslach et al., 1996); however, the Copenhagen Burnout

Inventory and the Counselor Burnout Inventory (both typically abbreviated CBI) were also used in several of the studies that are included in this section. All 3 measures confirmed the prevalence of burnout for MHCs, albeit, by using different criteria to do so (Bardhoshi et al., 2019; von Hippel et al., 2019; Yang & Hayes, 2020). Because most of the literature that I reviewed refers to the MBI, which consists of 3 subcategories of burnout (EE, cynicism, and personal accomplishment), I will also discuss burnout in accordance with the MBI criteria. Burnout will be defined as a severe EE that often coincides with a high level of cynicism, and the perception of having low personal accomplishment.

While the American classification of mental disorders, the Diagnostic and Statistical Manual for Mental Disorders 5 (DSM5) does not recognize burnout as an official diagnosis (American Psychiatric Association, 2013), the International Classification of Diseases (ICD) does (World Health Organization, 2019). Canada currently adheres to the DSM5, so Canadian psychiatrists would have to use a different term(s) in their respective diagnostic formulations to describe burnout. Even though a person could be diagnosed with burnout in many countries, burnout is better understood on a continuum, perhaps opposite to flourishing (Yang & Hayes, 2020).

Though Maslach et al. (1996) identifies EE as a category of burnout, more recent work refers to exhaustion more broadly and synonymously with burnout, describing a state of significantly low psychological energy impeding one's ability to function (Demerouti et al., 2014). While EE is referring to personal energy levels, cynicism is centered around professionals' beliefs about their clients. Cynicism is a cynical attitude towards clients, often causing MHCs to disengage from their work with them (Acker, 2010; Demerouti et al., 2014;

Yang & Hayes, 2020), which Figley (2002) considers to be a maladaptive coping strategy for MHCs who are experiencing high levels of OS and CF.

A major challenge for MHCs is reducing the negative impact of CF. Compassion fatigue is often referred to as vicarious trauma (VT) or secondary traumatic stress (STS) (Bride et al., 2007). I consider CF to be an umbrella term that includes the negative affects of VT, STS, and residual CS, from frequently providing empathy and compassion to those suffering (Figley, 2002). If CF is not addressed, it can lead to compassion fatigue burnout, which is a form of burnout where MHCs experience more isolation and feel more helplessness (Figley, 2002).

The OS and OHs in mental health care are problematic for MHCs, and consequentially, for their clients as well (Acker, 2010a; Figley, 2002; Yang & Hayes, 2020). One way to contextualize a problem is to frame it by considering the antecedents, behaviours, and consequences (ABCs) of a problem (Sturmey, 2008). There are data pertaining to both the causes and effects of OS and OHs in mental health care (Acker, 2010a; Demerouti et al., 2014; Figley, 2002; King, 2009; Puig et al., 2012; Rees et al., 2015; Yang & Hayes, 2020). In order to adequately understand why MHCs at SC are not sufficiently addressing the OS of their work (the PoP), it is important to identify what the occupational stressors for MHC are, what causes them, and why the PoP is relevant (Storey & Maughan, 2015). By completing an ABC analysis of the OHs of providing mental heath care, which includes a discussion of occupational stressors, these questions will be made clear.

Causes of compassion fatigue and burnout

The work of a MHC consists of both clinical and non-clinical challenges. Regarding clinical challenges, MHCs who have a more strenuous caseload (involving working more hours, having more clients, and/or having clients with more severe mental health issues) have an

increased likelihood of experiencing OS, CF, and burnout (Figley, 2002; Kim et al., 2018; Steel et al., 2015). von Hippel et al. (2019) defines this type of burnout as client-related burnout, a form of burnout that occurs when MHCs have clients that are not improving from therapy. The more clients that a MHC has that are not improving, the higher the likelihood that the MHC will experience client-related burnout (von Hippel et al., 2019). Regarding the demographic risk factors for burnout, Yang and Hayes (2020) reviewed 44 studies and concluded that women who are White and under the age of 35 are most at risk. This is particularly relevant to consider as half of the MHCs at SC fit into this heightened risk category.

Figley (2002) specifies that the burnout MHCs experience from their clinical demands is compassion fatigue burnout, which has a much more rapid onset than traditional burnout does. Figley (2002) created a model for CF. It conveys that CF is caused by MHCs spending a lot of time bearing the suffering of others while continuously trying to be empathetic and provide clients with support. Residual CS accumulates over time, which can evolve into CF. The development and severity of CF is both hastened and amplified when other occupational stressors are present, or when MHCs have particularly challenging clients (Figley, 2002).

Reduced personal accomplishment (sometimes referred to as reduced personal efficacy) is the most complex subcategory of burnout, as it can be both a cause and consequence of EE and cynicism (Maslach et al., 2001). The terms cynicism and depersonalization are often used synonymously by Maslach et al. (2001). I will use the term cynicism exclusively in this OIP, because the definition of depersonalization may vary depending on the source. For instance, the DSM5 describes depersonalization as a person experiencing a disconnection from their own thoughts and body (American Psychiatric Association, 2013), whereas Maslach et al. (2001) describes depersonalization as a disconnection and a distancing from others. Personal

accomplishment also relates to both clinical and non-clinical demands. Research from Europe shows that when MHCs have more confidence in their abilities, their clients are more likely to experience positive outcomes (Heinonen et al., 2012), and when clients experience better outcomes MHCs are less likely to endorse burnout (von Hippel et al., 2019). Similarly, Puig et al. (2012) found a correlation between MHCs with high self-perceived incompetence scores and MHCs with lower scores in several areas of personal wellness. A low sense of personal efficacy is correlated with burnout, and a high sense of personal efficacy reduces the likelihood of burnout occurring (Dreison et al., 2018). Having higher role clarity and professional autonomy have been shown to increase a MHC's perceived personal accomplishment, thus higher role clarity and professional autonomy are likely to prevent burnout as well (Dreison et al., 2018; O'Connor et al., 2018).

In addition to clinical challenges, non-clinical challenges are also relevant to the mental health of MHCs. Non-clinical challenges are linked to low job satisfaction, low organizational commitment, high-levels of EE for MHCs (Acker, 2010a; Acker 2010b). Non-clinical challenges may include factors such as documentation and reporting practices, correspondence requirements, and adherence to other various regulation and policy requirements. These factors can cause role conflict and role overload, which are significantly linked to burnout for MHCs (Green, et al., 2014). Role overload occurs when there is not enough time to complete all of the required tasks, and role conflict "suggests a work environment in which there are multiple competing demands on providers' time and cognitive resources" (Green et al., 2014, p. 46). Administrative support for the team psychiatrist at SC was reduced several years ago, giving MHCs additional administrative responsibilities. Mental health clinicians now schedule their client's appointments with the team psychiatrist, and they are responsible for supporting their

clients when they are having issues with their medication. This correspondence often involves relaying the client's medication issues to the team psychiatrist, and faxing the client's prescriptions for medications to pharmacies. These roles can increase role conflict and role overload for MHCs. Although these tasks may not seem overly cumbersome, MHCs often have one-hour appointments and they complete other important, and often mandated, tasks in the brief time between sessions. With this new requirement, MHCs are sometimes navigating acute medication issues between clients, pharmacists, and psychiatrists, in a limited time window. As clients are often reporting adverse reactions to medications in these circumstances, MHCs may be accumulating CS, in addition to the OS from role conflict and role overload.

Mental health clinicians have individual perspectives and life situations that are linked to burnout as well. Mental health clinicians that have families may be more likely to be disengaged at work, however, there are a number of factors that affect this, such as gender (Rothbard, 2001). Acker (2010a) found that OS may increase when there are differences between the organizational values, and the values of individual MHCs. This occurs at SC, as MHCs often prioritize providing psychotherapy sessions and maintaining correspondence that supports their clients, instead of completing other administrative requirements. This task prioritization has been expressed in informal communication with MHCs. Being behind on administrative requirements may lead to MHCs not taking their breaks, or staying at work late to mitigate this problem.

Consequences of compassion fatigue and burnout

Compassion fatigue and burnout have a negative impact on MHCs, the organizations that they work for, and their clients (Acker, 2010a; Bride et al., 2007; von Hippel et al., 2019). Burnout and CF are correlated with lower job engagement, lower productivity, poorer workplace wellbeing, low organizational commitment, absenteeism, turnover, lower quality work, clinical

errors, and lower therapeutic efficacy (Acker, 2010a; Figley, 2002; O'Connor et al., 2018; von Hippel et al., 2019), as well as physical issues, such as cold and flu symptoms (Acker, 2010b; Green et al., 2014). Because of the severity of the consequences of burnout and CF, the American Counselling Association's (ACA) Code of Ethics "mandates that counselors be aware of their own physical, psychological, and/or emotional problems; refrain from offering therapeutic services when these problems are likely to affect treatment; and seek help in dealing with their own problems as they arise" (Puig et al., 2012, p. 99). In other words, the negative impact of burnout and CF can make it unethical for MHCs to practice therapy.

Thus far I have described the consequences of CF and burnout more broadly. I will now focus on the specific impairment that the issues can cause MHCs directly. Secondary traumatic stress and VT (which both fall under the umbrella term CF) can cause significant suffering for MHCs. Secondary traumatic stress "is nearly identical to post-traumatic stress including symptoms of… intrusive imagery, avoidance, hyperarousal, distressing emotions, cognitive changes, and functional impairment" (Bride et al., 2007, pp.155-156). While burnout is analogous to a depressive disorder, Post-Traumatic Stress Disorder (PTSD) is classified as an anxiety disorder in the DSM5 (American Psychiatric Association, 2013); thus, the consequences of CF and burnout may result in MHCs having clinical levels of anxiety and depression. Compassion fatigue and burnout are OHs, as they go beyond the topic of job satisfaction into realm of suffering and whether or not MHCs are able to ethically provide therapy to their clients.

Critical Perspective

A critical theorist would find the following sequence problematic, perhaps even oppressive. Community MHCs have higher rates of CF and burnout (O'Connor et al., 2018), CF and burnout are correlated with lower quality of service and clinical errors (Demerouti et al.,

2014; Figley, 2002), and marginalized groups are more dependent on community MHCs. Not surprisingly, Kilbourne et al. (2018) reports that "among persons with mental disorders, disparities in quality and outcomes of care are more pronounced for racial/ethnic minorities and those from lower socio-economic status groups" (p. 30). Even in Canada, with public healthcare, the above sequence of issues is an example of how the mental health care system may perpetuate inequity. To disrupt the above sequence, SC could focus on providing VT-informed care. This could help to reduce the rates of CF and burnout among MHCs; thus improving services to the marginalized groups that MHCs serve. Providing VT-informed care aligns with SC's strategic plan, which aims to improve services for Indigenous people (Strong Communities, 2022b).

The health inequities experienced by racial and ethnic minorities (including Black, Indigenous, and People of Colour [BIPOC]) and groups with low socio-economic status (SES) may be linked to their inability to receive mental health services (Cawthorpe, 2018). In the United States, Kazdin (2008) found that only 34% of children who needed mental health services received them, and that half of the clients dropped out of services after waiting for them. This problem is worse for Black and Latino people (Cook et al., 2014). Mental health service providers often utilized waitlists to manage their referrals. The current waitlist for individual therapy at SC is approximately 4-6 months for higher acuity clients, and 7-8 months for moderate mental health presentations. Most psychotherapy groups are facilitated 2-3 times per year, so the waiting time depends on when clients come for an intake. Clients with significant life-threatening behaviours are often prioritized, and may be assigned to a MHC almost immediately. When this occurs, MHCs often over-extend themselves, which increases their OS. Although Thomas et al. (2021) does not report specific time-frames, they express that longer

wait times for accessing mental health services are associated with poorer outcomes for clients with several mental health issues.

The lack of access to mental health services in Canada may be as problematic as the American situation reported by Kazdin (2008), as the number of children and youth in Canada who are experiencing mental health problems continues to increase at a faster rate than the resources that are allocated to provide mental health care (Cawthorpe, 2018). While a critical perspective may want to explore how marginalized groups are affected by mental health issues in Canada, Cawthorpe (2018) cautions against this, reasoning that it "may serve to further marginalize groups of individuals and increase stigma" (p. 1181). Cawthorpe is concerned about associating mental health issues with certain ethnicities or groups of people (immigrants, for example). A primary approach that the PCG uses to reduce waitlist times, is facilitating various psychoeducational groups, including caregiving groups, and groups for youth with specific mental health issues. While many clients find group-based interventions effective, they do not seem sufficient for clients with severe and persistent mental illnesses. This problem may be reduced if mental health issues were treated more effectively.

Guiding Questions from the PoP

A great irony in the field of mental health counselling is that MHCs help their clients to improve their lives, but they often do not take the steps necessary to improve their own lives. Despite being experts in mental health and human change theories, chronically high OS levels, CF, and burnout, are widespread problems for MHCs (Figley, 2002; O'Connor et al., 2018). I aim to better understand this irony by exploring three questions: (1) What strategies prevent and treat burnout and CF on mental health teams? (2) What is preventing MHCs from effectively managing their OS? (3) How can various levels of leadership better support mental health

clinician's wellbeing? These 3 questions explore the PoP in individual, team, and leadership contexts. Understanding these areas of the PoP will provide a more accurate blueprint of the current situation for MHCs at SC, which should increase the likelihood of a successful solution.

1. What strategies prevent and treat burnout and compassion fatigue on mental health teams?

The MHCs at SC are likely to have various degrees of burnout, as burnout is best understood as being on a continuum (Yang & Hayes, 2020). Compassion fatigue can be understood as being on a continuum as well, as Figley (2002) presents a model for CF that shows a progression of severity that is similar to a continuum. As there are various degrees of burnout and CF some MHCs may benefit from a preventative approach, while others may benefit from a more reactive approach. This is likely the situation for the PCG at SC, which is a relatively large team with a diversity of age and experience. Although there is prudence in taking a preventative approach to problems, prevention may not be sufficient, as CF and burnout are so prevalent in mental health services (Demerouti et al., 2014; Figley, 2002) that some MHCs at SC may need to treat the burnout and/or CF they already have.

A second function of asking this question is that it is likely to reveal the benefits and shortfalls of different approaches to addressing the PoP. For example, brief therapy models may reduce the workload pressure associated with longer waitlist; however, brief therapy may not be sufficient for severe mental health issues (Thomas et al., 2021), and prematurely concluding therapy may lead to other challenges. Having a number of strategies to consider would be a valuable resource for the PCG, as the problem is very complex (Leiter & Maslach, 2005), and a one size fits all approach may not be sufficient to address the PoP. This question will be considered when determining the solution(s) for the PoP.

