EVIDENCE-BASED RESOURCE GUIDE SERIES

Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies

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Acknowledgments

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Abstract

Burnout is a complex issue resulting from chronic workplace stress. It encompasses:

- Exhaustion—feeling depleted, overextended, and fatigued
- Depersonalization—being detached from oneself and emotionally distant from one's clients and work
- Feelings of inefficacy—having a reduced sense of professional accomplishment

Burnout has physical and emotional consequences for individuals and impacts their work with clients and within an organization. To fully address burnout, organizations need to adopt strategies that improve their organizational culture and climate to modify the six drivers of burnout: workload, control, reward, community, fairness, and values.

This guide highlights organization-level interventions to prevent and reduce burnout among behavioral health workers.

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies.*

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policy makers, and others with the information and tools to incorporate evidence-based practices into their communities or clinical settings. As part of the series, this guide aims to highlight organization-level interventions to prevent and reduce burnout among behavioral health workers.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illness are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community stakeholders must give attention to health equity to improve individual and population health.

Burnout is an occupational phenomenon that has physical and emotional consequences for individuals, as well as repercussions for individuals' work with clients, patient safety, and health system operations. This guide discusses organization-level strategies to improve workplace culture and climate by modifying six drivers of burnout: workload, control, reward, community, fairness, and values. I encourage you to use this guide to implement policies and programs to prevent and address perpetual cycles of burnout.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

FOREWORD

Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health and/or substance use disorders. It is designed for providers, administrators, community leaders, health professions educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provided input for each guide in this series. The panels include accomplished researchers, educators, service providers, community members, community administrators, and federal and state policy makers. Members provide input based on their lived expertise, knowledge of healthcare systems, implementation strategies, evidence-based practices, provision of services, and policies that foster change.

A priority for SAMHSA is strengthening the behavioral health workforce. To do so, complex issues, such as burnout, need to be addressed. Burnout results from chronic workplace stress that encompasses:

- Exhaustion—feeling depleted, overextended, and fatigued
- Depersonalization—being detached from oneself and emotionally distant from one's clients and work
- Feelings of inefficacy—having a reduced sense of professional accomplishment

Burnout has physical and emotional consequences for individuals and impacts their work with clients and within an organization. To fully address burnout, organizations need to adopt strategies that improve their organizational culture and climate to modify the six drivers of burnout: workload, control, reward, community, fairness, and values.

This guide highlights organization-level interventions to prevent and reduce burnout among behavioral health workers. While the guide is focused on behavioral health workers, many of these lessons may extend to other healthcare staff and organizations. Implementing new programs and practices requires a comprehensive, multi-pronged approach. This guide is one piece of an overall approach to implement and sustain change. Readers are encouraged to review the SAMHSA website for additional tools and technical assistance opportunities.

Behavioral health equity is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. As population demographics continue to evolve, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for under-resourced populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including the workforce, SAMHSA is committed to behavioral health equity.

Content of the Guide

This guide contains a foreword (FW) and five chapters (1–5). Each chapter is designed to be brief and accessible to organizational leaders, human resources staff, and other staff interested in implementing strategies to address burnout within the behavioral health workforce.

This guide reviews the literature on organization-level strategies to address burnout in the behavioral health workforce, distills the research into recommendations for leaders and staff, and provides examples of how other organizations have implemented strategies to address burnout.

FW Evidence-Based Resource Guide Series Overview

Introduction to the series.

1 Issue Brief

Overview of the prevalence of burnout among the behavioral health workforce, what factors contribute to burnout, and the implications of burnout.

2 What Research Tells Us

Current evidence on organization-level interventions to prevent and reduce burnout.

3 Identifying and Implementing Emerging Strategies to Address Burnout

Considerations and practical information for providers, staff, and organizations to consider when implementing organization-level strategies to address burnout.

4 Examples of Organizations Implementing Evidence-Based Interventions

Descriptions of programs that use strategies from Chapters 2 and 3 to implement organization-level approaches to address burnout.

5 Resources for Evaluation

Guidance and resources for evaluating organization-level strategies to address burnout and monitor outcomes.

FOCUS OF THE GUIDE

The guide provides an overview of the prevalence of burnout among the behavioral health workforce, factors that contribute to burnout, and the implications of burnout.

This guide presents evidence-based organization-level strategies to address burnout. It outlines broad lessons learned from previous studies investigating the complex causes and mediators of burnout, focusing on the domains of workload, control, reward, community, fairness, and values.

The guide provides examples of organizations implementing organization-level strategies to address burnout within the healthcare landscape.

These approaches will assist organizational leaders, human resources staff, and other staff interested in implementing strategies to address burnout within the behavioral health workforce.

