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The Roles of Individual and Organizational Factors in Burnout among Community-Based Mental Health Service Providers

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Abstract

Public sector mental health care providers are at high risk for burnout which negatively affects not only provider well-being but also the quality of services for clients and the functioning of organizations. This study examines the influence of demographics, work characteristic, and organizational variables on levels of burnout among child and adolescent mental health service providers operating within a public sector mental health service system. Additionally, given the dearth of research examining differences in burnout levels among mental health sub-disciplines (e.g., social work, psychology, marital and family therapy) and mental health programs (e.g., outpatient, day treatment, Wraparound, case management), analyses were conducted to compare levels of burnout among multiple mental health disciplines and program types. Surveys were completed by 285 providers across 49 mental health programs in a large urban public mental health system. Variables representing dimensions of organizational climate and transformational leadership accounted for the greatest amount of variance in provider reported burnout. Analyses demonstrated significantly lower levels of depersonalization among Wraparound providers compared to traditional case managers. Age was the only demographic variable related to burnout. Additionally, no significant effects were found for provider discipline or for agency tenure and caseload size. Results suggest the need to consider organizational development strategies aimed at creating more functional and less stressful climates and increasing levels of transformational leadership behaviors in order to reduce levels of burnout among clinicians working in public mental health settings for youth and families.

Keywords

Burnout; leadership; transformational leadership; organizational climate; public sector services

Burnout is a significant problem among mental health service providers, with a recent review indicating that 21-67% of mental health providers experience high levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Burnout has important influences at the provider, client, and organizational levels (Maslach, Schaufeli, & Leiter, 2001; Morse, et al., 2012). Recent efforts have begun to explore correlates and predictors of

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burnout in order to design effective interventions to reduce burnout and its subsequent negative effects. Although a considerable body of research indicates a need for more organizational level interventions, a dearth of research on these interventions persists (Morse, et al., 2012). In order to design programs to promote system-wide change aimed at reducing provider burnout in mental health settings, and thereby improving client outcomes, organizational characteristics must be considered in conjunction with individual characteristics.

Burnout among human service professionals has been described as having three main components: emotional exhaustion (i.e. exhaustion), depersonalization (i.e. cynicism), and reduced feelings of personal accomplishment (i.e. lack of professional efficacy) (Maslach, Jackson, & Leiter, 1996; Maslach & Schaufeli, 1993). From a service quality standpoint, these dimensions of burnout relate to reduced levels of emotional energy needed to put forth towards client care (emotional exhaustion), decreased levels of compassion towards clients and their presenting or ongoing problems (depersonalization), and lack of a sense of competence and satisfaction with one's work (reduced feelings of personal accomplishment). By definition, burnout inhibits an individual's ability to perform optimally at work, hence likely sacrificing service quality. Not surprisingly, negative impacts of burnout on client outcomes has been established, particularly where clients present with more severe symptoms (Morse, et al., 2012). For example, one study found that increases in team level emotional exhaustion predicted decreased client satisfaction, but only for clients with more severe symptoms (Garman, Corrigan, & Morris, 2002).

In addition to negatively influencing the quality of care, high levels of burnout can also have deleterious effects on a clinician's physical and mental well-being. Many of the physical health issues associated with burnout are related to emotional exhaustion and are similar to the physical health correlates of prolonged stress (Maslach et al., 2001). Other studies have cited a relationship between burnout and more specific physical conditions, such as flu-like symptoms and gastroenteritis (Acker, 2010), as well as neck and back pain (Peterson et al., 2008). Numerous studies have supported a relationship between burnout and increased substance use, depression, and anxiety (Morse et al., 2012), as well as diminished well-being (Stalker & Harvey, 2002). Finally, burnout has a negative impact on an organization as a whole. Among various populations, burnout has been linked to reduced work engagement (Halbesleben, 2010), absenteeism (Harvey & Burns, 1994; Schaufeli, Bakker, & Van Rhenen, 2009; Stalker & Harvey, 2002), turnover (Green, Miller, & Aarons, 2013), lower levels of job satisfaction (Prosser, et al., 1997), and decreased employee morale (Stalker & Harvey, 2002), placing considerable burden on organizational functioning.