2. What is preventing mental health clinicians from reducing their occupational stress?

This question is similar to the previous one, but with more of a focus on the individual barriers to being healthier as an MHC, and factors that sustain the PoP in mental health services. I assume that people do well when they can, and that if they are not doing well there is a reason for it (Greene, 2005). Organizational factors significantly influence the likelihood of OS (King, 2009; Leiter & Maslach, 2005), but there are individual factors to consider as well such as MHC's mental health and resiliency (Bonanno, 2004; Leiter & Harvie, 1996). Posing this question fosters inclusivity, as it helps to identify the barriers that may otherwise prevent MHCs from successfully engaging in the change plan.

As there are a number of strategies that should have improved the situation for MHCs by now, there are likely contingencies that have not been sufficiently accounted for. For example, a healthy diet and exercise might be emphasized to reduce exhaustion, however, as Puig et al. (2012) establishes, "counselors who are exhausted from job stress do not feel up to exercising and eating well regularly and appropriately" (p. 104). Knowing this information could empower MHCs to overcome this challenge. It could also identify important workplace issues (such as reasonable access to healthy food options) or potential interventions (such as tracking steps or going for team walks). This question helps to troubleshoot possible continencies and better set this OIP up for success.

3. How can various levels of leadership better implement evidence-based strategies on mental health teams?

Supervision practices are linked to OHs in many ways (Dreison et al., 2018; Figley, 2002; King, 2009). Understanding these dynamics is essential to understanding the PoP. While I do not have the authority to dictate team structure and supervision practices, I am compelled to

communicate relevant information with leadership at SC, particularly as SC is supporting me to investigate the PoP via an academic scholarship. I need to understand the literature on my role as an informal leader, in order for me to be competent in this role. It is important for me as an informal leader to look around and understand the landscape of mental health services. Studying the questions in this subsection will reveal the paths that others have taken while attempting to resolve this problem. This will be an invaluable resource to have as I begin to plot the course for the PCG in this OIP. This question will be addressed in chapter 3 when discussing the change roles and the change implementation plan.

Leadership Focused Vision for Change

My leadership vision for change is for mental health teams to be using evidence-based practices to reduce their OS, and prevent and treat OHs. By doing so, MHCs would be entering into a positive feedback loop (see Figure 2), where an optimal response to OS would improve MHCs wellbeing, particularly compared to the status quo of mental health services. The status quo refers the general state of mental health service provision, where MHCs have high-rates of OS and OHs (Figley, 2002; O'Connor et al., 2018), and where the mental health of MHCs is often insufficiently maintained (Puig et al., 2012). By addressing these issues, it is hypothesized that MHCs would provide improve therapeutic treatment and outcomes. A second way of conceptualizing the vision for change is MHCs moving along a continuum, away from OHs (burnout and CF), and towards flourishing (see Figure 3). This process would involve mitigating the accumulation of OS, including compassion stress, and reducing the instances of MHCs languishing in their work. Because the causes of burnout and CF are chronic in mental health services (Figley, 2002; O'Connor et al., 2018), MHCs will be regularly engaging in evidence-based practices to mitigate OS. It is possible that some MHCs have mild-moderate OS. In which

case, the vision for change will be more preventative, and help to them sustain their health throughout their career. My priorities are focused on changing the behaviors of MHCs, because larger programming areas are outside of my sphere of influence as an informal leader.

Figure 2

Model of Status Quo vs. Desired Change

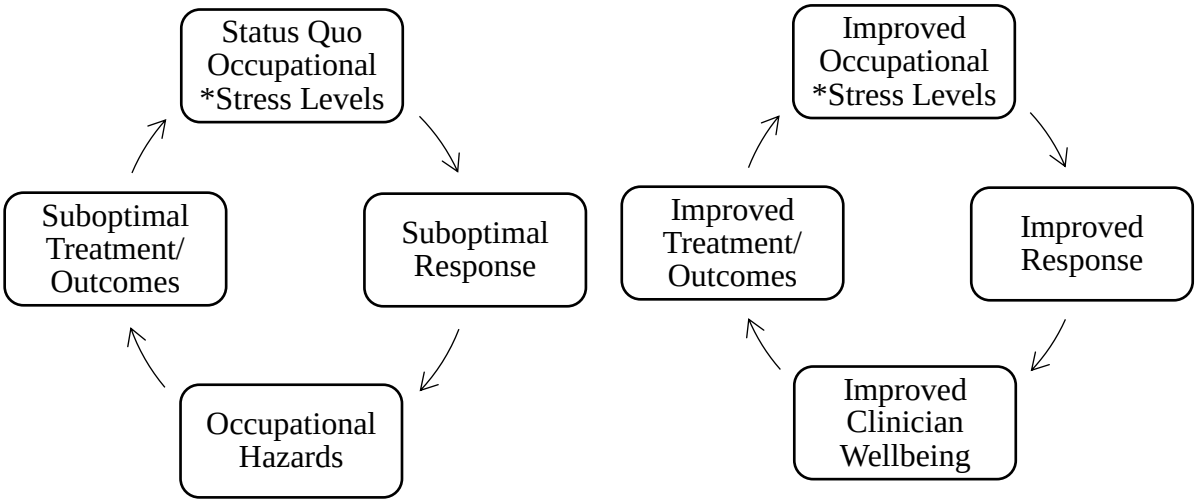
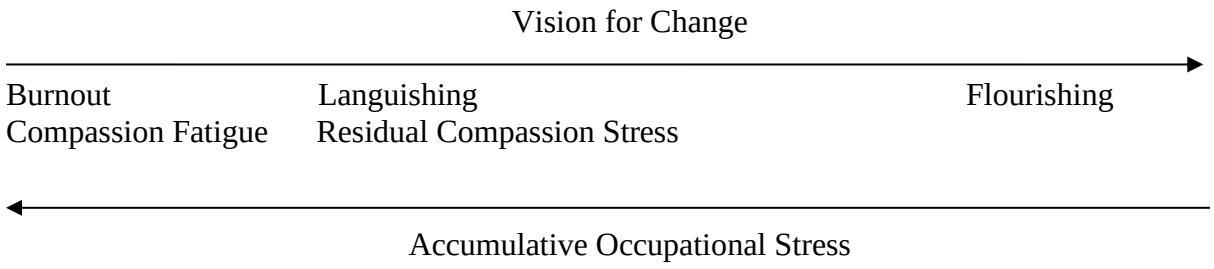


Figure 3

Accumulative Occupational Stress and the Vision for Change



The impact of behavioural changes should lead to gradual improvements in MHC's physical and mental health over time. Similar to Yang & Hayes' (2020) conceptualization of burnout, Overmars (2019), who writes about Indigenous wellbeing, argues that "mental health

and illness is better suited to a continuum than binary" (p. 18). Similar to the process in many therapeutic modalities, MHCs would initially do more work to identify their place on these respective continuums. After this phase, they would engage in a positive feedback loop (see Figure 2) by engaging in behaviours that reduce their OS, and the likelihood of OHs being developed.

Mental health clinicians are currently engaged in large amounts of non-clinical work, in the areas of administration (including organizing, scheduling, referrals, documentation, and reporting), correspondence (including emails from the employer and stakeholders, text messages with clients, and care team involvement), and other work, such as committee work and meetings. Although it is beyond my sphere of influence to enact direct changes to these issues, it is my vision that MHCs will be more attuned to their needs, more organized, and work at a healthier pace. By containing and managing non-clinical issues more effectively, MHCs will have less OS, and more energy to invest in their clients. By investing more in their clients, MHCs will be more effective therapists, which will increase their progress toward flourishing and reduce their digression towards OHs (Puig et al., 2012; Rossi et al., 2012; von Hippel et al., 2019).

Another way to view the vision for change is on a continuum (Figure 3), with OHs on one side, languishing (Grant, 2021) just inside of it, and flourishing (Bono et al., 2011) on the other side. Yang and Hayes (2020) reported that burnout and flourishing could be considered in on a continuum. I have added languishing, as Grant (2021) suggests that languishing is a widespread issue for many professionals that is not as severe as burnout. Flourishing is correlated with people who "have a positive approach to the self, others, and work situations; and they have an active, engaged, and forward-looking approach to work, including novel or challenging situations" (Bono et al., 2011, p. 134). The leadership vision for change involves

MHCs moving towards flourishing, and experiencing the improvements in attitude and energy that Bono et al. (2011) describes.

While many MHCs at SC can be positive and optimistic at times, informal correspondence has revealed that some MHCs feel that they are languishing in their work, due to both organizational and individual issues. Further, several MHCs are on employment leave of absences, or have resigned over the past two years, reporting high OS. Sociologist Corey Keyes used the term languishing to describe a state where mental health is absent, but mental illness is not evident (Keyes, 2002). Languishing often presents with stagnation and involves reduced motivation and reduced ability to focus (Grant, 2021). The desired state would involve MHCs moving from languishing to flourishing on the respective continuum.

Chapter 1 Summary

The status quo of mental health services is under-resourced in Canada, particularly for children and youth (Cawthorpe, 2013). This under-resourcing of services translates into high workloads and work pressures for MHCs. Many MHCs across Canada are experiencing mental health issues (Kirby, 2008), and informal communication with MHCs indicates that the situation at SC is no exception. The vision for change moves away from the status quo of mental health services in Canada, which is plagued with languishing and "human costs" (King, 2009, p. 457). Instead, MHCs will move towards flourishing, which will have a positive impact on many aspects of their work and personal lives (Bono et al., 2011). Flourishing MHCs will exhibit many positive symptoms of mental health, as they have less OS, and become less likely to experience OHs. While OS and OHs are common in mental health services, the vision for change is that MHCs at SC mitigate and prevent these issues, and move towards a state of flourishing.

Chapter 2 – Planning and Development

In this chapter I describe how my leadership approaches will help to mobilize the vision for change. These leadership approaches reveal the values, priorities, and specific strategies that will support the MHCs of the PCG as they move towards the desired state of practice. A change framework is a vital aspect of implementing organizational change (Deszca et al., 2020). In this chapter I articulate how the chosen change framework(s) account for the unique dynamics on the PCG. Change readiness also needs to be assessed in a manner that considers the influence of various stakeholders and circumstances. A change readiness scale is used to identify the organizational, leadership, team, and individual factors that influence change, before moving into the change process. Finally, three possible solutions to the PoP are evaluated to determine which one is the best choice for the PCG.

Leadership Approach to Change

Having an explicit leadership approach is important, as it can be a touchstone for decisions, and guide actions. The two key leadership approaches that inform my role as an informal leader and MHC are: 1) Servant Leadership and 2) the five practices of exemplary leadership (FPEL) (Kouzes & Posner, 2017). In this section I will describe both of these approaches, and report on how they align with my leadership positionality and address the PoP.

Servant Leadership

There are many different ways to understand and demonstrate SL (Blanchard & Broadwell, 2018). The literature on SL was largely philosophical for many years, which led to many theoretical divergences and total of 44 characteristics of SL being identified in the literature (van Dierendonck, 2011). Because there is the potential for ambiguity in what SL entails, I specify precisely how I align with SL, and how SL will be operationalized in this OIP.

Servant leadership can be broken down into 2 parts (Blanchard, 2018) and 6 characteristics (van Dierendonck, 2011). The 2 parts are: (1) a visionary/leadership role, and (2) an implementation/servant role (Blanchard, 2018). The visionary aspect of SL in this OIP is both the mission—moving from the status quo to the desired state of practice—and the strategy to get there. The mission of a servant leader should be based on compassion for others (Groeschel, 2018). This OIP is inspired by compassion for MHCs, who are, to some extent, suffering (Capper, 2019) as they try and relieve the suffering of others. Although it may seem like an embellishment to describe highly educated professionals (with all of their associated privilege) as suffering, the literature strongly suggests that this is often the case (Acker, 2010a; Figley, 2002; O'Connor et al., 2018); thus, preventing and relieving this suffering is the mission.

In SL, the role of a visionary must bridge into the role of an implementer, as it is not enough to want things to be different, leaders must act on their goodwill (Blanchard & Broadwell, 2018). As a front-line employee, I need the support of a capable champion (Judge & Douglas, 2009) in a formal leadership position to bring my vision into fruition. My capable champion is my supervisor. Consistent with the implementation/servant aspect of SL, I support my supervisor by pursuing what is important to them. Where possible, I cultivate win-win situations (Blanchard & Broadwell, 2018) for the betterment of multiple parties. Creating win-win situations (with both formal leadership and MHCs) is an example of what Spears (1998) describes as persuasion. Greenleaf (1977/2002) shares how servant leaders have used "gentle but clear and persistent persuasion" (p. 43) to achieve incredible change. I will be persuasive through identifying a shared vision and aligning the desired behaviour with that shared vision, instead of trying to convince MHCs to heed my vision. This OIP is an example of a win-win situation. By investing in MHC's health (win for MHCs) there is a predicted improvement in the work

environment (Acker, 2010a) (win for the organization), and in client outcomes (von Hippel et al., 2019) (win for clients and the community).

van Dierendonck (2011) analyzed decades of literature on SL and concluded that SL has 6 main characteristics: empowering and developing people, humility, authenticity, interpersonal acceptance, providing direction, and stewardship. Based on many studies of SL, van Dierendonck (2011) created a conceptual model of SL. The model conveys that leading with the 6 characteristics of SL leads to positive outcomes, in and of themselves. van Dierendonck (2011) also describes the necessity of sustaining leader-follower trust. Fostering trust and declaring intentions operationalizes SL, as these practices "will eventually materialize in[to positive] behavioral norms and then ultimately in systems and structures" (Covey, 2018, p. 28).

My leadership approach also considers the FPEL which adds practical wisdom to the theoretical foundation of SL. In an article comparing SL, transformational leadership, and adaptive leadership approaches to healthcare, Trastek et al. (2014) resolved that "because health care is about caring for others[,] and [because] there should be alignment with how we treat patients and how we work together as staff, servant leadership may be considered the dominant model" (p. 380). This aspect of modeling desired behaviour, which is so vital that it distinguishes SL as dominant over other leadership approaches in health care, is also a central aspect of my second leadership approach, the FPEL. The FPEL add experiential knowledge to my leadership approach, which helps to bridge the gap from leadership theory to observable leadership practice.

Five Practices of Exemplary Leadership

Though it is important to have a theoretical understanding of leadership, Kouzes and Posner (2017) have found that leadership is ultimately about behaviour. Through an extensive process of surveying hundreds of thousands of employees, and analyzing the data, Kouzes and

Posner (2017) created the FPEL. The FPEL are: “Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart” (Kouzes & Posner, 2017, p. 20). I will demonstrate how each of the FPEL aligns with SL, and how I will consider these practices in operationalizing this OIP.