CHAPTER

1

Issue Brief

The behavioral health workforce includes a diverse set of professionals who work in a broad range of settings, including community-based outpatient or inpatient programs, primary and emergency healthcare settings, criminal or legal settings, social services agencies, and educational settings. Staffing shortages and high rates of turnover place enormous demands on the workforce, and jeopardize the provision of care, especially to underserved individuals.[2] Moreover, the nature of the work, which often involves helping individuals manage mental health issues, substance use issues, trauma, or behavioral health crises, can be emotionally taxing. The behavioral health workforce experiences high levels of work-related stress, relatively low salaries, high student debt, and full caseloads.[3] These combined factors place individuals working in the behavioral health field at high risk for experiencing burnout.

Over 50 percent of behavioral health providers report experiencing symptoms of burnout.[3] The rate of burnout will likely increase given continued growth in the number of people seeking behavioral health care along with behavioral health staffing and retention challenges. Although this guide focuses on behavioral health workers, burnout may affect all health workers.

Behavioral health provider refers to professionals addressing mental health and substance use disorders, including, but not limited to, psychologists, psychiatrists, nurses, peer support specialists, patient navigators, therapists, addiction and mental health counselors, recovery coaches, case workers, social workers, psychiatric aides and technicians, paraprofessionals working in psychiatric rehabilitation and addiction recovery fields, and additional medical and other professionals who manage behavioral health issues.[1] Primary care providers and their teams may also provide behavioral health services.

Burnout can have lasting harmful effects on a provider's physical and mental health, including insomnia, hypertension, depression, anxiety, and substance use. It also has both direct and indirect costs for organizations. Providers[a] experiencing burnout may become disengaged from their jobs and are more likely to leave their positions. This affects clients'[b] access to care and the quality and continuity of their care. As a result, organizations must invest considerable additional resources into constant new hiring and training.[8]

[a] For simplicity, the term "provider" is used throughout this guide to refer to individuals providing health services, including behavioral health services. The authors recognize that some settings may use other terms, such as clinician or practitioner.

[b] "Client" is used throughout this guide to refer to individuals receiving behavioral health services. The authors recognize that while some professional roles or settings may use this term exclusively, other organizations, professional roles, or settings may use other terms, such as patient.

Burnout is distinct from, but often related to, other concepts listed below. These concepts can accelerate an employee's likelihood of experiencing burnout or exacerbate issues of burnout.

Moral injury describes the psychological, social, or spiritual distress caused by committing or failing to prevent or stop an act that is inconsistent with an individual's values.[4]

Vicarious trauma is the compounding impact on behavioral health staff of working with patients who have experienced traumatic life events.[5]

Compassion fatigue is the decreased capacity to care for clients because of repeated exposures to their suffering and trauma.[6]

Second victim syndrome occurs when a provider becomes traumatized by a client's traumatic event during patient care, especially as a result of a medical error, resulting in the provider feeling personally responsible for the client's outcome and doubting their clinical skills, knowledge base, and career choice.[7]

Organizations are positioned to mitigate impacts on behavioral health staff by implementing policies and programs that prevent and address perpetual cycles of burnout.

Burnout Defined

The World Health Organization (WHO) defines burnout as an occupational phenomenon "conceptualized as resulting from chronic workplace stress that has not been successfully managed."[9] Burnout is not a medical or mental health diagnosis. It is distinct from, although can be exacerbated by, mental health disorders (e.g., anxiety and depression), general stress, job dissatisfaction, secondary and vicarious trauma, and compassion fatigue.[8, 10]

Burnout is typically characterized by three dimensions:

- Sustained feelings of exhaustion
- Depersonalization
- Professional inefficacy

The WHO noted that burnout applies strictly to occupational settings and does not apply to experiences in other aspects of life. Addressing burnout may include strategies to impact the symptoms of burnout, but as a workplace phenomenon, improving burnout requires system- and organization-level solutions.