Although burnout occurs throughout a variety of work contexts and job roles, extant literature indicates that mental health providers may be at heightened risk for burnout due to the emotional demands associated with mental health care (Awa, Plaumann, & Walter, 2010; Zapf, Seifer, Schmutte, Mertini, & Holz, 2001). Despite the increased risk for burnout among mental health care workers, there is currently a lack of research comparing burnout levels across disciplines (i.e. psychology, social work, or marriage and family therapy) and program types (i.e., outpatient, day treatment, case management, and Wraparound) that may provide distinct experiences and risk factors. A recent review of burnout noted that most

mental health studies have only examined levels of burnout within one discipline or have aggregated responses across multiple disciplines working in a single service setting, limiting the ability to describe differences that may be important for burnout prevention and intervention programs (Morse et al., 2012). With regard to differences among burnout levels in different types of mental health programs, clinicians working in outpatient services have been found to be at a higher risk for burnout compared to those working in inpatient settings (Prosser, et al., 1997). However, this study did not consider variability among various types of outpatient services.

Predictors of Burnout

Burnout occurs as a result of a complex interplay between individual and organizational factors. Several individual level factors, including external locus of control, poor self-esteem, and maladaptive coping styles, have been associated with burnout (Maslach et al., 2001). The association of demographic risk factors with burnout has also garnered some support. A recent meta-analysis examining gender differences in burnout across a wide range of occupations found that women reported significantly higher levels of emotional exhaustion ($k=199$, $d=.09$), and men reported significantly higher levels of depersonalization ($k=184$, $d=-.19$) (Purvanova & Muros, 2010). Meta-analytic results have also indicated a negative relationship between age and emotional exhaustion ($k=34$, $r=-.16$) (Brewer & Shapard, 2004). However, this finding should be interpreted cautiously due to the possibility of a survival bias whereby employees experiencing the highest levels of burnout may have higher levels of job turnover at younger ages (Brewer & Shapard, 2004; Maslach et al., 2001). Thus, individuals with lower levels of burnout symptoms may be over-represented among older employees who remain in a particular line of work.

Mixed results have also been found regarding work characteristics such as job tenure at a particular agency and the size of an individual's workload. With regard to job tenure, meta-analytic results indicated significant, albeit small, negative correlations between emotional exhaustion and two measurements of tenure, experience in a field ($r=-.13$) and experience in a position ($r=-.10$) (Brewer & Shapard, 2004). However, these results should be interpreted cautiously given the low strength of these correlations and presence of contradictory results from more recent studies (Ballenger-Browning, et al., 2011; Griffin, Hogan, Lambert, Tucker-Gail, & Baker, 2009).

Caseload size has often been used as an objective measure of workload for mental health providers. However, cross-sectional studies examining the relationship between caseload size and burnout have produced mixed results. Larger caseload size has been shown to be significantly related to greater role stress but unrelated to emotional exhaustion among mental health workers in managed care settings (Acker & Lawrence, 2009). Other studies have failed to find a significant relationship between caseload size and burnout among social service providers (Garner, Knight, & Simpson, 2007; Onyett, Pillinger, & Muijen, 1997). These heterogeneous findings suggest the need for a better understanding of the relationship between caseload size and burnout.

An employee's organizational environment has also been shown to be related to increased levels of burnout (Maslach et al., 2001; Morse et al., 2012). One aspect of the organizational environment related to burnout is organizational climate. Organizational climate is defined as shared worker attitudes and perceptions of the work environment (James & Sells, 1981) and has been associated with numerous outcomes including enhanced treatment outcomes (Glisson & Green, 2011), provider attitudes toward evidence-based practice (Aarons & Sawitzky, 2006), and staff turnover (Glisson et al., 2008a). Although many conceptualizations of organizational climate exist, organizational climate is thought to be comprised of several dimensions, including role overload, role conflict, role clarity, growth/advancement, and cooperation (James & Sells, 1981). For the purposes of the current study, we defined organizational climate as being functional and/or stressful (Glisson et al., 2008b).

Stressful organizational climates are characterized by high levels of role overload and role conflict. Role overload, a work environment in which the employee feels overloaded in their work (Glisson et al., 2008b), has been consistently implicated as a predictor of burnout (Maslach, et al., 2001). Further, high levels of role conflict, a work environment with high competing demands in which the employee feels they are unable to finish necessary tasks (Glisson et al., 2008b), has also been associated with burnout (Maslach, et al., 2001; Thompson & Rose, 2011). Overall, perceptions of high levels of role conflict and role overload contribute to a stressful organizational climate (Glisson et al., 2008b) that is likely to contribute to the experience of burnout (Lee & Ashforth, 1996).