Kouzes and Posner (2017) argue that “leadership is not about personality…. It’s about behaviour” (p. 13). This point is emphasized in the first practice. Modeling the way is essential to earn trust and respect from followers, and to inspire change (Kouzes & Posner, 2017). While many people may claim to be servant leaders, their actions need to be consistent with their words for their claims to have merit. It is not enough for MHCs to think differently, they must act differently as well. As a servant leader I must model the changes that I am encouraging others to make, as well as the attributes that I want others to demonstrate, such as being curious, respectful, and showing initiative. A central aspect of this practice is affirming shared values, which “ensure[s]… that everyone is aligned—uncovering, reinforcing, and holding one another accountable to what ‘we’ value” (Kouzes & Posner, 2017, p. 61). Modeling the way guides MHCs to develop their own SL.

Inspiring a shared vision is the second practice of the FPEL. Kouzes and Posner (2017) offer guidance on how leaders can promote a shared vision, such as by being curious about what is important to MHCs, and by communicating the meaning behind change initiatives. Consistent with this advice, Sinek (2009) directs leaders always share “why” an organizational change is important. As an informal leader, I will remind MHCs about the bigger picture and how our efforts will have a positive affect on our clients, which will make their work more meaningful for them.

The third practice, “challenge the process”, is consistent with CT and SL, which both seek to improve upon the status quo (Capper, 2019; Greenleaf, 1977/2002; Kouzes & Posner, 2017). Kouzes and Posner (2017) direct leaders to challenge the status quo by learning from others and by taking risks. Brown (2018) suggests that servant leaders “won’t solve the complex issues we’re facing today without creativity, innovation, and engaged learning” (p. 76). I will foster an environment of collaboration, where MHCs are being creative and innovative.

Enabling others to act is the fourth practice of the FPEL. Consistent with this practice, Kutsyuruba and Walker (2015) direct leaders to give “each member a sense of efficacy and agency in the attaining of the greater ends” (p. 118). Enabling others (MHCs) to act will involve inclusion, collaboration, delegating, empowering, and equipping MHCs through the change process. This principle is akin to the SL principle of capacity building (Greenleaf, 1977/2002), which is within the task authority given to me by formal leadership at SC.

The fifth and final practice of encouraging the heart focuses on gratitude, recognition, and celebration. Kouzes and Posner (2017) summarize the benefits of expressing gratitude, which include being “healthier, more optimistic, more positive, and better able to cope with stress[, and being] more alert, more energized, more resilient, more willing to offer support to others, more generous, and more likely to make progress towards goals” (p. 267). An aspect of the vision for change is for MHCs to be more positive and encouraging. I will model encouraging the heart by expressing gratitude, validation, and encouragement to MHCs.

The insights from SL and the FPEL will increase my effectiveness as an informal leader and MHC at SC. As a servant leader, I will anchor the change plan in what is best for the growth and development of MHCs (Greenleaf, 1977/2002). Providing strong SL, and utilizing the FPEL,

I will encourage and empower MHCs. The positive impacts of these leadership approaches will not only mitigate the PoP, but they will support MHCs through the change process as well.

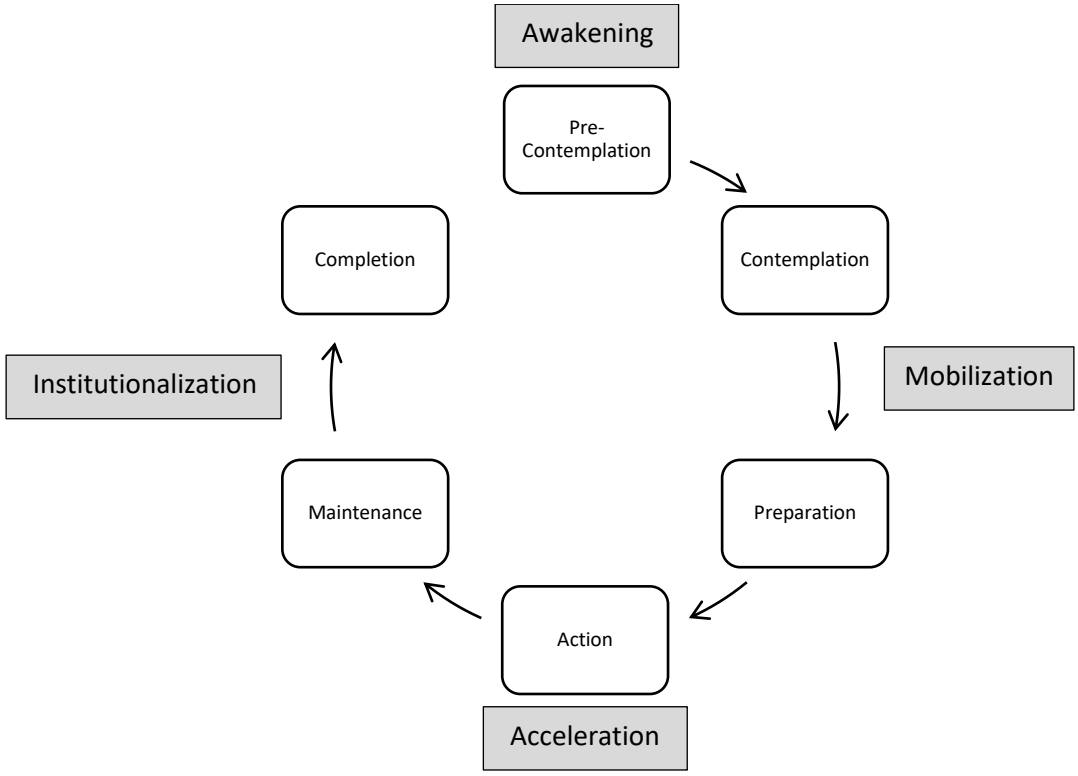
Framework for Leading the Change Process

Organizational change is inevitable if organizations want to stay relevant over time (Deszca et al., 2020). Even though organizational change is expected, it can be disruptive for employees and increase their OS (Woodward et al., 1999). Leaders in mental health services need to consider the stressful nature of organization change, as MHCs are already experiencing high levels of OS, and are vulnerable to the OHs (Figley, 2002; O'Connor et al., 2018). As a servant leader in mental health services, I need to be particularly sensitive to levels of OS, as SL been positively correlated with increasing OS for subordinates (Peng et al., 2023). Because of the heightened potential for OS in organizational change processes, and because MHCs are already susceptible to high levels of OS, burnout, and CF, it is ethically imperative that I consider both the organizational and individual contexts of change when creating a change framework.

To sufficiently consider the organizational context and the individual psychology of MHCs, my change framework consists of 2 change models, The Change Path Model (CPM) (Deszca et al., 2020) and the Stages of Change (SoC) model (Prochaska & DiClemente, 2005). Please see Figure 4 and Appendix A for more information on this hybrid change framework. The CPM underlays the change process at an organizational level (Deszca et al., 2020), and the SoC model considers the individual psychology of participants (Norcross et al., 2011). The CPM is the foundational change framework, and the SoC model is a parallel process that fits within the larger CPM. This change framework aims to consider the organizational context and strivings at SC, while also supporting the wellbeing of MHCs, who may have high OS.

Figure 4

Hybrid Change Framework



Note. This figure demonstrates a clockwise process, beginning at the top.

Before discussing the CPM, it is essential to describe the different change roles, as defined by Deszca et al. (2020). The change initiator role is somewhat self-described. It is the person who first identifies the need for change, and begins the change process. Change champions are people in formal leadership positions, who get involved and support the change initiative. Change implementers are the employees who will help to lead the change initiative by investing in the day-to-day change plan activities. Lastly, change recipients are participants in the change plan (Deszca et al., 2020). Leaders and MHCs may have multiple roles. These roles will be discussed more comprehensively in the chapter 3.

Organizational Change Framework - Change Path Model

The CPM (Deszca et al., 2020) is the organizational change framework for this OIP. The CPM has 4 phases: awakening, mobilization, acceleration, and institutionalization (Deszca et al., 2020). I will outline how the CPM will be implemented as a change framework in each phase.

The first phase in the CPM is the awakening phase. During this phase, change initiators scan the organization's internal and external environment to assess the issues and systems that impact the PoP (Deszca et al., 2020). In the awakening phase, change initiators identify the PoP and create a leadership vision for change. As implied in the title of this phase, there is a waking up to the insufficiency of the status quo and the need for change to occur. I will communicate the negative aspects of the status quo, and awaken leadership and MHCs to the pressing need for change. This process has similarities with John Kotter's first stage of change, "establish[ing] a sense of urgency[, where]… leaders need to illustrate the threats to the system and move enough organizational members from a sense of invulnerability to vulnerability" (Deszca et al., 2020, pp. 53-54). I will begin the process of organizational change by validating the current challenges for MHCs, and emphasizing the literature on MHCs experiencing OS, CF, and burnout. This will awaken leadership and MHCs to the PoP and the need for change.

The mobilization phase goes deeper than the awakening phase, by more thoroughly analysing the differences between the status quo and the desired state of practice. The main process in the mobilization phase is a gap analysis (Deszca et al., 2020). A gap analysis will include how MHCs perceive the gap between the PoP and the desired state of practice. Change initiators may help identify multiple gaps in practice, by reflecting upon an event or situation (Deszca et al., 2020).

A gap analysis can help to determine whether first-order change or second-order change is needed. First-order change typically involves a surface level adjustment to current practices, and second-order change is a "deep change that requires the questioning of underlying assumptions" (Eddy & Kirby, 2020, p. 48). Second-order changes may involve modifying core values (Smith, 2018). Although it is important to address first-order changes, Tagg (2007) argues that not considering organizational values is "the fatal flaw" (p. 39). Dialogue with MHCs will consider the different change-types when assessing the PoP and the vision for change.

One of my priorities as a servant leader is to help MHCs further develop their leadership capacity (Greenleaf, 1977/2002; van Dierendonck, 2011). Though all of the MHCs in the PCG will go through the change process together, there will likely be individual variances in their readiness for change, and in their commitment and engagement to the change initiative. I anticipate that some MHCs will be change implementers and some will be change recipients. The change initiative will be voluntary; however, as a team-based initiative MHCs would be strongly encouraged to attend. Based on my knowledge of the PCG members and the team dynamics, I anticipate that every MHC will actively participate in the change initiative. In later sections I will discuss the strategies used to promote participation in the change plan. My supervisor and I will work collaboratively with MHCs to identify further roles, in order to foster growth in some MHCs, while containing the workload for others (Deszca et al., 2020). This is important to identify as employees who do not think they have the capacity of change are more likely resist change initiatives (Cunningham et al., 2002). As a servant leader I can help develop MHCs' leadership capacity by empowering MHCs through lateral coordination (Bolman & Deal, 2021), decentralized command (Willink & Babin, 2017), and decentralized power (Bush, 2018). Covey (2018) shares that "servant leader[s] seek[] to unleash talent and creativity by extending

trust to others" (p. 30). The change framework will strongly consider the aspect of MHC empowerment and development.

The third phase in the CPM is Acceleration, where MHCs will engage in the change initiative with a more defined pace. I will increase support to change implementers, by expressing gratitude and encouraging them to ask questions and provide feedback. If a change implementer identifies an issue with the change initiative, I will prioritize the issue and aim to address it promptly. Effective communication is vital in this stage (Deszca et al., 2020). As an informal leader and the change initiator in this initiative, I will need to actively engage with formal leadership and MHCs to ensure that issues are being address as they inevitably arise (Deszca et al., 2020).

The final phase in the change framework is the institutionalization phase. The specific details around institutionalizing the change initiative will depend on the chosen solution and the outcomes of the change initiative. The institutionalization phase begins towards the end of the change initiative. In this phase, change implementers celebrate the change initiatives successes, highlight what changes happened and the subsequent benefits of those changes, and focus on next steps for the PCG (Deszca, 2020). For this stage to be successful, I will need to ensure that sufficient monitoring and evaluation practices have taken place throughout the change plan. Because there is often organizational inertia that, like gravity, pulls new initiatives back toward the status quo (Godkin, 2010), the institutionalization phase will need leadership to be engaged in the process of amalgamating the lessons learned from this change plan, into the new normal.

Individual Change Framework – Stages of Change

Though it is necessary to consider the organizational lens of a change framework, it is also important to consider the individual lens as well. Kotter and Schlesinger (2008) suggest that

leaders select a change strategy that "selects specific tactics for use with various individuals and groups; and that is internally consistent" (p. 139). Prochaska and DiClemente's SoC model (2005) is "internally consistent", as it is widely known across the different teams at SC, particularly the PCG. Literature on the SoC model highlights the change process for individuals, and provides specific strategies to enhance the effectiveness of the change process (Prochaska & DiClemente, 2005).

The SoC model consists of 6 stages, which are presented as the inner circle in Figure 4. In this section I describe the defining characteristics of each stage, the corresponding leadership considerations, and where each stage fits in to the CPM's foundational framework. The SoC model consists of 6 stages: pre-contemplation, contemplation, planning, action, maintenance, and completion stages. Prochaska and DiClemente (2005) share that "a stage of change represents both a period of time and a set of tasks needed for movement to the next stage" (p. 149). The first stage is the pre-contemplation stage, which is primarily focused on the change initiator, as the MHCs (both individually and collectively) are largely unaware of change initiative to come. Change initiators should increase their understanding of the PoP and the vision for change in this stage. The contemplation stage will be initiated with a formal presentation of the change plan to the MHCs. It is essential that I thoroughly communicate the landscape of the PoP, the solution, and what participating in the PoP will look like for MHCs, for both change implementers and change recipients. Norcross et al. (2011) suggests a focus on developing "insight and awareness [in] the early stages" (p. 152) and behavioural activation in the later stages. Mental health clinicians need to know all the variables to make an informed decision. By genuinely caring about the team of MHCs, individually and collectively, and by listening to their priorities and validating their perspectives, I will be establishing a respectful, collaborative, and engaging

process early in the change initiative. This process will model SL, and demonstrate that the change is for them.

In the preparation stage, change implementers will be identified and supported. There will be a focus on building excitement for the change initiative. Mental health clinicians are expected to make the mental shift from focusing on the benefits of the status quo, to experiencing and valuing the benefits of the change (DiClemente, 2007). There will also be a focus on practical matters, such as ensuring that resources are acquired and lines of communication are established. The action stage is "the stage in which individuals modify their behavior, experiences, and/or environment to overcome their problems" (Norcross et al., 2011, p. 144). During this process, leaders encourage the efforts of change implementers and change recipients, and troubleshoot challenges and barriers that arise, as they work to routinize the new behaviours. The maintenance stage begins when new behaviours are thought to be routinized. The goal is to accumulate the benefits of the change, and prevent a relapse (Norcross et al., 2011). A relapse is when change efforts fail and change agents fall back into their previous status quo behaviour. A prolapse is when a change agent(s) engage in the behaviour associated with the PoP; however, it is considered a mistake and they remain in the maintenance stage.