The Three Dimensions of Burnout

Sources: Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health, 39*(5), 341-352. https://doi.org/10.1007/s10488-011-0352-1

World Health Organization. (2019). *Burn-out an "occupational phenomenon": International classification of diseases.* World Health Organization. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon- international-classification-of-diseases

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111. https://doi.org/10.1002/wps.20311

Prevalence of Burnout

An estimated 50 percent of behavioral health providers report feeling burnt out due to high levels of stress, low salaries, perceived lack of career advancement opportunities, and increased caseloads.[3, 12] Studies show the prevalence of burnout among mental health professionals is substantial and varies depending on the sample and setting. For instance, one review found burnout prevalence ranged across studies from 21 to 67 percent.[8]

Signs and Symptoms of Burnout[11]

Burnout is a spectrum with many symptoms that can vary in severity. Common signs include:

- Sense of failure
- Procrastination
- Physical illness
- Helplessness
- Loss of motivation
- Withdrawal from relationships and responsibilities

Burnout is more prevalent among physicians than in the general population,[16] and especially among psychiatrists, with burnout rates reported as high as 78 percent in 2017–2018 surveys.[17] A review from 2018 found that between 20 and 40 percent of psychotherapists experienced symptoms of burnout.[18] In another survey from the same year, the prevalence of burnout among substance use treatment counselors was 33 percent, with 65 percent of opioid treatment program counselors reporting some symptoms of burnout.[19]

The COVID-19 public health emergency (PHE) contributed to significant increases in the burnout prevalence among the healthcare workforce. This is especially true for communities of color, who experienced COVID-19-related challenges more acutely and severely than their White counterparts. In particular, physicians of color reported higher rates or an onset or increase in burnout due to COVID-19.[13-15]

Burnout rates for specific **provider roles, disciplines, or treatment settings** are less available.[8, 12] Some studies indicate that mental health counselors working in outpatient settings and the public sector have higher rates of burnout than inpatient or private practice providers. Reasons for this include less autonomy and workplace contextual factors, such as level of coworker support or perceived fairness of the organization.[23, 24]

Codes of Ethics Related to Burnout

Many professional organizations have sections within their code of ethics around professional competence that create an ethical imperative for addressing burnout.[20]

For instance, the American Psychological Association's (APA) Code of Conduct requires providers to take steps to stop working when they experience issues interfering with their work.[21] The National Association of Social Workers' Code of Ethics states that social workers who are aware of a colleague's impairment due to psychosocial distress or mental health difficulties that interfere with practice effectiveness should consult and assist when possible.[22]

Compared to urban substance use treatment counselors, those in rural settings have reported more contributors to burnout, including office politics and low occupational prestige.[25] Greater shortages of behavioral health providers in rural settings, with about 13 percent of rural counties having no psychologists, psychiatrists, psychiatric nurse practitioners, social workers, or counselors, may compound these factors.[26]

Studies on the prevalence of burnout among different **sociodemographic groups** are limited and many show inconclusive or inconsistent findings.[12, 24, 27] A 2021 systematic review exploring racial and ethnic differences in burnout reported mixed results, with two studies finding higher rates of burnout among racial and ethnic populations that are typically underrepresented in the medical field, two finding lower rates of burnout, and nine finding no difference.[28]

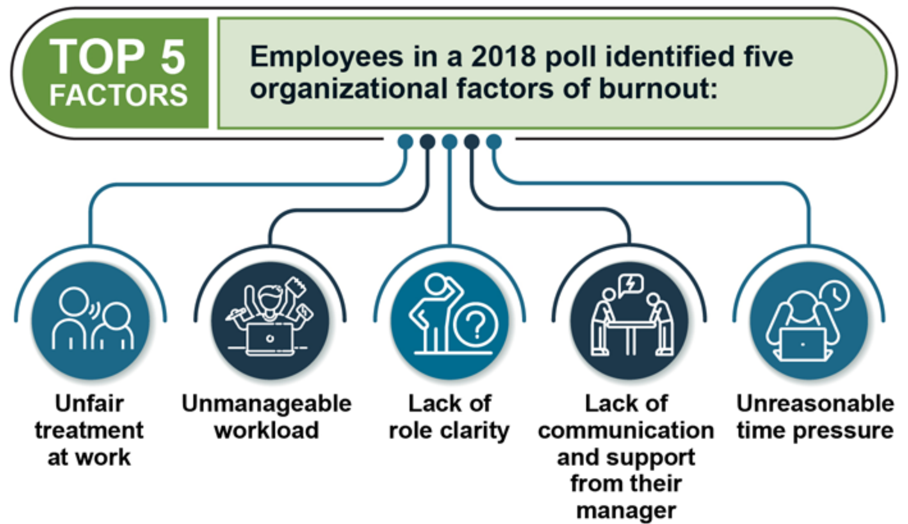
Individuals may experience burnout differently due to stressors within or beyond the work environment, such as family or childcare pressures, lack of access to transportation, limited support from social networks, or

gender or racial discrimination. Burnout is likely underreported, due to societal stigma of related concerns (e.g., mental health diagnoses) and providers' concerns about licensing repercussions.[29] More research is needed to explore rates of burnout among behavioral health providers, including analyses focused on differences by sociodemographic groups.