Conversely, functional organizational climates are characterized by perceptions of opportunities for growth and advancement (a work environment in which the employee perceives opportunities for personal advancement), high role clarity (a work environment in which the employee has a clear understanding of where they fit and how to work within the organization) and high levels of cooperation, indicated by a work environment in which the employee receives necessary help from coworkers and administrators to successfully complete their job (Glisson et al., 2008b). Meta-analytic results have found role clarity to be negatively related to both emotional exhaustion and depersonalization (Lee & Ashforth, 1996). However, the relationship between growth/advancement and cooperation with burnout has received less attention in the literature. These aspects of an organizational climate are important to consider as they represent components of a functional climate that have been associated with other relevant outcomes such as decreased employee turnover (Glisson et al., 2008a). Thus, although relationships between some organizational climate factors and burnout have received empirical support, more research on the relationship between burnout and functional aspects of organizational climate, such as potential for growth/advancement and cooperation among employees, is warranted.

Another aspect of the work environment hypothesized to be related to burnout relates to characteristics of team leaders. Transformational leadership has recently begun to receive attention as an important factor to consider in creating successful and robust mental health organizations (Aarons, 2006; Aarons & Sommerfeld, 2012; Green, et al., 2013). Transformational leadership, as described by the full range model of leadership, is comprised of four dimensions: idealized influence, inspirational motivation, intellectual

stimulation, and individual consideration (Bass, 1990). Idealized influence is the extent to which leaders instill pride in their team, provide a model for ethical behavior, and garner the trust and respect of their team. Inspirational motivation is the extent to which leaders communicate high expectations and a vision for the future. Intellectual stimulation is the extent to which leaders foster creativity and independent thinking, as well as welcoming new ideas from their staff. Individual consideration is the extent to which leaders interact with their staff on a personalized basis to assist their individual development (Bass, 1990). Although not directly assessing transformational leadership ratings, a few studies have indicated a relationship between leadership ratings and burnout. More positive leadership ratings have been found to be correlated with lower burnout among counselors in a drug-free treatment setting (Broome, Knight, Edwards, & Flynn, 2009) and decreased emotional exhaustion and depersonalization among clinical staff in community mental health agencies (Webster & Hackett, 1999). Additionally, one study specifically examined the relationship between transformational leadership and burnout in 236 leaders and 620 subordinates across 54 mental health teams. In this study, high transformational leadership was associated with significantly lower ratings of emotional exhaustion and depersonalization, and higher ratings of personal accomplishment (Corrigan, Diwan, Campion, & Rashid, 2002).

Current Study

The primary goals of the current study were to identify correlates of burnout including provider demographics (age, sex, and education) provider work characteristics (agency tenure and caseload size), and leadership and organizational characteristics (organizational climate and transformational leadership). A secondary exploratory goal was to describe differences in levels of burnout among multiple disciplines (social work, psychology, marriage and family therapy) and program type (outpatient, day treatment, case management, and Wraparound) in a large community mental health system for children and families. We hypothesized that although provider demographics and work characteristics will be related to burnout, variables relating to the work environment such as leadership and organizational climate will account for the greatest amount of variance in provider burnout.

Methods

Participants

Participants were 322 clinical and case management service providers who participated in a study of organizational issues within 49 public-sector mental-health programs providing services for children, adolescents, and their families in San Diego County, CA. Complete data on all variables of interest was available for 285 (89%) of the 322 individuals surveyed. Chi-square analyses, performed to compare ratios for gender, education, discipline, and program type between the sample of 285 and 37 individuals with missing data, revealed no significant difference. Programs served from 8 to 2800 clients per year ($M = 258$, $SD = 453$). The number of staff at each program ranged from 1 full time equivalent (FTE) employee to 72 FTEs ($M = 14.6$, $SD = 16.2$). Organizational and individual participation rates were high (91% and 96%, respectively).