The final stage of the SoC model is the completion stage. This stage is usually not included in the SoC model (see Norcross et al., 2011, for example); however, I have included it because the change initiative will be a time-limited intervention, ending with an evaluation and celebration (to be discussed in chapter 3). During the completion stage, MHCs will engage in a final evaluation. During the final evaluation, MHCs will discuss the strengths and weaknesses of the change initiative. I will gather information during the final evaluation. After the change initiative is completed, I will use this information to create an enhanced wellness resource.

Even though there are distinct attributes within each of the SoC, research supports some overlapping themes across various stages. For instance, participants "optimally progress from precontemplation and contemplation into preparation by using consciousness raising, self-liberation, and dramatic relief/emotional arousal. [Also, participants] progress best from preparation to action and maintenance by using counterconditioning, stimulus control, and reinforcement management" (Norcross et al., 2011, p. 152). Counterconditioning refers to MHCs changing their default responses to a preferred behaviour, such as taking a calming breath when they're anxious. Stimulus control refers to reducing the sources of problematic behaviour, such as silencing phones so people are not distracted. Lastly, reinforcement management will involve shaping behaviour through rewards, such as starting sessions on time to encourage MHCs showing up on time. The SoC model provides leaders with insights into the psychological processes of change recipients, and it also provides action prompts to increase a change implementer's effectiveness.

Summary of Leadership Framework for Change

Change implementations are more effective if they consider both organizational and individual contexts (Cunningham et al., 2002). It is vital to consider the organizational change process (Deszca et al., 2020); however, Mento et al. (2002) argues that "when developing a plan for [change] implementation, one must tailor the approach to the frame of reference… of the individual participants" (p. 51) as well. There is evidence to demonstrate that the SoC model is effective in this regard (Norcross et al., 2011). The CPM (Deszca et al., 2020) outlines the phases that the PCG will go through, which is supplemented by the SoC model's information on individual MHCs' change processes (Prochaska & DiClemente, 2005). By implementing

literature on the different aspects of change, the change initiative will be more effectively implemented.

Organizational Change Readiness

Assessing organizational readiness for change is an important prerequisite to implementing a change plan (Deszca et al., 2020). By identifying change readiness factors, change initiators can make an informed decision regarding whether to pursue a change, or not. Change initiators can use readiness for change assessments to identify the stakeholders that they need to invest in, as well as the potential barriers that they need to troubleshoot (Judge & Douglas, 2009). There are many measures that can be used to formally assess organizational change readiness (Deszca et al., 2020; Holt et al., 2007). In this section I will then describe how I have considered the themes from the Organizational Capacity for Change (OCC) construct (Judge & Douglas, 2009), to assess organizational readiness change at SC.

The Organizational Capacity for Change construct

Deszca et al. (2020) found value in the OCC construct, so much so that they used the OCC construct as one of several models that they amalgamated into their Rate the Organization's Readiness for Change scale (p. 106). The OCC construct consists of eight themes of organizational change, that an extensive literature review determined were important to be considered in assessing change readiness. Please see Table 1 for a list of the OCC construct themes and key features. The eight themes of organizational change are: trustworthy leadership, trusting followers, capable champions, involved mid-management, innovative culture, accountable culture, effective communication, and systems thinking (Judge & Douglas, 2009). I will assess organizational change readiness at SC by considering these eight themes, as they apply to organizational change at SC.

Table 1

Organizational Capacity for Change (OCC) Construct: Themes and Key Features

Theme	Key Feature
1. Trustworthy Leadership	Upper leadership's ability to express a clear vision and act in a way that fosters trust with their subordinates.
2. Trusting Followers	The likelihood that subordinates of upper leadership will adhere to their vision, or engage in respectful dialogue.
3. Capable Champions	The presence of competent leaders who help their subordinates grow and develop their occupational abilities.
4. Involved Mid-Management	Mid-level leadership's capacity to communicate the organizations vision, with lower leadership and employees.
5. Innovative Culture	Organizations promoting innovative practices, and leaders and employees being innovative in their work.
6. Accountable Culture	Organizations, leaders, and employees, acting with integrity and being able to meet their goals.
7. Effective Communication	Efficient communication across organizational leadership, employees, and their clients.
8. Systems Thinking	Leadership and employees' inclination to consider correlations and connections, both inside and outside of their work.

The OCC construct breaks down each of the 8 themes of organizational change into four categories, making it a 32 item assessment; however, I am not completing the full 32 item assessment, as several of the items on the 32 item assessment evaluate attributes of my superiors, which is not appropriate for me to do as a front-line employee. Agreeingly, Judge and Douglas (2009) state that the full 32 item change readiness assessment is not intended for front-line employees to complete. Instead, I will broadly assess each of the 8 themes of organization change, as they apply to the change initiative at SC. In do so, I will assess organizational change without evaluating specific attributes of various leaders at SC.

Trustworthy leadership

Haque et al. (2020) found correlations between employee's trusting their leaders, and employees having higher organizational change readiness, organizational commitment, and feelings of empowerment. Senior leadership at SC are elected officials. Because the current executive director is relatively new, and there have been multiple changes in executive leadership over the past 2 years, this theme is currently to be determined. Fortunately, this theme is less relevant in the context of the change initiative, as there are many degrees of separation between front-line MHCs and the governing political leadership.

Trusting followers

This theme is a strength of the PCG, as the change implementers and change recipients have generally expressed support for the governing strategic plan at SC. As noted earlier, the vision for change is aligned with the strategic plan at SC. As this change initiative is led by an informal leader on the front-line, the context is adapted to refer to MHCs likelihood of following me, as their informal leader. The MHCs at SC consistently demonstrate their trust in me as an informal leader.

Capable champions

The supervisor is the capable champion. The supervisor has expressed excitement and commitment to the change initiative. They have significant formal authority to support a change initiative. As the supervisor has consistently demonstrated their willingness to invest in the growth and development of MHCs, this theme indicates readiness for change.

Involved mid-management

The community executive at SC is the closest role to a mid-manager. They have made a commitment to personally connecting with front-line MHCs and supporting the supervisor. The

community executive does communicate the strategic plan down the chain of command to the supervisor, and to MHCs as well. The community executive has expressed support for this change initiative.

Innovative culture

The PCG prides itself on innovation. Mental health clinicians are often seeking new and innovative ways to facilitate groups and practice therapy. The community executive expresses interest in front-line employee's ideas for innovation, as does the supervisor. As MHCs have high workloads, they may be apprehensive about an innovative plan initially (Cunningham et al., 2002).

Accountable culture

In general, there is much accountability and integrity shown by leadership at SC, and by MHCs; however, OS and OHs may have a negative impact on this theme. High OS can increase MHCs disengagement and decrease their work performance (Acker, 2010a). As such, MHCs are more likely to be behind on their work goals, which is a feature of this theme. I have considered this factor and will prioritize a change initiative that is easily implementable and desirable, particularly for the MHCs who choose to be change recipients.

Effective communication

This theme is a strength of the PCG. Mental health clinicians all work onsite, in the same area of the building. Mental health clinicians all have access to work emails and work phones, and have demonstrated effective communication with each other.

Systems thinking

Mental health clinicians are trained in systems thinking, whether it is in regard to family systems (Lafrance et al., 2020), or post-structuralist analyses (Madigan, 2011). This theme is a

strength at SC. For instance, it is common knowledge at SC that intergenerational trauma exists in society, and that colonization has had a devasting impact on Indigenous people to this day.

Summary of Change Readiness

By exploring the themes of the OCC construct, as they apply to the organizational context at SC, I have identified that there is likely to be a high-level of acceptance to change at SC. Five of the themes on the OCC indicate a strong acceptance for change (trusting followers, capable champions, involved mid-management, effective communication, and systems thinking), however, the other three themes were characterized by uncertainty (trustworthy leadership, innovative culture, and accountable culture). As this change initiative is being implemented for front-line MHCs by a front-line informal leader, the uncertainty in upper levels of leadership is not of significant concern. The concerns regarding innovation and accountability will be considered when choosing a solution, and the subsequent sections on change planning and monitoring practices.

Deszca et al. (2020) argue that change leaders should "understand how the existing situation can be leveraged in order to increase the prospects for success" (p. 60). To do this, I will validate how a change initiative can be perceived as negative when there are already high-levels of OS, and I will seek to provide support for concerns. When employees perceive that the benefits of a change are high, and the risk low, there is expected to be a high readiness for the change (Cunningham et al., 2002). By supporting MHCs to move away from languishing and towards flourishing, while being considerate about their workload and not adding unnecessary tasks, employees are likely to have lower resistance to change and a higher acceptance of change.

Strategies/Solutions to Address the Problem of Practice

With the number of mental health issues rising in Canada (Cawthorpe, 2018), and modern challenges having a negative impact on neurodevelopment and mental health (Neophytou et al., 2021), mental health teams need to innovate practice. Mathieu (2012) expresses that "clients and patients will not stop needing help and support[;]… trauma will occur. Helping professionals need to continue to explore ways to remain healthy while doing this deeply challenging and rewarding work" (p. 6). Despite strategies that have been developed at local, provincial, and national levels to address these challenges (Government of B.C., 2021; Kirby, 2008), the PoP persists. In this section, I explore three potential solutions to the PoP. The three solutions are listed on Table 2, with several characteristics. Only solutions that are congruent with my position as a front-line MHC will be considered. Solutions that would entail a major program overall, and solutions directed at formal leadership, were not included in this section as they would be incompatible with my position and agency on SC's organizational hierarchy.

Table 2

Potential Solutions to the Problem of Practice (PoP)

Solution	Focused on	Intervention	Size
1. Therapeutic Skills Training	Therapeutic skill development	Peer-based trainings on theoretical frameworks and therapeutic modalities.	Team-based
2. Group-Based Clinical Consultations	Peer support and case conceptualization	Group-based clinical consultations to address specific client issues	Small groups
3. Collaborative Wellness Program	Routinizing self-care practice	Promoting individual and workplace health practices	Team-based

Solution 1 – Therapeutic Skills Training

Mental health clinicians of the PCG are all "generalist" clinicians, meaning that they work with children and youth from 0-19 years old, who have a broad range of mental health issues. This is significantly different from the role of MHCs in private practice, who typically develop specializations and work with specific mental health issues. As MHCs at SC work with a variety of mental health issues, they need a diverse therapeutic skillset. In this OIP, therapeutic skills refer to MHC's competence applying theoretical frameworks and therapeutic modalities in group and individual counselling sessions. Theoretical frameworks are also referred to as types of therapy, such as Cognitive Behavioural Therapy (CBT), or Emotion-Focused Therapy. Therapeutic modalities are sometimes referred to as therapeutic techniques, such as talk therapy, art therapy, and exposure therapy. Steel et al. (2015) argue that "increasing the number of theoretical frameworks that… therapists can draw on and providing opportunities for work in different modalities and with varied client groups is likely to increase a sense of personal accomplishment, protecting against burnout" (p. 37); thus, working as generalist clinicians could actually be protective against burnout, if MHCs are sufficiently trained in different theoretical frameworks and therapeutic modalities.

The emphasis in solution 1 is MHCs developing their competence with therapeutic skills. There many are emerging changes in the field, such as therapists providing online therapy, and even utilizing social media in therapy (Naslund et al., 2016). Many MHCs have not been trained in these therapeutic modalities, which may reduce their sense of self-efficacy. Improving self-efficacy is highly correlated with resiliency, self-compassion, and self-regulation (Steele, 2020). Empowering MHCs by providing them with the opportunity to develop their therapeutic skills is an example of de-centralizing power, which is a concept in servant leadership (Bush, 2018).

This solution involves providing MHCs with educational resources on various therapeutic skills, and participating in a one-hour therapeutic skills training session per month. I would be the change initiator and the main organizer of this initiative. I would begin this solution with an orientation session where I would gather information about the types of therapeutic skills that MHCs would like to develop competence in. I would recruit change implementers to help support this change initiative. The prospective change implementers and I would divide the topics, based on our skills and competence. If no MHCs wanted to present a therapeutic skill, then I would be the sole change implementer for this change initiative. This solution utilizes the unique strengths of the PCG, as many MHCs have taught therapeutic skills before. The PCG has engaged in a similar therapeutic skills initiative in the past, however, this initiative faded over time with the significant changes in staffing at SC over the past several years.

Though there are benefits to this solution, there are also limitations. The supervisor has approved one-hour of therapeutic skills training session per month. As it takes time to learn and develop new skills, it is unlikely that there would be a significant enhancement in MHC's therapeutic skillset from a one-hour monthly session and studying resources. Planning to facilitate monthly trainings would take worktime, which may reduce the number of MHCs who would be willing to become change implementers. After considering these limitations, therapeutic skills training is still a possible solution, as there would be a number of benefits for MHCs, and MHCs regularly express their interest in therapeutic skills training.

Solution 2 – Group-Based Clinical Consultations

The focus of this solution is for MHCs to utilize peer knowledge and support, to enhance the existing clinical supervision practices a SC. While solution 1 focuses on the development of therapeutic skills, solution 2 focuses on supporting MHCs by helping them to better understand

their clients' functioning and mental health issues. Clinical supervision is a vital aspect of mental health counselling; however, it is often inconsistent and overshadowed by supervisors having high workloads, and prioritizing administrative supervision (Schriger et al., 2023).

When MHCs receive comprehensive clinical supervision, they report less OS (King, 2009). Similarly, when co-workers provide clinical support, and peer support more generally, they are less likely to develop CF (Ray et al., 2013) and burnout (Yang & Hayes, 2020). Dreison et al. (2018) suggests that MHCs develop clinical support groups, stating that they "may be particularly beneficial for providers who serve high needs clients" (p. 128). This makes sense, as MHCs can become confused and overwhelmed by having clients with complex mental health issues.

This solution involves a one-hour group consultation per month. Each month, MHCs would be divided into groups of three. Group sizes may vary depending on the number of participants. Mental health clinicians would have approximately 20 minutes each to present a case that they find challenging. While they are presenting their case, the other MHCs will be listening, and providing support, encouragement, validation, insights, and feedback. This solution would be voluntary, but strongly encouraged, to prevent MHCs working in isolation. The solution would begin with an orientation session where I introduce the PoP, and the solution. I would suggest the format described above; however, I would explore MHCs preferences as a group, and aim to be collaborative.

This solution would reduce MHCs practicing in isolation, and give MHCs the opportunity to have peer support with challenging clients. Peer support has been referred to as "the future of mental health care" (Naslund et al., 2016, p. 113). Consistent with SL, this process would focus on developing community (Northouse, 2022), through peer support. This solution

would also take some of the pressure off of the supervisor, who has competing demands to provide both clinical and administrative supervision.