Contributors to Burnout

The causes of burnout can occur at organizational, interpersonal, and individual levels. Organizational factors are increasingly recognized as the primary contributors of burnout, with a broad range of employees in a 2018 poll identifying the top five reasons for burnout as:[30]

1. Unfair treatment at work
2. Unmanageable workload
3. Lack of role clarity
4. Lack of communication and support from their manager
5. Unreasonable time pressure



Source: Wigert, B., & Agrawal, S. (2018). Employee burnout, part 1: *The 5 main causes.* Gallup. https://www.gallup.com/workplace/237059/employee-burnout-part-main-causes.aspx

At the **organization level,** conditions that contribute to burnout can be classified into six core domains: workload, control, reward, community, fairness, and values.[11] Vulnerabilities in each of these domains contribute to the three dimensions of burnout.

Definitions of each domain and how it contributes to burnout are below.

Domain	Contribution to Burnout
Workload	Chronic excessive workload contributes to burnout by preventing employees from having the opportunity to rest and recover; it hinders their ability to meet job demands.[10] Both quantity and type of workload contribute to burnout.[31] Working overtime, excessive hours, or time pressures can lead to emotional exhaustion.[8, 31, 32] Work that staff perceive to be in addition to their usual role—such as administrative tasks, or work where they do not have the necessary skills to execute it due to lack of training or insufficient support—can increase one's workload and lead to burnout.[31] Understaffing can also contribute to workload pressures and increases burnout.[33]
Control	Lack of control relates to an employee's capacity to influence their workload and/or work environment, professional autonomy, and access to resources that support their work.[8, 10] The inability to control these factors contributes to job disengagement, which, over a sustained period, can lead to burnout.[8, 10, 34] Burnout due to perceived lack of control is especially seen in providers who work in fast-paced, highly demanding environments, such as inpatient settings.[27]
Reward	Insufficient or inconsistent recognition and reward can contribute to employees feeling that they or their work are unimportant or undervalued.[8, 10] These feelings can lead to burnout and employees withdrawing from their work. Low salaries and limited career advancement opportunities are common across behavioral health settings. Insurance networks provide low reimbursement rates for behavioral health services, causing providers to be underpaid. In some instances, insurance networks prohibit reimbursement altogether for peer counselors, community health workers, licensed professional counselors (LPCs), and marriage and family therapists (MFTs).[35]
Community	Lack of support and trust among coworkers can contribute to unresolved workplace conflict, leading to feelings of exhaustion and depersonalization.[10] Organizational environments centered on equity and respect enable employees to thrive and form positive connections. Supervisory skills in communication, conflict resolution, and team building also impact the sense of community within a workgroup.[33]
Fairness	Siloed decision-making that is not transparent or does not engage employees at all levels can contribute to feelings of unfairness or disrespect. Inequitable procedures can lead to cynicism towards one's job, which can result in burnout.[10]
Values	Dissonance between an employee's and organization's values can contribute to burnout as employees may experience less job satisfaction when their work or the organizational culture is not aligned with their personal goals or motivations.[10] Work environments that are diverse and inclusive affect staff's feelings of value and sense of belonging.

Although these organization-level factors are the root contributors, symptoms of burnout can be exacerbated by **interpersonal** relationships, individual experiences, or personality. Depending on the situation, interpersonal relationships with clients, families, and colleagues can provide mediating effects or create additional stressors that contribute to burnout. Family-related obligations and work-family conflict can create role pressure (role strain) and additional demands on individuals, leading to burnout.[36, 37]

Individual-level factors that contribute to burnout include the following:[38]

- *Low level of hardiness:* lacking a sense of power over events, disengaging from life activities, and resisting change.
- *External locus of control:* attributing achievements to others or chance versus attributing achievements to oneself (an internal locus of control).
- *Poor self-esteem:* lacking confidence in one's abilities.
- *Avoidant coping style:* responding to stressful situations passively rather than actively.

Ongoing systemic issues in the behavioral health landscape further compound these organization-, interpersonal-, and individual-level factors, including:

- *Workforce shortage:* The Health Resources and Services Administration (HRSA) projected that by 2030 there will be a national shortage of 12,530 adult psychiatrists and 11,530 addiction

counselors.[2] In 2021, the U.S. Department of Health and Human Services (HHS) designated 5,930 geographic areas, population groups, and facilities as having shortages in mental health professionals, with 39 percent of the U.S. population residing in these areas.[39]