Measures

Provider characteristics—The provider survey incorporated questions regarding sex, race, education, age, average caseload size, years at present agency, professional discipline, and program type. Seventy-six percent of respondents were female. The mean age for the sample was 35.74 ($SD = 10.28$) years, mean length of time at present agency was 1.96 ($SD = 3.13$) years, and the mean caseload size was 15.2 ($SD = 16.1$). Provider education level was assessed with ordered categories from low to high educational attainment including some college, college graduate, some graduate work, master's degree, and doctoral degree (Ph.D., M.D. or equivalent). Most providers reported a Master's degree (57.0%) as the highest level of education followed by college graduate (1.93%), some graduate work (10.9%), Doctoral level degree (9.7%), and some college (3.1%). Thirty-eight percent reported their primary discipline as marriage and family therapy, 37% as social work, and 25% as psychology. Providers were asked to describe the average amount of time they spent engaging in each of six categories of work (performing assessments, case management, counseling, administrative tasks, time in supervision, time supervising, time traveling) using a 5 point Likert scale from 0 (not at all) to 4 (to a very great extent). See Table 1 for mean levels of self-reported time allocation. Program types included outpatient, day treatment, case management, and Wraparound. Six providers included in the study worked in inpatient settings; however, they were omitted from these analyses due to the small sample size. Outpatient providers ($n=134$) provided direct mental health services to youth in a non-residential setting. Day treatment providers ($n=67$) work in facilities that provide intensive mental health services to youth during the day time hours; however, unlike inpatient facilities, these youth return to their home each evening. Case managers ($n=55$) work to organize treatment plans for youth including the brokerage of appropriate services. Wraparound providers ($n=60$) utilize an evidence-based form of case management. Wraparound providers serve as the lead facilitator for a team consisting of the primary caregiver(s) and mental health professionals in the creation, provision, and monitoring of a service plan specifically designed for the target child (Suter & Bruns, 2009).

Organizational climate—Subscales from the Organizational Social Context (OSC: Glisson et al., 2008a) measure were used to assess dimensions of stressful and functional organizational climates. The factor structure of the OSC has been confirmed in a large national sample (Glisson et al., 2008a). Stressful climates are characterized by employee perceptions of being overloaded in one's work and unable to get the necessary tasks done, whereas functional climates are characterized by employee perceptions of receiving the necessary help from coworkers and administrators to do a good job and having a clear understanding of how one fits within the organization (Glisson et al., 2008a). Role Conflict (e.g., “interests of the clients are often replaced by bureaucratic concerns such as paperwork,” 7 items, current sample $\alpha = .85$) and Role Overload (e.g., “the amount of work I have to do keeps me from doing a good job,” 7 items, current sample $\alpha = .81$) subscales are indicative of a stressful climate. Growth and Advancement (e.g., “this agency provides numerous opportunities to advance if you work for it,” 5 items, current sample $\alpha = .86$), Role Clarity (e.g., “my job responsibilities are clearly defined,” 6 items, current sample $\alpha = .87$), and Cooperation (e.g., “there is a feeling of cooperation among my coworkers,” 5 items,

current sample $\alpha = .78$) subscales represent a functional climate. Each item was rated on a 5-point scale ranging from 0 “Not at all,” to 4 “To a very great extent.”

Transformational leadership—The Multifactor Leadership Questionnaire-5x (MLQ-5x; Bass & Avolio, 1995) was used to assess participants’ perceptions of their supervisor’s transformational leadership behaviors. Providers were asked to report on the extent to which their immediate supervisor engaged in specific behaviors (e.g., spends time teaching and coaching). Each behavior was rated on a 5-point scale ranging from 0 “Not at all,” to 4 “To a very great extent.” Transformational leadership was assessed as a composite measure of the following five subscales: Idealized Influence-Attributed (four items assessing pride in and respect for the leader), Idealized Influence-Behavior (four items assessing whether the leader is a trust worthy and energetic role model), Inspirational Motivation (four items assessing a leader’s vision, optimism, and enthusiasm), Intellectual Stimulation (four items assessing whether the leader encourages questioning and critical thinking to address problems solving), and Individual Consideration (four items assessing how the leader meets the needs of individual followers). The overall 20 item Transformational Leadership scale has a Cronbach’s alpha of .94 in the current sample. The MLQ-5X has been found to have convergent validity with measures of charismatic leadership and divergent validity with measure of transactional leadership (Rowold & Heinitz, 2007). We included leadership as a variable contributing to overall organizational level variance in burnout.

Burnout—Provider reports of burnout were measured using mean scores on the Depersonalization, Emotional Exhaustion, and Personal Accomplishment subscales of the Organizational Social Context measure designed for children’s mental health service providers (Glisson et al., 2008a). The five item Depersonalization subscale (current sample $\alpha = .65$) maps directly to the Maslach Burnout Inventory (MBI) with questions modified for children’s service providers (e.g. At times, I find myself not caring what happens to some of the children). Personal Accomplishment (current sample $\alpha = .74$) is measured with 6 of the 8 MBI questions modified for children’s service providers (e.g. I feel exhilarated after working closely with the children in my caseload). The OSC’s Emotional Exhaustion subscale uses 6 of the 9 items subscale (current sample $\alpha = .90$) from the MBI’s Emotional Exhaustion subscale (e.g. I feel fatigued when I get up in the morning and have to face another day on the job). The factor structure of the OSC version of these subscales has been confirmed in a large national sample (Glisson et al., 2008a).