Similar to the previous solution, this solution could be perceived by MHCs as adding to their OS and not mitigating it. Some MHCs may not be comfortable discussing their client's mental health presentations, and/or providing their peers with advice. If MHCs believe that this solution will increase their OS, they will be more likely to resist the change initiative (Cunningham et al., 2002).

Solution 3 – Collaborative Wellness Program

Mental health clinicians are typically familiar with self-care strategies, and often practice them in their personal lives (Evans & Coccoma, 2014); however, the level of self-care that MHCs practice is often not proportionate to their level of OS (Steele, 2020). Engaging in self-care practice can often mood dependent, making MHCs less likely to engage in self-care when they may need to the most (Puig et al., 2012). This is concerning as research has found that self-care "practice was statistically significant in decreasing CF and burnout" (Evans & Coccoma, 2014, p. 111). To address this issue, solution 3 involves MHCs participating in a collaborative wellness program.

I chose the Wellbeing Workout (WW) (Hughes et al., 2019) as this solution's collaborative wellness program. The WW is a psychoeducational book on wellbeing. The WW was developed in the United Kingdom by counsellor Rick Hughes, psychologist Andrew Kinder, and university professor Cary L. Cooper. The WW is divided into three sections: 1) stress management, 2) personal and family management, and 3) personal resilience (Hughes et al., 2019). These three sections have 52 total subsection within them, on topics such as OS, resiliency, and personal and professional wellbeing (see Appendix B). The WW contains brief

lessons and engaging activities, such as self-evaluation questionnaires, thought-provoking checklists, and actions plans (Hughes et al., 2019).

Mental health clinicians would all be given a copy of the WW, and they would meet each week to complete a WW topic together. Ordering a copy of the WW for each MHC and the supervisor would cost under $400, which has already been approved by the community executive. All of the activities for this change initiative would take place during the PCG team meetings, so change recipients would not add to their workload by participating in the WW. The only activities for this change initiative that are outside PCG team meeting, would be the initial meeting for change implementers, and if change implementers requested a follow up meeting(s). Facilitating the WW sessions is a very straight-forward process, so email would likely be sufficient for most of the communication with the change implementers. Mental health clinicians would spend the first 30 minutes of weekly team meetings completing a WW topic. As the change initiator, I would begin this change initiative by hosting an orientation session on the WW and the plan for the change initiative. In addition to the orientation session and the 30 minute weekly meetings, I would also facilitate three evaluation meetings, where I would explore MHCs perspectives on the change initiative (to be discussed in chapter 3). The orientation session, 30 minute weekly meetings, and the three evaluation sessions, would all be done during the PCG's weekly team meeting time. When it is time for an evaluation session, the PCG will postpone that weeks WW session.

The WW would take a considerable amount of work-time to complete, however, SC has a norm of being generous with work time for team initiatives. My supervisor has already approved the plan for the change initiative, as described above. All MHCs would be encouraged to become change implementers. If none of the MHCs volunteer to be a change implementer, then I will be

the only one. If this is case, then the PCG would miss a WW session if I was unable to attend work that day. The following week we would decide whether we wanted to skip the previous session or not. During the orientation session, I will review the outline of the WW (see Appendix B) and inquire about whether MHCs would prefer to exclude any of the topics. I anticipate that several of the 52 sessions will be removed from the change initiative.

I would recruit change implementers during the orientation session, and over the first couple sessions of the WW. Facilitating WW sessions would be the main role of change implementers. As the WW sessions have a very clear process, facilitating WW session would involve minimal preparation. I would facilitate the first two sessions of the WW to model the way for change implementers (Kouzes & Posner, 2017), and show them what their roles entails. The meetings for the change initiative would be voluntary; however, as the WW sessions are scheduled during team meetings, MHCs would be expected to attend. Being familiar with the preferences of MHCs, and the dynamics of the PCG, I anticipate that all of the MHCs would engage in this change initiative.

A limitation of the WW is that it does not explicitly use the terms CF, STS, or VT. Instead, the WW discusses these concepts through the topics of employee crises, EE, and burnout. Evans and Coccoma (2014) identified that exercising, practicing grounding and self-awareness, utilizing support, setting boundaries, and planning time for yourself, are all evidence-based strategies for reducing CF. Even though the WW does not explicitly refer to CF, all of these practices that reduce CF are included within it (Hughes et al., 2019).

The WW includes topics that could trigger emotional responses from MHCs. As these are issues that regularly arise in their work with clients, MHCs would be expected to have reasonable resilience to these topics. As mentioned, the PCG will meet as a group and decide if

there are any sessions that they would prefer to exclude from the change initiative. Also, MHCs would have an outline of the WW sessions and would have the option of opting out of sessions that they did not feel comfortable attending. The WW sessions will be a part of team meetings, and team meetings end at lunch time. This will give MHCs the ability to have a break between participating in the WW and practicing therapy. I will remind MHCs about the no-cost counselling services that are available to us by our employer during the orientation session.

Solution Comparison

Several evaluations were used to establish which solution would be the best fit for MHCs at SC. In this section I evaluate the solutions based on their likelihood to reduce OS, burnout, and CF, as well as that the likelihood that they would be successful implemented. This evaluation is demonstrated in Table 3. While issues such as workload are strongly correlated with OS and OHs (King, 2009; Kinter & Kati, 2022), I have no agency to address workload issues in my position as a MHC. As such, workload, and similar issues, are notably absent in the discussion of possible solutions.

Therapeutic skills training is the first solution to be evaluated. Previous experience indicates that this solution would be easy to implement, and correspondence with MHCs indicates that many MHCs would be willing to be change implementers for this solution. Though therapeutic skills training would logically improve therapeutic competence, an 18-month study of 5,000 clients found that therapist's individual characteristics influenced positive outcomes more than the specific modalities that they utilized (Schuckard et al., 2017). This suggests that training therapists on therapeutic modalities has a low return on investment. Similarly, Mathieu (2012) states that highly competent MHCs are more likely to develop CF. Even though

therapeutic effectiveness is important, competence in specific therapeutic modalities does not appear to significantly improve client outcomes, or reduce OS, burnout, or CF.

Implementing group-based clinical consultations is the second potential solution to the PoP. While this solution could reduce OHs by increasing therapeutic effectiveness (von Hippel et al., 2019) and enhancing peer support (Ray et al., 2013), there are many sources of OS that clinical consultations would not resolve. Also, previous attempts to enact similar initiatives for the PCG have not been successful. One reason that similar initiatives may have been unsuccessful in the past, is that clients at SC often have complex and stressful challenges that require prompt follow up. Mental health clinicians may not be able to wait for a monthly consultation session to discuss the cases that they find the most challenging. As this frequently occurs at SC, MHCs may prefer to promptly engage in informal consultations instead.

A collaborative wellness program is the third solution to be considered. The Wellbeing Workout (Hughes et al., 2019) is the chosen collaborative wellness program for solution 3. There are many positive outcomes associated with solution 3. Self-care has been shown to reduce stress and improve the quality of life for professionals in academic and health care settings (Ayala et al., 2018; Erdman et al., 2020). A study of nurses found that resiliency training resulted in 34% of participants reporting fewer burnout symptoms, and 19% reporting fewer CF symptoms (Flarity et al., 2013). As a servant leader, I have been listening to MHCs and observing their preferences (Spears, 2018). I have noticed that self-reflection exercises and self-care practices, generally seem to energize MHCs and improve their attitudes at work.

As illustrated in Table 3, the WW is the most promising solution to address the PoP; therefore, it is the solution that has been chosen. The reflective and supportive nature of the WW is an asset of the program. With the diverse ages and experience levels of MHCs of the PCG,

MHCs could learn from each other and encourage preventative strategies. The WW addresses a number of issues that cause OS for MHCs (Hughes et al., 2019). By utilizing the WW, MHCs could reduce OS and move closer towards flourishing in their work. By reducing the likelihood of OS and OHs at SC, MHCs are more likely to thrive and provide better therapeutic services to their clients (Acker 2010a; Figley, 2002; O'Connor et al., 2018).

A benefit of a team-based intervention that is scheduled during team meetings, is that it allows for more MHCs to participate in the change initiative. This reduces barriers for MHCs who would want to participate in a change initiative, but have difficulty adding new meetings to their schedules. As a servant leader and critical theorist I need to prioritize inclusivity and ensure that MHCs do not miss out on experiencing emancipation from their OS because they are already struggling. In addition to prioritizing inclusivity there are other benefits to focusing on participation levels, such as higher participation satisfaction and faster goal attainment (Holt et al., 2007).

Table 3

Solutions and Evaluation Criteria

Solutions	Reduce Occupational Stress	Reduce Burnout	Reduce Compassion Fatigue	Probability of Successful Implementation
1.Therapeutic Skills Training	Low	Low	Low	High
2.Group-Based Clinical Consultations	Low	Moderate	Moderate	Low
3.Collaborative Wellness Program	Moderate	Moderate	Moderate	High

Note. Evaluation Criteria has been determined by the perspective of author, based on their consideration of relevant literature and their familiarity with the dynamics of the PCG.

Additional Considerations

One factor that makes engaging in regular self-care more challenging in mental health services is the exhaustion that MHCs experience from CF (Puig et al., 2012). As noted earlier, CF is often referred to synonymously with VT (Evans & Coccoma, 2014). Munroe et al. (1995) argues that VT is an OH, and organizations are ethically required to inform employees of OHs, and how to treat them. While trauma-informed practice (TIP) has been gaining popularity in mental health services, much of the literature continues to overlook the issue of VT when discussing the future of TIP (Evans & Coccoma, 2014).

Because VT is a significant concern for MHCs, a long-term ambition is for the PCG to become a VT-informed team. As VT is also an issue for the other teams at SC, ideally SC would become a VT-informed organization. The concept of a VT-Informed Organization (Office for Victims of Crime [OVC], n.d.) addresses many of the workplace concerns that were identified throughout this OIP. While many of the practices promoted in the WW are first-order changes, positioning these practices under the deeper focus of the PCG becoming a VT-informed team, could be the catalyst for a future second-order change. This is important because first-order changes could be inadequate to address the complexity of the PoP (Smith, 2018), and second-order changes would be more transformational as they address underlying values and priorities (Eddy & Kirby, 2020; Tagg, 2007). The journey to second-order change will be a focus in the final phase of the change initiative, the institutionalization phase (Deszca et al., 2020). Although I have already established that the WW is the chosen solution to the PoP, in Table 4 I demonstrate how the WW is the solution that is the most consistent with being a VT-informed organization.

Table 4

Solutions and Being a Vicarious Trauma (VT)-Informed Organization

VT-Informed Organizational Strategy	Solutions		
	Therapeutic Skills Training	Group-Based Clinical Consultations	The Wellbeing Workout
Leadership and Mission	Low	Low	Low
Management and Supervision	n/a	High	n/a
Employee Empowerment and Work Empowerment	Moderate	Moderate	High
Training and Professional Development	High	Low	High
Staff Health and Wellness	Low	Low	High

Note. Adapted from the "Vicarious Trauma Toolkit" by Office for Victims of Crime (OVC) (n.d.). https://ovc.ojp.gov/program/vtt/what-is-the-vt-org#framework

Chapter 2 Summary

This chapter began with describing my leadership approach to change. I explained how SL will be operationalized in the change plan. I then described how I will utilize the FPEL (Kouzes & Posner, 2017) to improve the change process and better ensure that it is successful. Afterward, I discussed the change framework for this OIP, which is a combination of the CPM (Deszca et al., 2020) and the SoC model (Prochaska & DiClemente, 2005). Once the change framework was made clear, I described how I used the themes of the OCC construct to complete a readiness assessment for change (Judge & Douglas, 2009).

In the latter half of this chapter, three possible solutions to the PoP were reviewed. After evaluating the three solutions, it was determined that the WW (Hughes et al., 2019) was the best

solution for the MHCs at SC. This is consistent with Kouzes and Posner (2017), who express that leaders “look[] outward for innovative ways to improve” (p. 16). The following chapter will describe a change plan for this solution, that incorporates change implementation, communication, monitoring, and evaluation, in order to optimize this change plan.

Chapter 3: Implementation, Communication, and Evaluation Plan

Organizational change is frequently sought after by leadership, but many change initiatives fail (Kotter, 2012). Organizational change is needed at SC, particularly with the PCG, as there are mounting challenges in Canadian mental health services (Cawthorpe, 2018), and MHCs have high rates of OS and OHs (Acker, 2010; Figley, 2002; O’Connor et al., 2018). The solution to the PoP is implementing the WW (Hughes et al., 2019); however, the change process is a major aspect of the solution as well. In this final chapter, the plan to implement the WW is discussed, with a focus on the change process. This plan will ensure that the WW is optimized with the PCG, leading to positive outcomes for MHCs and their clients.

The previously described Change Path Model (CPM) (Deszca et al., 2020) and Prochaska and DiClemente’s (2005) Stages of Change model (SoC) guide the change implementation plan. Consistent with SL, my priority task is to empower other MHCs to develop their own leadership capacity throughout the change process (Covey, 2018). In order to implement the WW at SC optimally, I have developed a communication strategy and a knowledge mobilization (KMb) plan (see Appendix C). Additionally, monitoring strategies and an evaluation plan are utilized to consolidate progress and sustain positive changes. The evaluation plan will involve three plan, do, study, act (PDSA) cycles, each containing a strengths, weaknesses, opportunities, threats (SWOT) analysis in the *study* stage.

Change Implementation Plan

The plan for implementing the WW is based on the application of the CPM phases (Deszca et al., 2020), integrated with Prochaska and DiClemente's (2005) insights into individual change processes as well. The change implementation plan is outlined in Table 5, with more specific details expressed in Appendix A. The plan identifies the key tasks for change implementers, and me as the change initiator. It is vital to note that both the CPM and the SoC are flexible, processes; thus, the key tasks in Table 5 may not always be exact. In fact, Deszca (2020) states that the four phases of the CPM are "interrelated and overlapping" (p. 8), and DiClemente (2007) describes the SoC as being dynamic and non-linear. As these two flexible models are being combined with a third process, the WW, the key task are approximate. Table 5 is therefore intended to be a general guide of the change implementation process, and not a rigid criteria for change.

According to the change roles reported in Deszca et al. (2020), the supervisor will be the change champion and could be a change implementer if they desire. Requests for funding are submitted by the supervisor and are approved by the community executive. Both the community executive and the supervisor understand the importance of optimizing MHC's mental health, and they have expressed interest and support for the team collectively engaging in the WW. I will be the change initiator and change implementer in this change initiative. As the change initiator I have the most active role in all phases of the change plan, especially the awakening phase, as this phase includes the genesis of the PoP and the vision for change (Deszca et al., 2020). All other MHCs will have the option of being change implementers or change recipients. Change implementers will meet once early in the change initiative, so that I can express gratitude and clarify which WW session(s) each change implementer will be facilitating.