- *Increased behavioral health needs:* In 2020, 14.5 percent of respondents aged 12 and over had a substance use disorder in the past year and 21 percent of respondents aged 18 and over reported any mental illness in the past year.[40] In the same year, 30.5 percent of adults with any mental illness reported an unmet need for services in the past year.[40] In a survey by the APA, over 50 percent of psychologists reported seeing more clients for anxiety, depression, and trauma- and stress-related disorders, compared to before the COVID-19 PHE.[41]
- *Budgetary considerations:* During the 2009 to 2011 recession, states cut more than $1.8 billion cumulatively from their mental health budgets[42] and have been slow to rebuild. As of 2015, fewer than half of states had increased their budgets.[43] At the same time, certain behavioral health providers, including community health workers, are unable to be reimbursed for their services in some states.[35]
- *Stigma related to behavioral health services:* Behavioral health stigma, including among behavioral health providers, negatively impacts engagement with behavioral health services.[44] The peer support workforce in particular often reports feeling stigmatized by colleagues and less valued within their organizations.[45]
- *Shifts in service delivery and policies:* The rapid uptake in the use of telehealth as a result of the COVID-19 PHE required providers to adapt to new demands.[46] In 2020, 96 percent of psychologists reported treating clients remotely[47] and in 2021, the number of psychologists using a hybrid approach increased by 17 percentage points (from 33 percent in 2020 to 50 percent in 2021).[48] In addition, new transparency laws—effective January 1, 2022, which are designed to give clients cost estimates upfront—present challenges for behavioral health providers, as diagnoses can take time and treatment needs often change.[49]
- *Systemic inequities:* For communities of color and sexual and gender minority populations, contributors to burnout are exacerbated by systemic inequities and discrimination within and outside the workplace, including interpersonal racism, racial injustice, homophobia, and transphobia.[50-52]

In 2022, the U.S. Surgeon General called for a whole-of-society approach to address health worker burnout at the systems level and to build a thriving health workforce.[53] This approach, in part, highlights the need to reevaluate financial incentives, create more human-centered health information technology, and rebuild trust through public-private collaborations and increased social support programs for health workers.[53]

The Cost of Burnout

Burnout and responses to burnout can be costly for organizations. Burnout is associated with increased rates of medical error, resignation from the workforce, and turnover.[54] Estimates for average turnover rates in the behavioral health workforce are around 30 percent annually, and higher than other high-turnover professions, such as physicians and teachers.[55] Organizations can face significant costs due to turnover, lost clinical hours, and absenteeism.[56, 57] Additionally, burnout negatively impacts client outcomes, creating a patient safety issue.[8] Studies exploring the costs of turnover and lost clinical hours have estimated an annual loss of $7,600 per physician,[17] and conclude that a one-percent increase in registered nurse turnover will cost the average hospital $270,800 per year.[58]

However, addressing burnout requires upfront, short-term costs for organization-level change. These costs may be significant and include both direct (e.g., purchases of new technology or training fees) and indirect (e.g., staff time necessary for participation or increased supervision) costs. While long-term benefits may offset these costs, they might be difficult for some organizations to cover.[55] Many organizations, including small, community-based, behavioral health organizations, may have limited resources to support organization-level change, due in large part to reliance on potentially inconsistent federal, state, or philanthropic funding streams and chronic underinvestment in behavioral health services.[58]

Federal and state policies, regulations, and legislation may be able to alleviate some systemic issues in the behavioral health workforce by expanding opportunities and funding for workforce training and reimbursement for behavioral health care. Academic institutions and accreditation bodies can also integrate mental health services and supports into training programs to better support the well-being of students and trainees.[53]

Implications of Burnout

Burnout has physical and emotional consequences for individuals, as well as implications for their organization and interpersonal relationships with clients, family, and friends.[59-61]

Implications of Burnout at the Organization, Interpersonal, and Individual Levels

Adapted from: Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health, 39(5), 341-352. https://doi.org/10.1007/s10488-011-0352-1

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Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: A meta-analysis. Journal of General Internal Medicine, 32(4), 475-482. https://doi.org/10.1007/s11606-016-3886-9

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Hagar, J. (2017). How physician burnout affects relationships. Physician Family Magazine, Summer 2017, 8-9. https://www.physicianfamilymedia.org/archives

Preview of Strategies to Address Burnout

This guide focuses on organizational strategies to address burnout. Organization-level factors, such as excessive workload, lack of transparency in policies and procedures, and role autonomy, are stronger predictors of burnout than are individual-level contributors.[8, 62] Organizational approaches to remedy burnout target the root causes of burnout, while individual strategies typically help to address or mitigate symptoms of burnout. Individual approaches are important for personal resilience and managing stress; however, interventions targeting the symptoms of burnout have limited long-term impact than when combined with organization-level interventions.[8, 63]