Procedures

Each of the 54 publically funded mental health programs for children and adolescents operating in a large California County were recruited by the principal investigator to participate in a study of organizational factors in child and adolescent mental health services. A program manager was contacted at each program and the study was described in detail. Permission was sought to interview each program manager and to survey service providers who worked directly with youth and families. Provider survey sessions were scheduled at the program site at a time designated by the program manager and surveys were administered to groups of providers. The project coordinator and a trained research assistant administered provider surveys and were available during the survey session to answer any

questions that arose. Participants received a verbal and written description of the study and informed consent was obtained prior to the survey administration. Upon survey completion, providers handed in the survey packet to the survey administrators, who then checked the surveys for completeness. The respondent then completed any missing responses, if possible. Extra surveys were left for providers who were not in attendance at the survey sessions. Such surveys were either mailed back in a prepaid envelope or picked up by a research assistant. This study and procedures were approved by the appropriate institutional review boards.

Analyses

Pearson product moment correlation analyses were conducted to examine zero-order correlations between the components of burnout and the hypothesized provider and organizational level variables. The sample size for these correlations ranged from 314-322 due to missing items by participants on several of the scales. Because providers (level 1) were nested within mental health programs (level 2) resulting in potential dependency of responses within programs, multilevel hierarchical linear model (HLM) analyses were conducted to control for the effects of the nested data structure (Hedeker, Gibbons, & Davis, 1991; Raudenbush & Bryk, 2002; Snijders & Bosker, 1999). All HLM analyses were conducted using maximum marginal likelihood estimation for mixed effects models (Hedeker & Gibbons, 1996) using IBM SPSS Statistics 20 (IBM Corp., 20.0). First, three HLM regression analyses were conducted in order to examine the associations of individual and organizational level predictor variables with each dimension of burnout. All continuous level 1 predictor variables were mean centered at the level 2 program level prior to performing HLM analyses. For each regression model, an unconditional model including only the intercept was estimated to compute the intraclass correlation coefficient (ICC). The final model included participants with no missing data ($n=285$). R-square values for linear mixed models were calculated for each model (Edwards Muller, Wolfinger, Qaqish, & Schabenberger, 2008). To examine the exploratory hypothesis, a series of analyses were conducted to examine differences in each component of burnout by discipline (social work, psychology, marriage and family therapy) and program type (outpatient, day treatment, Wraparound, case management), while controlling for nesting of providers in mental health programs.

RESULTS

Descriptive Data

Table 2 displays bivariate correlations between the burnout variables and potential covariates. Generally, leadership and organizational variables had significant moderate to large correlations with the outcome variables. Additionally, age was positively related to personal accomplishment, and years at agency was negatively related to emotional exhaustion. However, gender and caseload size, were not significantly correlated with the burnout variables. Bivariate correlations should be examined with caution as they do not account for the nested structure of providers within programs or the relationships among the covariates.

Multi-level Regression Analyses Predicting Dimensions of Burnout

Intraclass correlation coefficients (ICCs) were computed for each model to provide an estimate of the degree of clustering of responses to each component of burnout within mental health programs. The ICC for emotional exhaustion was .14, for depersonalization .10, and for personal accomplishment .08, indicating that 8-14% of the variance in burnout outcomes is accounted for by mental health clinic, necessitating the need for random regression models to account for clustering. Results of the three multi-level regression analyses are presented in Table 3. Higher role clarity, cooperation, and greater levels of transformational leadership behaviors, were associated with higher levels of personal accomplishment. Greater role conflict and role overload were associated with increased provider report of emotional exhaustion. Finally, higher role conflict and younger age were associated with higher levels of depersonalization. The change in R-squared indicated a significant increase of variance accounted for by the set of organizational variables for each of the three burnout outcomes over that of both demographic and job-related variables (See Table 3).

Difference in Burnout by Program Type and Primary Discipline

A secondary explorative aim of the current study was to examine differences in burnout levels by professional discipline and program type. Overall, no significant differences were found in levels of emotional exhaustion, depersonalization, and personal accomplishment by provider primary professional discipline, while controlling for the nested structure of the data. Further, no significant differences were found in program type for personal accomplishment or emotional exhaustion. However, a significant effect was found for depersonalization [$F(4,315)= 7.97, p<.001$]. Tukey-b post hoc tests revealed a significant difference in mean levels depersonalization between Wraparound providers ($M=.78; SD=.49$) and traditional case managers ($M=.28; SD=.30$), with a large effect size (Cohen's $d=1.22$).