Table 5

Change Implementation Plan: Outline of Key Tasks and Timeline

CPM Phase, SoC Stage, and Time-Frame	Change Initiators Tasks	Change Implementers Tasks
Awakening/Pre-Contemplative *(Currently underway)*	-Comprehensively understand the PoP -Create a change plan -Obtain approval for change plan	Not applicable. Change implementers have not been recruited at this point
Awakening/ Contemplative *(Fall, 2023)*	-Orient the PCG to the PoP and the vision for change -Explore the pros and cons of change with MHCs and leadership -Recruit change implementers -Develop the change plan collaborative with MHCs create roster of WW session facilitators -Acquire workbooks and establish scheduling -Meet with the change implementer group -Present initial WW session -Model desired behaviour -Increase availability to MHCs	
Mobilization/ Preparation *(Fall, 2023)*		-Attend change implementer meeting -Understand role and expectations -Clarify level of engagement in the change plan as well as which WW session(s) each person is facilitating -Support MHCs by responding to questions and concerns -Model the desired participation in WW sessions
Mobilization/ Action *(Fall, 2023)*		
Acceleration/ Maintenance *(Fall, 2023-Summer, 2024)*	-Facilitate respective WW sessions -Support change implementers -Facilitate 2 PDSA cycles/SWOT analyses -Reward desired behaviour -Regularly provide support and encouragement; solicit feedback -Utilize communication strategy -Celebrate small wins	-Facilitate respective WW session(s) -Participate in 2 PDSA cycles/SWOT analyses -Encourage participant engagement and solicit feedback. -Utilize communication strategy -Celebrate small wins -Promptly address issues
Institutionalization/ Completion *(Fall, 2024)*	-Facilitate final PDSA cycle/SWOT analysis -Organize celebration -Recognize contributions -Begin creating wellness resource	-Participate in final PDSA cycle/SWOT analysis -Provide recognition and encouragement -Acknowledge personal efforts

In the awakening and mobilization phases, I will be a more visible leader as I advocate for resources, present the PoP, vision for change, and change plan to the team, and recruit change implementers. As evident in Table 5, in the acceleration phase/maintenance stage, I have the majority of tasks. As the change plan progresses, change implementers will have more of an active role in the change initiative.

The change implementation plan is scaffolded into four foundational phases: awakening, mobilization, acceleration, and institutionalization (Deszca et al., 2020), that consider the individual context of Prochaska and DiClemente's (2005) SoC model (see Table 5). The SoC model outlines the behavioural change process for individuals, and provides a list of corresponding skills. This information will help to provide MHCs with targeted support throughout the change process.

Awakening Phase/Pre-Contemplation Stage

The beginning of any organizational change initiative entails an awakening phase/pre-contemplative stage where future participants are engaged in their status quo roles and activities. As the change initiator, my primary task in this phase is to comprehensively understand the PoP, and to develop a change plan. Once I have done this, I will attempt to awaken other MHCs to the PoP, by sharing information about the causes, consequences, and prevalence of OS and OHs in mental health counselling. As the MHCs of the PCG seem to consider high-levels of OS to be an acceptable norm of their occupation, I will describe OS and OHs as being on a continuum, and I will conceptualize this change initiative as a harm reduction approach for them. Having reasonable expectations for this change initiative is likely to reduce MHCs resistance for change (Cunningham et al., 2002).

The change plan needed to be approved by my supervisor before being presented to MHCs. As noted in the solutions section of this OIP, I obtained permission from my supervisor for the change plan. Comprehensively understanding the PoP and the change plan was essential in this regard, as I was able to emphasize the need for change, based on evidence. The change plan is currently in the awakening phase/pre-contemplative stage. It is transitioning into awakening phase/contemplation stage as more MHCs begin to hear about the upcoming change initiative.

Awakening Phase/Contemplation Stage

In this change plan, Prochaska and DiClemente's (2005) contemplative stage is understood as being within the latter half of the awakening phase. As a final step in the awakening phase, Deszca et al. (2020) directs change agents to "disseminate the vision for the change and why it's needed through multiple communication channels" (p. 60). As the change initiator, it is my responsibility to awaken others to the need for change. I will do this by communicating the data regarding the high-levels of OS for MHCs in general, and the possibility that OS will evolve into OHs for some of the MHCs in the PCG, given the prevalence of these OHs in their roles (Figley, 2002; O'Connor et al., 2018). I will also share the list of negative symptoms associated with CF and burnout. I will meet with my supervisor and MHCs separately, as their involvement in the change initiative is different. Deszca (2020) advises leaders to "engender commitment to the change that appeals to people's hearts (we're doing this for a higher purpose)" (p. 13). This advice is well-aligned with the FPEL, which emphasizes encouraging others in a meaningful way (Kouzes & Posner, 2017). It is also aligned with SL, which empowers others and encourages contributing to the community (Northouse, 2022). I will remind MHCs of the many benefits that being healthier could give them, and subsequently their

clients. Addressing this greater good, with evidence and a plan of action, is likely to foster commitment to the WW.

Prochaska et al. (1994) express that when individuals are in the pre-contemplative and contemplative stages of change, they are more focused on the negative aspects of change; therefore, a leadership task in these stages is building awareness of the positive aspects of changing behaviour. Mental health clinicians, and formal leadership, need to have a clear understanding of the pros and cons of changing vs. the status quo if they are going to move into the preparation stage with enthusiasm. During this phase I will invite MHCs to become change implementers in the change plan. We would meet to assess their desired level of engagement.

Mobilization Phase/Preparation Stage

The mobilization phase refers to mobilizing the "people and resources needed to launch the change" (Deszca, 2020, p. 8). The mobilization phase/preparation stage begins in an overlapping manner with the previous phase/stage, beginning approximately during the orientation session. A foundational aspect of the mobilization phase/preparation stage is having MHCs familiar with their role in implementing and/or participating in the WW. In the mobilization phase the different participant roles are established to ensure clarity and reduce role confusion; however, MHCs will be able to become change implementers at any point in the change initiative. The mobilization phase/preparation stage ends in an overlapping manner with beginning of the mobilization phase/action stage when the WW sessions have begun.

The change initiative will start off with a orientation and planning session, where I will present the WW, rally the team, recruit change implementers, and address any questions that MHCs may have. While the WW sessions will be the first 30 minutes of team meetings, my supervisor has approved spending the entire team meeting on this orientation session. As MHCs

often struggle with high OS (O'Connor et al., 2018), a priority of this change plan is to mitigate the additional time and energy that MHCs are asked to give to participate in the WW. My supervisor has already approved the allocation of the first 30 minutes of our weekly team meetings for the WW, to limit adding to the workload of MHCs. All of the MHCs who would like to take on a change implementer role in this change initiative would be able to do so. Being a change implementer involves the additional time requirements of participating in a planning meeting and being available to participate in an addition meeting(s) during the change initiative, if it is deemed necessary by the group of change implementers. Change implementers would be expected to participate in the evaluation sessions as well. These sessions would be held during the first 30 minutes of team meetings at the end of each section of the WW (see Appendix B). My team supervisor has approved using the entire team meeting for these evaluation sessions, should we go beyond the first 30 minutes.

Establishing a draft of the change plan, with a timeline of important activities, is a key consideration in the mobilization phase (Deszca, 2020). Table 5 shows the general timeline of the plan, and Appendix B outlines the WW sessions. In the orientation session the PCG will review Appendix B and collaboratively decide if there are any sections that they want to exclude from the change initiative.

Budgetary requirements need to be identified and communicated (Deszca, 2020). The workbooks are low cost and easily obtainable, and for each MHC to have a physical copy it will cost under $400. The community executive has pre-approved this purchase. As the change initiator I have taken on this preparation task, as well as organizing tasks such as booking boardrooms.

Mobilization Phase/Action Stage

The action stage will begin on the first week of the WW, because that is when MHCs are formally engaged in the change behaviour. The action stage is the briefest stage in the SoC model and it is akin to the lift-off phase of a space mission. Fortunately, the WW begins with an extremely relevant and engaging topic, "managing workload pressure" (Hughes et al., 2019, p. 3). I will facilitate the first couple of WW sessions to model the way for the other change implementers (Kouzes & Posner, 2017). Mental health clinicians will be able to observe me facilitate the first two WW sessions, to inform their decision regarding whether or not they want to take on the role of change implementer. In the mobilization phase, specific details, such as the roster of WW session facilitators and the dates of evaluation sessions will be established. The change implementers will meet some time after the first two sessions to sign up for the WW session(s) that they are willing to present. Northouse (2022) states that servant leaders focus on "helping followers grow and succeed" (p. 262). Helping MHCs grow is the impetus for this OIP. I will make myself more available for all MHCs during this time, to provide support, encouragement, and appreciation for their contribution to the change initiative (Kang, 2015). I will also focus on creating enthusiasm about the change initiative for all MHCs.

Acceleration Phase/Maintenance Stage

The acceleration phase "involves listening carefully to [change implementers and change recipients] concerns and insights, adjusting… [the] approach and helping them adapt to better understand what is in it for them and the organization" (Deszca, 2020, p. 22). This is consistent with Prochaska and DiClemente's (2005) maintenance stage, where change leaders seek to support participants, so that they do not relapse into their previous problematic behaviours. I will invite MHCs to provide me with feedback about the change initiative at any time, I will also

encourage MHCs to participate in the plan, do, study, act (PDSA) cycles, and the strengths, weaknesses, opportunities, threats (SWOT) analyses during this stage. These evaluation processes will be thoroughly described in the evaluation section.

During the acceleration phase, MHCs will ideally be attending the WW sessions regularly, actively participating, and applying the WW content into practice. Although it is discussed in a later section, utilizing the communication strategy is a major component of this phase (Deszca, 2020). Additional strategies may be used to improve the process during the Acceleration Phase, such as celebrating small wins (Kotter, 2012), and giving rewards for team accomplishments (Deszca, 2020). These strategies could be utilized at various times, including during WW sessions, SWOT analyses, as well as informally in the correspondence with the MHCs. If resistance to the change plan develops, I will address it with curiosity and concern. As a servant leader I will strive for awareness of MHCs perspective, and personally support them (Northouse, 2022). I will anchor my leadership stance in empathy and support, focusing on shared values and a shared vision (Kouzes & Posner, 2017). Any issues that arise need to be addressed promptly, in order to optimize the positive impact of the WW (Deszca, 2020).

Institutionalization Phase/Completion Stage

A goal of the institutionalization phase is that MHCs will be regularly engaging in more self-care. The WW is approximately 1 year in duration; however, the longer-term goal of this change initiative is that self-care practices become institutionalized indefinitely on the PCG, eventually becoming a second-order change with time. As an informal leaders, I will advocate for regular team-based self-care practice, and that the PCG be reconceptualized as a VT-informed team; however, formal leadership will ultimately decide the extent to which self-care will be institutionalized beyond this change initiative.

A significant aspect of the institutionalization phase is using assessments to measure success (Deszca, 2020). Assessment will be done using the PDSA cycles. As a final team-based assessment, all MHCs will be invited to participate in the final SWOT analysis. The final SWOT analysis would be a part of the *study* phase of the final PDSA cycle. The outcome of this final SWOT analysis will be the PCG's vision to address the OS and OHs of providing mental health care. The PCG will then apply the desired changes in the final *act* component of the final PDSA cycle. As a separate aspect of KMb, I will create a wellbeing resource that considers MHC's feedback on the content and the process of the change initiative. I will then present this KMb resource to my supervisor as a resource for them to consider utilizing in the future.

Near the end of the change initiative I will begin to solicit feedback regarding the MHCs' preferred way of celebrating the end of the change initiative. I will recognize the PCG's support and willingness to engage in the change initiative. I will also recognize my supervisor for their support throughout this process as well. Factors, such as work-time and costs of the celebration, would be determined collectively towards the end of the .

Summative Discussion

While the WW has been adapted into a one-year program, the change implementation plan is longer, including months of pre-implementation work in the awakening phase, and the development of the enhanced wellness resource that will continue after the change initiative is completed. As the change initiator I have aimed to balance providing MHCs with leadership opportunities, while also being mindful of the competing demands for their time, particularly in the fall when services are predictably busier. This intention is consistent with Portoeghese et al. (2014), who concluded that "managers should devise strategies aimed at reducing workers' workload and increasing their sense of control" (p. 201). As a servant leader, I will strive to be

attuned to emotional needs of my followers in this change plan (Northouse, 2022). Consistent with critical theory, I will strive to improve the working conditions for those on the front-line, in order to reduce their potential suffering (Capper, 2019). This change implementation plan aims to accomplish both of these feats by replacing the first 30 minutes of team meetings with a brief WW session. The supervisor has reported that the timing of this change initiative is ideal, as there has been a lack of agenda items at team meetings. The supervisor is supportive of my vision to fill this void with health promoting practices.

In addition to the many benefits of the change implementation plan, there are also some limitations. Given the length of the WW, MHC's engagement could wain over time. Also, as identified in the OCC, there are many shifts in upper leadership that are currently underway at SC. If new leadership proposes changes that impact the MHCs directly, MHCs may be distracted and less engaged in the change process. For this reason, I will focus on sustaining engagement with both change implementers and change recipients. The communication plan will guide much of this process.

Communication and Knowledge Mobilization Plan

Communication is the most important competency in leading change (Woodward & Hendry, 2004). A communication strategy is essential for organizational change as it can clarify the who, what, where, when, why, and how of change, and reduce ambiguities, barriers, and delays. After reporting on some of the foundational attributes of communication, I discuss how communication will be stakeholder specific. Lastly, I present a communication strategy that change implementers can use to enhance their communication throughout the change process.

Skillful communication requires leaders to know their audience (Lewis, 2019). As the purpose of a change initiative can vary across stakeholders and participants, it is important to use

targeted messages (Lewis, 2019), particularly with formal leadership. Being a front-line MHC, I need to communicate to formal leadership regarding how this change initiative is aligned with SC's strategic plan (Strong Communities, 2022b). When communicating with MHCs, I will explain how the WW is aligned with the strategic plan, with emphasis on the aspects of this alignment that are important to MHCs. I will communicate how, from a critical perspective, my purpose in this change initiative is to empower MHCs and improve mental heath services to people from marginalized groups. This message will likely resonate with all of the MHCs.