Examples of Organization- Versus Individual-Level Strategies to Address Burnout	
Organization-Level Strategies	**Individual-Level Strategies**
Strategies targeting organizational processes and culture: • Practice delivery improvements • Workflow modifications • Institutional policy changes (e.g., time off and leave policies) • Organizational culture change • Expanding resources for staff (e.g., childcare and family support programs)	Strategies focused on fostering individual coping mechanisms: • Stress management and resilience training • Self-care tools and mindfulness-based approaches (e.g., meditation, yoga) • Professional development trainings to improve confidence and work performance • Somatic therapy

Impact of Organizational Interventions to Address Burnout

- **Reduce Burnout** (emotional exhaustion, depersonalization, personal inefficacy)
- **Improve Work-Related Attitudes** (morale, job satisfaction, organizational commitment, stress)
- **Improve Organizational Culture and Climate** (role conflict, effort-reward imbalance, organizational rigidity, psychosocial demands)

Organizational strategies have the potential for a more enduring impact on reducing burnout because they affect all staff and place accountability on the organization rather than the individual. Scaling up effective organization-level strategies has the potential to reach more people and have a greater impact than individual-level interventions.

The chapters that follow describe:

- Evidence for organization-level strategies to address burnout (Chapter 2)
- Strategies to support implementation of organization-level interventions (Chapter 3)
- Case studies highlighting organizations that have implemented organization-level strategies (Chapter 4)
- Recommendations for ongoing evaluation (Chapter 5)

CHAPTER

2

What Research Tells Us

Burnout is an occupational phenomenon characterized by sustained feelings of physical and emotional exhaustion, depersonalization, and professional inefficacy. It can have lasting effects on an individual's physical and mental well-being and can negatively impact client care and organizations.

This chapter explores the evidence for organization-level policies and programs that successfully reduce burnout. Because research on organizational interventions specific to behavioral health professionals is limited, this review examined research addressing burnout among all types of healthcare professionals. The review focused on organization-level strategies, as evidence indicates they are more effective at reducing burnout and related outcomes than individual-level interventions.[58] Organizational interventions target root, systemic contributors to burnout, including workload, control and professional autonomy, reward and recognition, sense of community, fairness, and organizational values.[11]

This chapter discusses strategies that emerged from a comprehensive literature review (detailed in Appendix 2). Although there is robust evidence outlining contributors to burnout, there is limited literature examining organization-level interventions to address or reduce it. Research in this area is limited primarily to large health systems that have the resources available to implement and conduct evaluations. In addition, individuals with varying racial, ethnic, gender, and other identities may experience burnout differently; the findings in this review are limited by a lack of studies across sociodemographic groups.

An **intervention** is a program, initiative, service, or policy designed to address burnout or its contributors.

Burnout Outcomes

Researchers can use a variety of outcomes to measure burnout and its related contributors, including:

- **Burnout dimensions:** Sustained emotional exhaustion, depersonalization (feelings of cynicism and detachment), professional inefficacy.
- **Work-related attitudes:** Morale, job satisfaction, organizational commitment, perceived stress, intent to leave, turnover.
- **Organizational climate and culture:** Role conflict, growth and advancement, organizational rigidity, centralized decision-making, rewards, effort-reward imbalance, supervisor support, psychosocial demands.

The literature review identified three types of interventions designed to address burnout:

1. **Multicomponent, evidence-based practices that are broad in scope and address the multi-faceted and pervasive nature of burnout**. These interventions address issues such as leadership, culture change, and organization-wide or department-specific practices and policies. These programs, described below, reported statistically significant improvements in outcomes related to burnout in the behavioral health workforce or among other health professionals and/or settings.
2. **Small-scale interventions designed to improve one component of burnout.** An example of this type of intervention is an educational training for managers about the impact of burnout on the workforce. This type of intervention did not show statistically significant improvement in outcomes related to burnout and is therefore not discussed in this guide (see Appendix 3 for more information on these studies).
3. **Practice change interventions, where the primary outcome was improvement of a driver of burnout, and not burnout itself**. These practice change interventions were designed to improve components of burnout, such as a culture of civility in the workplace, but not burnout itself. Because the focus of this guide is to provide evidence for programs that reduce burnout, the interventions targeting mediators of burnout are not included in this chapter. (see Appendix 3 and the textbox below for more information on these studies).

Interventions That Address Drivers of Burnout

Although outside the scope of this review, organization-level interventions focused on addressing drivers of burnout may provide potential strategies for reducing burnout. Examples of these programs include:

- Interdisciplinary **Schwartz Rounds**, case-based, interactive discussions that provide different perspectives on psychosocial topics.[64] Schwartz Rounds are hypothesized to improve organizational culture and sense of community. The study showed improvement in outcomes related to energy, support, stress, and isolation at work.
- **Civility, Respect, and Engagement at Work (CREW) Program**, a facilitator-led intervention that is designed to improve organizational culture, in particular its sense of civility.[65] The study showed improvement in the impact of workload on mental health symptoms.