DISCUSSION

Overall, the findings of the current study confirm our hypotheses regarding the relative impact of organizational climate and leadership compared to demographic and work characteristic variables on burnout. In the current study, age was the only demographic variable related to the burnout outcomes when examined in multilevel hierarchical regression analyses. Although past studies have found a negative relationship between age and emotional exhaustion (Brewer & Shapard, 2004; Maslach, et al., 2001), results from the current study supported a positive relationship between age and personal accomplishment, whereby older providers were more likely to report increased feelings of personal accomplishment in their job. Caseload size, number of years at an agency, level of education, and provider sex were not related to any of the burnout components in the present analyses when examined in multilevel hierarchical regression analyses. These non-significant findings are important and suggest that these differences (some of which are often less amenable to change) may contribute less to the variance in burnout than other more dynamic and changeable factors, such as leadership and organizational climate for which there are evidence based interventions (Glisson & Schoenwald, 2005).

The set of organizational related variables accounted for a significant proportion of variance above that accounted for by the demographic and work related variables. The greatest amount of variance was found for predictors of emotional exhaustion, with a change in R -squared of .42 above the demographic and work related variables. Specifically, role conflict and role overload, indicative of a “stressful” climate, were strongly associated with emotional exhaustion. Higher role overload suggests a work environment in which there are too many tasks and not enough time to complete them, whereas greater levels of role conflict suggest a work environment in which there are multiple competing demands on providers’ time and cognitive resources. Role clarity and cooperation, indicating a functional climate, as well as transformational leadership were significantly related to provider reports of personal accomplishment. However, the increase in variance accounted for was relatively smaller at 12%. These findings suggest that having an inspiring leader who provides individualized attention could relate to greater levels of perceived work efficacy (personal accomplishment). Additionally, perceiving greater levels of cooperation among team members and having a clear idea of one's job responsibilities may also lead mental health providers to experience greater levels of competence and efficacy in their work. The sole significant predictor of depersonalization was role overload, accounting for an additional 19% of the variance in depersonalization. It should be noted that internal reliability for Depersonalization Scale was slightly lower than desired at .65, which may have limited the ability to determine significant relationships in the population. However, the strong relationship between depersonalization and role overload suggests that individuals who feel they are assigned too many tasks without enough time to complete them may experience a lack of connection to their clients. Overall, decreasing levels of role conflict and overload, increasing role clarity and cooperation, and the presence of a transformational leader appear to be protective against burnout in publicly funded mental health service providers. Suggestions follow for future research as well as ways organizations can work to reduce burnout among mental health providers.

Competing work demands, often in the form of increased clerical and administrative duties, may result from the strict requirements of managed mental health care and/or productivity requirements often prevalent in publically funded mental health service systems. In the current study, the highest mean level of provider reported time allocation was for administrative and clerical work, rather than direct psychotherapy or assessment. Such requirements may lead to greater role conflict among providers whose primary training lies in the provision of direct therapeutic services. Future studies should further examine the extent of conflicting demands in such settings to determine which are most detrimental to employee and organizational well-being and potentially amenable to change.

Additionally, organizational interventions should be implemented to assist providers in utilizing structured methods to streamline record keeping and reporting data in order to reserve time for meeting clients’ needs. For example, electronic health records could facilitate the efficient documentation of service provision and allow for efficient access to client information. The streamlining of such processes may lead to decreased feelings of role overload and in turn the creation of a less stressful climate. Additionally, findings relating to the personal accomplishment component of burnout suggest that supervisors who display

transformational leadership behaviors; organizations that present clear, planned objectives for providers; and organizations where employees receive support from coworkers and administrators to successfully complete their job; are significantly related to the provider's sense of competence and satisfaction with their job. Leadership development and organizational interventions should be developed to improve the work context for providers. One example of such an intervention is the ARC (availability, responsiveness, continuity) organizational intervention (Glisson & Schoenwald, 2005). The ARC organizational intervention has shown improvements in culture and climate of human service organizations with improvements in staff retention and client outcomes (Glisson & Green, 2011; Glisson et al., 2012; Glisson, et al., 2008b)