The communication plan addresses the different change roles that leadership and MHCs have. It is largely based on the work of Laurie K. Lewis (2019), who describes many communication strategies and techniques. The WW has been broken down into easy-to-follow sections. Please note the outline of the WW sessions in Appendix B. Simplicity was prioritized in the communication strategy, to best coincide with the simplicity of the WW. This pairing enhances the clarity and synchronicity the change process, and allows me and the other change implementers to utilize the communication strategy in a practical manner. Deszca et al. (2020) would validate this approach, stating that "when the change is simple and straightforward, the nature of the communication plan is also simple and straightforward" (p. 24). This section includes the KMb plan as well. See Appendix C for the complete KMb plan. I anticipate that much will be learned over the course of the change initiative. The KMb plan focuses on transferring knowledge from the WW to the PCG. A second aspect of the KMb plan is capturing the strengths from the WW and the change process, and then creating an enhanced wellness resource that can be utilized in the future.

Communication with Stakeholders

In this communication plan, I include MHCs, the supervisor, and the community executive, as the relevant stakeholders. There are a variety of formal approaches to communication (e.g., announcements, calendar invitations, agenda items in team meetings, scheduled group meetings, and supervision sessions) as well as informal approaches to communication (e.g., an open-door policy and occasional check-ins in with leadership and MHCs) that I will be able to utilize when engaging with stakeholders (Lewis, 2019). Regular dialogue and timely responses to ideas, questions, and concerns, will be a priority, as they should help to reduce resistance to change and optimize the effectiveness of the change plan (Deszca et al., 2020). During discussions I will prioritize requests for input and feedback, which can also help reduce resistance to change, as well as increase employee satisfaction, increase the stakeholders' feeling of control, and reduce change uncertainty (Lewis, 2019). The 50+ WW sessions (see Appendix B) will be the foundational opportunity for team-based communication to occur in person.

Communication with Leadership

The two main leaders influencing the change initiative are the supervisor, and the community executive. Because SC has a "chain of command", I will direct the bulk of communication to my supervisor. As I co-chair a committee with the community executive, I will engage in informal dialogue about the change initiative with them. This is a norm of practice at SC, endorsed by the community executive who has a relational approach to leadership. Regarding formal communication with the community executive, I will speak to them regarding their desired level of involvement, and oblige their preference. The supervisor is the change champion of this change initiative. I will maintain regular correspondence with the supervisor,

and solicit their input throughout the change process. Northouse (2022) suggests that servant leaders be persuasive, using “gentle non-judgemental argument” (p. 256). I will use this approach with leadership and MHCs.

Communication with Mental Health Clinicians

The literature suggests that correspondence between change leaders and front-line employees should be frequent during the implementation of organizational change (Kotter, 2012). Multiple methods of communication can help the team function properly during the change. Some information may also be more detailed and require more in-depth discussion. Lewis (2019) highlights the vital need to disseminate information with stakeholders, especially with regards to:

- clarifying roles, tasks, responsibilities, and procedures
- reminding stakeholders of the rationale and goals of change
- widespread dissemination of information to multiple stakeholders
- repetition of messages
- communicating about change in everyday activities (p. 63).

The communication themes identified by Lewis (2019) will be applied to the PCG team as a whole, as well as with the group of change implementers separately, because the roles, tasks, goals, and responsibilities are different among these two groups. While all MHCs may have the goal of reducing CS, for example, change implementers will likely have other goals that are distinct to their roles as well, such as effectively presenting the WW session, or developing their informal leadership capacity. I will support MHCs in their career goals, as this is a priority of servant leaders (Northouse, 2022).

Change implementers will be involved in both lateral and vertical communication. I will include change implementers in several emails to the community executive. There are many positive functions of this behaviour, such as: modeling inclusivity as a leader, recognizing the MHCs who are stepping into informal leadership roles, and demonstrating trust in followers. All of these functions support collaboration and change efforts (Deszca et al., 2020; Kouzes & Posner, 2017).

Communication Strategy

As the change initiator and the primary change implementer, it will be my responsibility to ensure that there is clear communication throughout the change process. In order to do so, I have created a basic communication strategy that sequentially considers the CPM's phase of organizational change (Deszca et al., 2020), the FPEL (Kouzes & Posner, 2017), and smaller/micro communication strategies (Lewis, 2019). I will utilized this communication strategy to increase the effectiveness of communication with change implementers and change recipients.

Lewis (2019) identifies the following communication strategies: disseminating information/soliciting feedback, one-sided or two-sided messaging, gain or loss frames, blanket/targeted messages, and discrepancy/efficacy (p. 161). Disseminating information and soliciting feedback are the foundations of clear communication. They will be done in a thorough and inclusive manner, as previously described. One-sided messaging narrowly focuses on the need for stress-reducing practices and the benefits of the WW, whereas two-sided messaging (discussing both sides of the argument) would express the functions of the status quo behaviour (Lewis, 2019). Both strategies will be utilized, so that MHCs can see the entire situation, inclusive of both benefits and challenges. The next strategy is Gain or Loss Frame. Gain refer to

the benefits of engaging in the change, and loss refers to the problems associated with disengagement in the change process (Lewis, 2019). I will use gain or loss frames in the orientation session, by encouraging MHCs to engage in the change initiative to prevent the likelihood of experiencing an OH. A balanced approach to these change strategies is ideal, as catastrophizing current practice, or exaggerating the benefits of the change plan, could compromise my leadership credibility (Lewis, 2019).

Sending blank and targeted messages involves broadly distributing information, or privileging certain stakeholder groups with more details, or inside information (Lewis, 2019). I will utilize both communication strategies in this change plan, as sending targeted messages to change implementers will spare change recipients from receiving excessive and irrelevant correspondence. I will send blank messages, such as team emails, to foster collaboration and promote inclusivity. The final communication strategies are discrepancy and efficacy. Discrepancy refers to the importance of change, and efficacy refers to the likelihood that the WW will have a positive impact (Lewis, 2019). Most of the weekly sessions in the WW utilize discrepancy and efficacy, as they typically begin with communicating why the topic is important, and end with suggesting ways to improve upon the respective issues (Hughes et al., 2019). Discrepancy aligns well with SL and the FPEL, as using discrepancy will encourage MHCs by connecting the change initiative with meaningful outcomes (Kouzes & Posner, 2017; Northouse, 2022).

These micro communication strategies are the last variables to consider in the greater/macro communication strategy. First, I will consider the phase of change that I am in (Deszca et al., 2020). Next, I will consider how my intentions align with the FPEL (Kouzes & Posner, 2017). The FPEL provide evidence-informed direction on effective focuses of

communication, such as inspiring a shared vision, providing meaningful encouragement, and challenging processes. Kouzes and Posner (2017) also direct leaders to consider non-verbal communication, such as modeling desired behaviour. The last aspect of the macro communication strategy is determining if communication would be further enhanced by using the smaller/micro communication strategies described by (Lewis, 2019). This sequence identifies *where* the change process it at, *what* I am trying to accomplish, and then *how* I can effectively move the change initiative forward through skillful communication.

Knowledge Mobilization Plan

Knowledge mobilization is defined as "the reciprocal and complementary flow and uptake of research knowledge between researchers, knowledge brokers and knowledge users… in such a way that may benefit users and create positive impacts…" (Social Sciences and Humanities Research Council, 2019, definition). There are two distinct KMb processes in this change plan. The first is mobilizing the content knowledge from the WW, and the process knowledge reviewed in this OIP, into the change initiative. This will better ensure that the change initiative is done efficaciously. The second KMb process will consolidate the learnings from this change initiative into an enhanced wellness resource that will be shared with my supervisor and other PCG teams at SC. This will promote the concept of SC becoming a VT-informed organization. Both of these KMb processes are incorporated into the KMb Plan (see Appendix C). As the KMb plan is only a one-page document, it does not thoroughly report on all of the KMb that is expressed in this OIP. Instead, the KMb plan describes a flowchart of 9 phases that include the 2 KMb processes. Most of the second KMb process will occur after this change initiative is completed.

The first KMb process is transitioning the knowledge from the WW to the PCG. Strategies, such as integrating the change initiative into existing meetings promotes KMb, as it routinizes knowledge brokering, exchange, and disseminations, which are 3 domains of KMb (Carleton University, 2014). The second KMb process involves creating an advanced wellness resource after this change initiative. I will prepare for this by documenting feedback from the SWOT analyses. I will create this resource as an individual project after this change initiative is completed. Optimally, the vision for a VT-informed organization will be articulated effectively in the second KMb process. I will share this wellness resource with my supervisor and leadership at SC in neighbouring communities. My supervisor has expressed support for this process.

Summative Discussion

More communication is not always better (Lewis, 2019), particularly with MHC, as they have many competing demands (Acker, 2010a) and navigating excessive communication could add to OS. The WW will be the main knowledge that is mobilized to MHCs in this change initiative. After the change initiative, I will create a wellness resource that will be shared with leadership. Both of these KMb processes will focus on clearly communicating practical information (Carleton University, 2014). The WW is user-friendly and experiential, and the communication strategy consists of basic, but effective, techniques to promote change and KMb. An additional flowchart that includes the 9 phases of KMb has been created (see Appendix C). This communication strategy will allow for change implementers, change recipients, and leadership, to have genuine and skilled communication, without getting bogged down by excessive and overly specific information.

Monitoring and Evaluation Plan

To increase the likelihood that change efforts are both successful and effective, change leaders need to implement monitoring and evaluation practices (Topno, 2012). Even though the topic of evaluation is described toward the end of this OIP, it is perhaps the most important section. In this section I briefly define the key terms, before reporting on the monitoring and evaluation plans. As a servant leader, I have designed the monitoring and evaluation plans to optimize the experience for MHCs.

For the purpose of this change plan, monitoring is defined as: tracking the extent to which MHCs engage in the change initiative. Monitoring is an objective process with a behavioral focus, and its purpose is to reduce any barriers that might interfere with MHCs ability to engage in the change plan. Evaluation is distinctly different from monitoring, as it is "the planned, periodic, and systematic determination of the quality and value of a program, with summative judgment as to the achievement of a program's goals and objectives" (Markiewicz & Patrick, 2016, p. 150). The program being evaluated is not only the WW, but the entire change process.

Monitoring

An intentional monitoring process is vital to organizational change initiatives for several key reasons. The first reason is tracking employees' engagement in the change process, to ensure that the process sustains its integrity and the MHCs experience the benefits. Markiewicz and Patrick (2016) explain that "the word *monitoring*, when traced to its Latin roots, [actually] means 'to warn'" (p. 121). Monitoring can warn change leaders as to whether or not MHCs are disengaging in the change initiative. Consistent with CT, the goal of identifying MHCs' disengagement in the change initiative is to understand the shortfalls of change process, and to use my privileged position to increase support to those who need it (Capper, 2019). Even though

monitoring practices can provide frequent insights into the change process, more monitoring is not necessarily better. If employees perceive themselves to be under surveillance, it will likely lead to negative consequences (Child, 2015). Table 6 outlines the monitoring focuses and the specific monitoring tools for each of the CPM phases. Change implementers and I are not explicitly tracking MHCs for accountability or correction. Instead, we will utilize these monitoring tools to build awareness into MHCs level of engagement. If MHCs seems to be disengaging from the change initiative, change implementers and I will seek to support the respective MHCs.

Table 6

Monitoring Plan

CPM Phase	Monitoring Focuses	Monitoring Tools	
Awakening	Participation	Attendance checks	One-to-one meetings
Mobilization	Engagement	Check-ins	Session Facilitation
	Collaboration	Content dialogue	Contribution
Acceleration	Leadership	Group feedback	Change talk
Institutionalization	Barriers or challenges	Individual feedback	

Note. Monitoring tools are to be casually implemented to promote engagement in the change process.

A second function of monitoring is to provide information and context that is essential for an accurate evaluation (Markiewicz & Patrick, 2016). The level of MHCs engagement in the change initiative could influence their evaluation of it. Even though monitoring is an essential practice, it is often received with anxiety by participants. For this reason, the monitoring tools in this change plan will be applied in a casual manner. For instance, attendance checks (see Table 6) are included as a monitoring tool to remind change leaders to be aware of who is present or

absent in room. Attendance checks would not involve formally tracking attendance. Servant leaders need have awareness of their surroundings to better support their followers (Northouse, 2022). By monitoring MHCs engagement in the change initiative, change leaders can make positive adjustments to the change process along the way, and optimize the benefits for change recipients (Markiewicz & Patrick, 2016).

Evaluation

Evaluation practices are utilized in this change plan to assess the impact of the WW on MHCs wellbeing, as well as to assess the effectiveness of the change process itself. This change initiative will be evaluated using three PDSA cycles (Deming 1994/2018). Evaluating multiple times throughout the change plan prompts adaptations and optimizes the change process (Deszca et al., 2020). The orientation session will initiate the first PDSA cycle. The *study* portion of each PDSA cycle will include a SWOT analysis. The *study* stage/SWOT analyses will take place during the three evaluation sessions of the change initiative. The third SWOT analysis will be the final evaluation meeting of the change initiative, which will take place during the institutionalization phase of the CPM (Deszca et al., 2020). The final *act* stage of the final PDSA cycle involves MHCs and the supervisor explicitly stating the VT-informed practices that they want the PCG to incorporate moving forward. They would then implement these collaboratively agreed upon practices. The final *act* stage continues beyond this change initiative. During the final *act* stage, I will build on the knowledge gained throughout this change initiative, and I will create an enhanced wellness resource.

The evaluation process in the change initiative involves three PDSA cycles. Each stage in the PDSA cycle will be described below. As mentioned, the *study* stage of each PDSA cycle will include a SWOT analysis. Using a SWOT analysis is an effective method to evaluate healthcare

practices and mental health services (Aslan et al., 2014; Ma et al., 2021). Other analyses, such as a force field analysis (Deszca et al., 2020) were considered; however, the SWOT analysis was chosen as it assesses both present and future contexts of the change initiative. All of the participants in the change initiative will be strongly encouraged to participate in each SWOT analysis, to ensure that the voices of front-line MHCs are heard. Strategies, such as providing food, will be used to encourage attendance and engagement. I will personally fund the food for the evaluation sessions unless the supervisor insists otherwise. As a servant leader, I am deeply interested in the unique perspectives of MHCs (Spears, 2018), as well as invested in their professional growth (Greenleaf 1977/2002). The three PDSA cycles will help to optimize the content of the WW over the course of the change initiative. Having three PDSA cycles will allow for any process issues to be promptly identified and addressed.

The Plan, Do, Study, Act (PDSA) Cycle

The PDSA cycle was created by the American engineer, William Deming (Deming 1994/2018). The PDSA cycle is the most commonly used continuous quality improvement approach to evaluation (Laverentz & Kumm, 2017). As such, staff at SC are typically familiar with the process. The PDSA cycle has four sequential stages that explore ways of improving processes and outcomes (Donnelly & Kirk, 2015). Taylor et al. (2014) explain that "the four stages [in the PDSA cycle] mirror the scientific method of formulating a hypothesis, collecting data to test this hypothesis, analysing and interpreting the results and making inferences to iterate the hypothesis" (p. 291). Both MHCs familiarity with the PDSA cycle, as well as the PDSA cycles resemblance of the scientific method, are likely to decrease resistance to the evaluation process, as MHCs on the PCG seem to value these attributes.