Multicomponent Evidence-Based Practices for Addressing Burnout

The review identified five multicomponent programs, all of which used a team-based approach to identify the factors contributing to burnout, and then developed and implemented strategies to address these factors.[66-71]

Organization-Level, Multicomponent Interventions		
Intervention	**Population and Setting**	**Outcomes**
Availability, Responsiveness, and Continuity (ARC) intervention, a team-based, manual-guided process aimed at creating positive organizational social contexts necessary to support innovation.[66] Intervention period: 18 months Cost: Not reported	• Social workers, psychologists, psychiatrists • Youth community mental health programs within a service system for economically-disadvantaged populations	• Statistically significant increases in morale, job satisfaction, organizational commitment, personalization (burnout component), and growth and advancement at 18 months following program initiation. • Statistically significant decreases in role conflict, organizational rigidity, and centralization at 18 months following program initiation.
Participatory workplace intervention focused on identifying adverse psychosocial work factors, developing targets for intervention, and implementing solutions in the areas of ergonomics, communications, training, work organization, staffing processes, and teamwork/spirit to reduce burnout and improve mental health outcomes.[67-69] Intervention period: 12 to 36 months Cost: Not reported	• Care providers • Acute care hospital	• Statistically significant increases in supervisor support and reward at work that were sustained for up to three years. • Statistically significant decreases in psychosocial demands, effort-reward imbalance, work-related burnout, client-related burnout, and personal burnout that were sustained for up to three years.
Multiple **workplace interventions** aimed at improving communication between staff, redesigning workflows, and implementing quality improvement projects addressing clinician concerns, such as achieving quality metrics and improving screening processes.[70] Intervention period: 12 to 18 months Cost: Not reported	• Primary care clinicians • Primary care clinics	• Statistically significant decrease in burnout and increase in satisfaction at 12 months following program initiation. • No effect on clinician-reported stress or intent to leave at 12 months following program initiation.
Multicomponent intervention consisted of leadership prioritizing physician well-being at a level equal to care quality and financial viability, physicians identifying individual and organizational stressors, and leaders and physicians jointly developing and implementing plans for improvement.[71] Intervention period: 5 years Cost: Not reported	• Physicians • Primary care group	• Statistically significant decreases in emotional exhaustion and work-related exhaustion (burnout component), sustained at three- and five-year follow-up periods. • No effect on depersonalization (burnout component) and slight, not statistically significant increase in personal accomplishment (burnout component) at five-year follow-up.

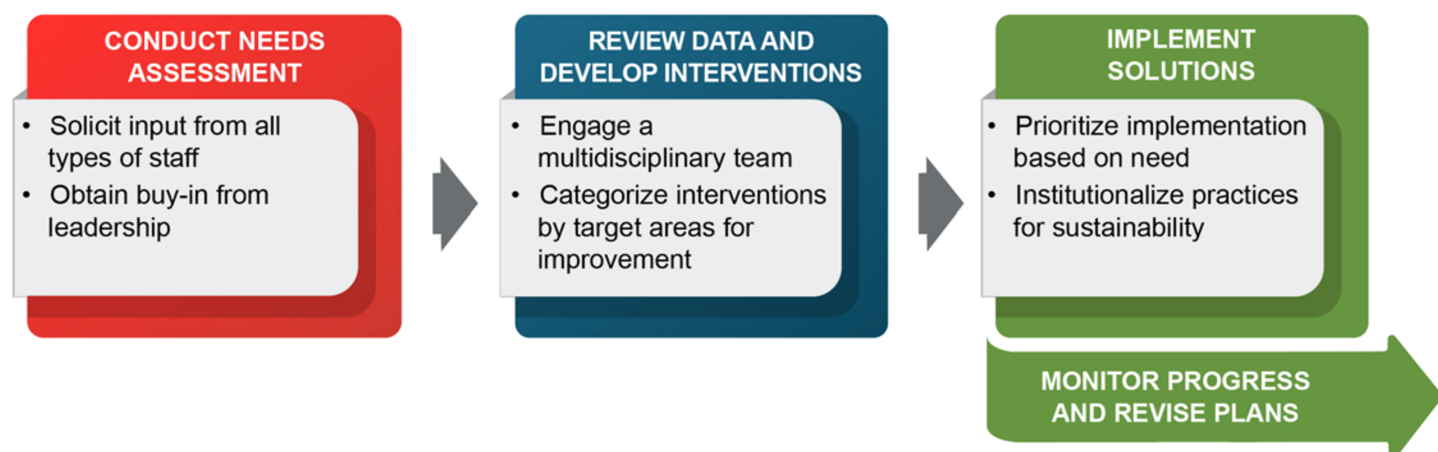
Organization-Level, Multicomponent Interventions		
Intervention	**Population and Setting**	**Outcomes**
Organizational pilot program to improve well-being, including an assessment, cultural transformation through leadership and team development, and workflow redesign.[72] Intervention period: 12 months Cost: Not reported	• Healthcare workers (physicians, nurse practitioners, medical assistants, front desk staff, practice administrators, client care representatives, clinic leaders) • Adult primary care, urology, pediatric primary care, and gastroenterology departments across three healthcare organizations	• Statistically significant decrease in emotional exhaustion (burnout component) at 12 months post intervention. • Statistically significant increase in likelihood to recommend workplace to friend or relative.