A second exploratory aim of the current study was to examine differences in the components of burnout by professional discipline and mental health program type. Analyses examining differences in levels of burnout by discipline (social work, psychology, marriage and family therapy) failed to find significant effects when nested at the mental health program level. Morse et al.'s (2012) systematic review reported a dearth of information regarding differences by mental health discipline; however, the lack of published results may relate to a lack of findings, which would be less likely to result in publication (i.e. the file drawer problem). Findings relating to differences in burnout in different mental health program types revealed a significant difference between levels of depersonalization among Wraparound providers and traditional case managers. Although past work in this area found greater levels of burnout among outpatient compared to inpatient providers (Prosser et al., 1997), the present study extends this finding by examining multiple types of outpatient services. Wraparound, a type of intensive case management utilizing a team-based collaborative approach towards implementing services for youth, primarily differs from traditional case management in its mission of being strength-based, family/child centered, and collaborative (Suter & Bruns, 2009); whereas the focus on traditional case management centers more on the coordination of services for a family, or traditional clinical services focused on an individual client, that may or may not embrace the philosophies present in Wraparound. Results of the current study suggest that a collaborative, strength-based approach may be helpful not only to the families it serves but also to the providers implementing it.

Limitations

Some limitations of the present study should be noted. First, the study utilized cross-sectional data; therefore, causality cannot be inferred. Second, all variables were based on provider self-report; hence, common method variance may have influenced the results presented here. However, the scales and measures were spread throughout a longer survey and many of the study's covariate measures assess specific observable behaviors. Third, although the study examined a wide range of demographic, job characteristic, and organizational variables, it did not include some other potentially relevant variables, such as provider personality variables, provider locus of control, stressors outside the work environment, and client level variables. Future studies should attempt to examine additional factors at the client and provider level in addition to organizational level variables to determine their relative impact on burnout. Additionally, our operational definition of

organizational climate and burnout were based on our selection of common measures specific to children's service settings. However, we acknowledge that other conceptualizations of these constructs exist and that results from this study may not generalize to other conceptualizations of these variables. Finally, this study took place in one county mental health service system and results may not generalize to other service sectors or workers. Specifically, the sample of providers in the current study had an average of less than 2 years of experience in their agency. Such statistics are not uncommon in mental health services systems; but may limit the generalizability to other service sectors and workers. However, as the results are based on reports from 285 clinicians in 49 different mental health programs representing variability in program size, type, and management structure, results may be more generalizable to publically funded mental health program service providers.

Clinical Applications

Burnout among community mental health providers is a persistent problem not only for the health and well-being of providers (Morse et al., 2012), but also for mental health agencies and systems. High levels of burnout contribute to diminished service quality (Morse et al., 2012) and increased job turnover (DePanfilis & Zlotnik, 2008). Results from the current study highlight the importance of attending to leadership and organizational characteristics to impact the well-being of public service mental health professionals. Although a number of research studies and intervention designs have focused on ways to identify providers at "high risk" for burnout, our research suggests that burnout may be a function of not only personal characteristics, but also, of larger organizational context attributes relating to the work environment within which the provider operates. Clarifying our understanding of environmental factors associated with burnout can help agencies and leaders work to effectively implement organizational interventions. For example, transformational leadership behaviors (associated with increased personal accomplishment in the present study) can be learned through structured training programs and have been previously shown to have an effect on job satisfaction and job well-being (Kuoppala, Lamminpaa, Liira, & Vainio, 2008). Therefore, leadership is a promising area for intervention and one that can improve the lives of supervisors and mental health providers (Glisson, Dukes, & Green, 2006; Morse et al., 2012). Additionally, findings related to organizational climate suggest that increased structure in the form of providing clear and concise goals and objectives for providers, and providing systematic ways to manage increasing demands on providers' time, may result in decreases in burnout and its related sequelae. By attending to leadership and organizational variables, mental health systems and organizations may be able to improve organizational functioning, provider well-being, and client outcomes.

Finally, individual provider level interventions could be utilized or developed in order to mitigate negative effects of stressful organizational climates. For example, interventions such as acceptance and commitment training have been utilized with substance abuse counselors to address burnout (Hayes et al., 2004). Other studies have used stress inoculation approaches to mitigate burnout among nurses (West, Horan, & Games, 1984). These types of interventions hold promise for reducing burnout in the face of

organizational climates that are less conducive to effective service provision (Lloyd, Bond, & Flaxman, 2013).