Consistent with this evaluation plan, Deszca et al. (2020) suggest that change leaders "break[] the change down into a number of smaller, manageable stages that begin with exploratory research and evaluation, followed by a pilot project…" (p. 147). Primary research on the PoP, the vision for change, and the change plan, has been completed and reported in this OIP. The change initiative will be broken down into three smaller PDSA cycles, commensurate with the three distinct sections of the WW (see Appendix B). I will facilitate a SWOT analysis after each section of the WW. The SWOT analyses will be a part of the *study* stages of the three PDSA cycles. These analyses will be the formal evaluation meetings of this change initiative. The final SWOT analysis will be the final evaluation meeting of the change initiative. Please see Appendix D for the template of SWOT analysis questions.

Plan. The *plan* stage requires that the problem, in this case the PoP, is explicitly stated (Donnelly & Kirk, 2015). The orientation session will initiate the first *plan* stage. During the orientation session I will inquire about MHC's perspectives on the PoP. Subsequent *plan* stages may identify other problems as well, such as problems with the change initiative itself. Connelly (2021) noted that "the term predicting also is used" (p. 61) to describe this stage. As a servant leader, I will express my intentions in this stage, in order to be transparent and foster trusting relationships (Covey, 2018). I will invite MHCs to share their intentions and predictions as well. This is consistent with Kouzes and Posner (2017) who encourage leaders to inspire a shared vision, as the second practice of the FPEL.

Do. The *do* stage typically involves tracking data to assess patterns over time (Donnelly & Kirk, 2015). This stage is important as it builds awareness about the change process. Awareness is a key characteristic of SL (Northouse, 2022). The data that will be focused on in this stage mainly includes the perspectives on the content of the WW and the change process

itself. While MHCs will be free to express issues pertaining OS, this type of information will not be recorded. I will track feedback, such as which WW topics MHCs found helpful, to inform SWOT analyses.

Study. As noted, the study stage will occur three times over the duration of the change initiative. In the *study* stage the focus is on analysing the content of the WW, and the process of the change initiative. Edward Deming, the creator of the PDSA model, sometimes used the term "check" instead of "study," to describe this stage (Moen & Norman, 2009). This nuance is helpful to consider, as it highlights the need to confirm that the initiative is running in an optimal manner (checking).

To have a more comprehensive discussion during the *study* stage, a SWOT will be utilized. This is consistent with the third practice of the FPEL, challenge the process (Kouzes & Posner, 2017). Strengths, weaknesses, opportunities, and threats analyses have four self-titled categories, each having a series of possible questions and discussion prompts. Please see Appendix D for the SWOT analysis template that will be utilized in this change initiative. The first two categories, strengths and weaknesses, explore "what is working well?" and "what is not?". The third quadrant in the SWOT analysis assesses opportunities to improve the change initiative. While the WW comprehensively addresses wellbeing (Hughes et al., 2019), it is lacking in information on CF, which MHCs may want to incorporate into the change initiative. As *listening* is core characteristic of SL (Northouse, 2020), I will prioritize the perspectives of MHCs regarding whether or not they would want to incorporate information on CF. If MHCs express that they want to incorporate information on CF, for example, we will collaboratively explore how to do this during the SWOT analysis sessions.

Act. Once the SWOT analysis is complete, the PCG will move into the *act* stage. Taylor et al. (2014) clarify that "the 'act' stage identifies adaptations and next steps to inform a new cycle" (p. 291). In the act stage, agreed upon changes are made explicit and practiced. I will initiate the *act* stage by sending MHCs an email after each SWOT analysis. These emails will summarize the highlights of the SWOT analysis, and share the agreed upon action items. Figure 5 displays the general content of each of the stages in the PSDA cycle.

Figure 5

Plan, Do, Study, Act Cycle (PDSA)

Plan -Explicitly state the problem(s) -During the orientation session, communicate the literature on the PoP. -Inquire about MHCs experience with the problem, and how they address it. -Express predictions about the outcomes of the change initiative.	**Do** -Participate in the WW as scheduled -Record feedback about the implementation process -Record MHCs perspectives of the WW
Act -Explicitly state changes that were planned in the *study* stage -Implement action items identified in the *study* stage -Build on new knowledge.	**Study** -Facilitate an evaluation session -Conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis

Note. There will be three PDSA cycles throughout this change initiative

Evaluation Summary

The three PDSA cycles will be the foundational evaluation process in this change initiative. A SWOT analysis will be conducted during each of the three *study* stages of the PDSA cycles. Each SWOT analysis will involve the group of MHCs collectively and comprehensively reviewing the change initiative, and proposing improvements for the follow PDSA cycle(s).

Consistent with CT, this evaluation process provides a platform for MHCs on the front-line to have their voices heard. I will strongly consider the input from MHCs when I develop an enhanced wellness resource, following this change initiative.

Chapter 3 Summary

In the final chapter of the OIP, a change implementation plan was developed to operationalize the WW at SC. The plan goes through the organizational change phases, described in the CPM (Deszca et al., 2020). Prochaska and DiClemente's (2005) SoC were linked to the CPM to optimize the change process for MHCs. A communication plan was developed that considers the phases of the CPM (Deszca et al., 2020), the FPEL (Kouzes & Posner, 2017), and smaller/micro change strategies (Lewis, 2019). Two main processes of KMb were described. The first KMb process will transfer knowledge from the WW to the MHCs. The second KMb process will transfer the content and process knowledge that will be gained during this change initiative, into a wellness resource that may be used by a broader audience at SC. Monitoring and evaluation plans were created to enhance MHCs engagement, and influence, in the change initiative. The evaluation plan includes three PDSA cycles, with a SWOT analysis during each of the *study* stages. The intention throughout this chapter, and the entire OIP, is to prevent the accumulation of OS, and the occurrence of OHs, at SC. As a servant leader I aspire to see all MHCs become healthy leaders themselves, and have a positive impact on the people they serve (Greenleaf 1977/2002).

Next Steps and Future Considerations

Although this OIP is focused on one mental health team in one community, the content and potential benefits could extend much further. Change may "look incremental in the short term, but have significant long-term effects" (Deszca et al., 2020, p. 147). While the benefits of

participating in this change initiative may seem small initially for MHCs, they could trigger significant change over time. By investing in their wellbeing, MHCs are more likely to flourish in their careers, and avoid CF and burnout. The benefits of MHCs investing in themselves are likely to trickle down to positive outcomes for their clients as well.

This OIP is also intended to "plant the seed" that the PCG becomes a VT-informed team, and SC becomes a VT-informed organization. This conceptual pivot and second-order change would require significant support of leadership at SC. Following this change initiative, I will begin to develop an enhanced wellness resource, building on knowledge gained from this change initiative. This wellness resources could be used by the PCG, or by other teams at SC in the future. Strong Communities also consists of social work and youth justice teams. Although there are differences among these teams, we are all helping professionals who sometimes suffer in our attempts to reduce the suffering in others (Acker, 2010a; Figley, 2002). My hope is that all front-line employees at SC engage sufficient self-care throughout their careers. By becoming a VT-informed organization, staff at SC could have careers helping others, while protecting their own health in the process.

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Appendix A: The Hybrid Change Framework: Key Characteristics and Change Strategies

Change Path Model (CPM) Phase	Key Characteristics	SoC	Change Strategies
Awakening	Problem of Practice is established Change plan is developed Support from formal leadership is obtained Professional Counselling Group is aware of the change initiative	Pre-Contemplative Contemplative	Consciousness raising Motivational Interviewing Self-liberation Dramatic relief/ Emotional Arousal
Mobilization	Orientation Session (overlaps with previous phase) Change plan is revised Change implementers join the change initiative Wellbeing Workout (WW) sessions begin	Preparation/ Action	
Acceleration	WW sessions continue Change implementers join the change initiative (overlaps with previous phase) Change implementers meet Facilitation roster for WW sessions is developed Two evaluation sessions occur	Maintenance	Counter-conditioning Stimulus control Reinforcement management
Institutionalization	Final evaluation session occurs Plan to routinize self-care establish Celebration ceremony Development of enhanced wellness resource begins	Completion	Recognize individual efforts.

Note. This appendix is a general timeline of events that was created to inform change leaders about change strategies in the Stages of Change (SoC) model (Prochaska & DiClemente, 2005). Specific information (such as: communication strategies, the monitoring plan, and the evaluation plan) are not included.

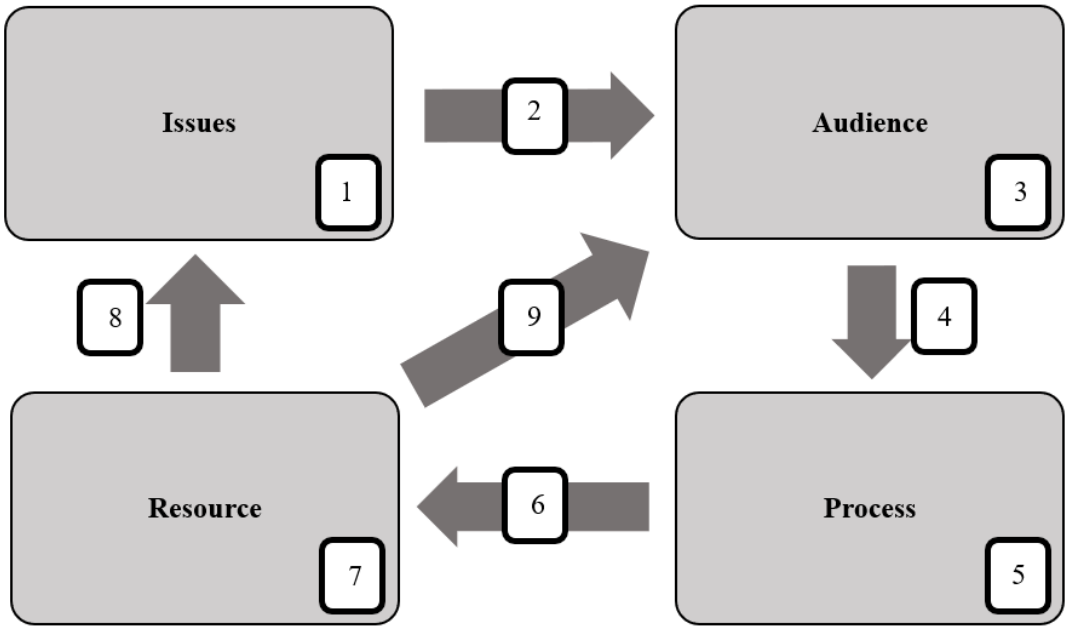
Appendix B: The Wellbeing Workout: Sections and Subsections

	Section 1: Stress Management	**Section 2: Personal and Family Life Management**	**Section 3: Personal Resilience**
1	Managing workload pressure	Spousal relationships: Annual reviews	Personal fulfillment, satisfaction, and purpose
2	Choice and control	When relationships end	Work-life balance
3	Task procrastination	Anxiety management	Personal and professional development
4	Constructive criticism and managing rejection	Living with depression	Acceptance strategies
5	Maximizing personal efficacy	Changing negative thinking patterns	Emotional intelligence
6	Dealing with difficult people	Bereavement and loss	Assertiveness
7	Managing conflict at home and work	Stages in life	Constructive anger
8	Redundancy and retirement	Help: Asking for it and finding it	Developing self-confidence
9	Work satisfaction	Parenting pre-teens	Setting meaningful goals
10	Effective delegation	Addictions	Mindfulness
11	To know or not to know	Personal wellness toolkit	Life cycle events: Losses and gains
12	How to get on in your career	Coping with illness	Rest and relaxation
13	Confident public speaking		Looking after yourself and self-care
14	The myths of perfectionism		Problem-focused resilience
15	Managing change in organizations		Solution-focused resilience
16	Working with global uncertainty		Change-focused resilience
17	Personal stress management toolkit		Managing a crisis
18	Organizational savviness		Avoiding burnout
19	Networking and your dream team		How to tolerate ambiguity
20	Spotting signs of stress in others		Procrastination

Appendix C: Knowledge Mobilization Plan

The Knowledge Mobilization (KMb) plan has 9 separate phases:

1. Identify the key issue and the plan to address it
    - Conduct a comprehensive literature review
2. Disseminate information
    - Facilitate orientation session for leadership and mental health clinicians (MHCs)
    - Create presentation with thought-provoking figures, tables, and images
3. Collaborate with the audience
    - Engage in meaningful dialogue with MHCs
    - Identify barriers and concerns, and plan to mitigate them
4. Recruit support (overlaps with the beginning of phase 5)
    - Present the opportunity for MHCs to become change implementers
    - Finalize change plan with presentation roster and identifying important dates
5. Implement the change initiative
    - Implement the change initiative according to the change plan
6. Consolidate learning (process begins during change initiative)
    - During the three Plan, Do, Study, Act (PDSA) cycles, identify both content and process strengths and weaknesses. With emphasis is on final evaluation session.
7. Create wellness resource (primarily following change initiative)
    - Use insights from the change initiative to develop an enhanced wellness resource
8. Prevention strategy (primarily following change initiative)
    - Advocate for conceptualization as a vicarious trauma-informed team/organization
9. Disseminate information (following the change initiative)
    - Expand the change initiative by sharing wellness resource



Appendix D: Strengths Weaknesses Opportunities Threats (SWOT) Analysis

STRENGTHS	**WEAKNESSES**
What do we do well?	Where can we improve?
What do our clients say we do well?	What do our clients frequently complain about?
How are we currently investing in wellbeing?	Which objections are hard to address?
What assets do we have?	Are we new or not well known?
What networking do we have?	Do we have any limitations in distribution?
What relevant skills do we have?	Are our resources and equipment outdated or old?
What wellbeing activities are we doing that others are not doing?	Are we lacking in staff, skills, or training?
OPPORTUNITIES	**THREATS**
Is there data that we could benefit from?	Are partner agency's programs sustainable/compromised?
Are there cultural shifts that may work in our favor?	Are there cultural shifts that may work against us?
Are there any untapped resources?	Are MHCs actively looking for other occupations?
Are there upcoming events we could benefit from?	Are there industry or economic trends that could work against us?
Are there geographic expansion opportunities?	Are there social or political trends that could work against us?
Are there potential new sources of financing?	Are there any new technologies that could work against us?
Are there any new technologies that could benefit us?	

Note. Adapted from "SWOT Analysis Template" *by* D. Shewan, 2022, *How to Do a SWOT Analysis (With Examples & Free Template!)*. Wordstream. https://www.wordstream.com/blog/ws/2017/12/20/swot-analysis. Copyright 2023 by WordStream.