Conclusion

Service system and organizational contexts are becoming increasingly demanding for direct service providers. In addition to high demands for productivity, there are sometimes diminishing resources both fiscal and emotional in the workplace. Leaders can strategically work to develop supportive organizational climates that reduce stressful climates and increase functional climates. Such a course of action is needed to reduce burnout and turnover, improve the work-life balance for service providers, and retain clinicians and case-managers in the workplace so that they may provide continuity in the delivery of mental health services for those in need in public sector service settings.

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Table 1

Provider Self-Report Time Spent Engaging in Work Activities (n=285)

	Mean	SD
Client Assessment	1.36	1.06
Case Management	2.25	1.26
Psychotherapy/Counseling	2.52	1.30
Administrative/Clerical	2.55	1.02
In Supervision	1.59	.95
Supervising	.79	1.21
Travel time	1.63	1.28

Note: 0-not at all, 1-to a slight extent, 2- to a moderate extent, 3- to a great extent, 4-to a very great extent

Table 2
Correlation Matrix of Demographic, Job-Related, Organizational, and Burnout Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
1. Age	1.00													
2. Sex	-.21**	1.00												
3. Education	.44**	-.05	1.00											
4. Case Size	.15**	-.08	.26**	1.00										
5. Years at Agency	.65**	-.22**	.40**	.08	1.00									
6. Role Conflict	.14**	-.07	.06	.00	.13*	1.00								
7. Role Overload	.08	-.01	.14*	.07	.17**	.71**	1.00							
8. Role Clarity	.04	-.07	-.03	-.01	.08	-.41**	-.24**	1.00						
9. Growth/Advancement	-.14**	.09	-.04	-.10	-.09	-.37**	-.23**	.51**	1.00					
10. Cooperation	-.08	.02	-.05	.00	.01	-.47**	-.27**	.52**	.40**	1.00				
11. Transform. Leadership	-.15**	.00	-.07	.02	-.06	-.36**	-.13*	.52**	.50**	.52**	1.00			
12. Emotional Exhaustion	-.01	-.02	.04	.04	.08	.66**	.67**	-.30**	-.27**	-.29**	-.23**	1.00		
13. Depersonalizations	-.06	-.04	-.03	-.03	.02	.46**	.28**	-.24**	-.17**	-.26**	-.19**	.59**	1.00	
14. Personal Accomplishment	.14*	.04	.05	.05	.06	-.16**	-.11**	.28**	.15**	.24**	.27**	-.27**	-.32**	1.00

n = 285

* $p < .05$

** $p < .01$

Table 3
 Multilevel Regressions of Demographic, Work-Related, and Organizational Variables on Burnout

Variable	Personal Accomplishment ICC (unconditional) = .08				Emotional Exhaustion ICC (unconditional) = .14				Depersonalization ICC (unconditional) = .10			
	<i>b</i>	<i>SE</i>	<i>t</i>	<i>r</i> ²	<i>b</i>	<i>SE</i>	<i>t</i>	<i>r</i> ²	<i>b</i>	<i>SE</i>	<i>t</i>	<i>r</i> ²
Intercept	2.60	.24	11.15	.02	1.21	.30	4.05	.02	.89	.20	4.40	.02
Demographic Variables												
Sex	-.01	.00	-.19	.02	.01	.09	.15	.02	.07	.07	1.05	.02
Age	.01	.00	1.81	.02	-.00	.00	-1.14	.02	-.01	.00	-2.04*	.02
Education	-.04	.04	-1.06	.02	-.02	.04	.35	.02	-.05	.03	-1.66	.02
Work-Related Variables												
Case load size	.00	.00	1.63	.02	.00	.00	.02	.02	.00	.00	1.17	.02
Years at agency	.01	.01	.48	.02	.00	.01	-.32	.02	-.00	.01	-.03	.02
Organizational Variables												
Growth and Advance.	-.01	.05	-.23	.12***	-.04	.06	-.62	.45***	.02	.05	.36	.19***
Role Clarity	.14	.06	2.41*	.12***	-.01	.07	-.14	.45***	-.03	.05	-.54	.19***
Cooperation	.15	.06	2.26*	.12***	-.05	.08	-.64	.45***	-.08	.05	-1.55	.19***
Role Conflict	.01	.07	.13	.12***	.22	.08	2.58**	.45***	.23	.06	3.81**	.19***
Role Overload	-.01	.07	-.15	.12***	.59	.08	7.66**	.45***	.03	.06	.59	.19***
Transformational Leadership	.10	.05	2.11*	.12***	-.07	.08	-.94	.45***	.06	.05	1.19	.19***

Note: *n*=285; Statistically significant values are in bold font

* *p*<.05

** *p*<.01