These programs began with a needs assessment or a similar process for collecting input from employees on work conditions and factors affecting well-being. A multidisciplinary team then reviewed the data and developed recommendations for interventions. The interventions implemented as a result of this process varied because they were specific to the organization and were generated from the unique concerns of their employees. Organizations implemented these programs over a period of at least 12 months and institutionalized interventions to sustain positive outcomes related to reducing employee burnout. Chapter 3 includes additional information on implementing programs that address burnout at the organization level.

The studies included in this chapter show that multicomponent programs with a range of interventions targeting multiple burnout contributors can have a positive impact on individual outcomes, including:

- Increased job satisfaction, morale, and sense of growth and advancement.
- Decreased emotional exhaustion, role conflict, and effort-reward imbalance.

Implementing these programs, however, requires extensive resources and active staff participation, as well as a longer implementation period of at least 12 months to achieve organizational culture changes. The initial short-term financial investment will likely be offset in the long term by a committed and more productive workforce with lower turnover and work absences that is aligned with organizational goals and objectives. However, the articles did not include costs for the implementation and sustainability of programs.



Availability, Responsiveness, and Continuity (ARC) Intervention

The Availability, Responsiveness, and Continuity (ARC) intervention is a team-based, manual-guided process implemented in community mental health programs and aimed at creating positive changes in organizational climate, culture, and work attitudes of staff.[66] External experts facilitated the intervention, which consisted of three components:

1. Clinical teams, with support from program leaders and supervisors, identified and addressed barriers to service effectiveness within the organization. Concerns included inefficient client referral processes, poor communication, extensive documentation requirements, and inadequate clinical supervision.
2. After the needs assessment, facilitators embedded the principles of effective services systems, such as being mission-driven, results-oriented, and participatory, into the organization's ongoing behaviors and processes.
3. Facilitators held regular meetings with program leaders and supervisors to develop the necessary mindset among clinicians and administrators for implementing innovation and improvement efforts, such as willingness to change, psychological safety in the workplace, and commitment to learning.

Program Outcomes

- Successful in improving multiple factors related to organizational culture, organizational climate, and work attitudes. An intervention period longer than 12 months was key in changing social contexts within the organization.
- Statistically significant increases in morale, job satisfaction, organizational commitment, personalization (degree of involvement with clients—one component of burnout), and growth and advancement.
- Statistically significant decreases in role conflict, organizational rigidity, and centralized decision-making.

Participative Program to Reduce Adverse Psychosocial Work Factors

The second program is a participative intervention focused on reducing adverse psychosocial work factors and their mental health effects in an acute care hospital.[67-69] The intervention began by obtaining commitment and collaboration from the management team and care providers, followed by an evaluation to determine the prevalence of four psychosocial work risk factors (high psychological demands, low decision latitude, low social support, and effort-reward imbalance). The evaluation also examined psychological distress among care providers.

Examples of Implemented Solutions[67]

- ✓ Held team meetings to discuss problems, adapt workloads, and manage conflicts
- ✓ Changed the hiring process to mitigate delays in filling positions
- ✓ Created additional nursing positions to replace staff on leave and enhance stability of care teams
- ✓ Increased involvement of nurses from all work shifts in decision-making process

Over a four-month period, a multidisciplinary intervention team, including nursing staff, a reception clerk, and representatives from human resources and unions, identified over 50 work conditions on which to focus the intervention. These work conditions were paired with recommended solutions and organized into six categories: teamwork and spirit, staffing, work organization, training, communication, and ergonomics. The team presented the recommended solutions, ranked by priority and feasibility, to management. After three years, the organization had implemented 80 percent of proposed solutions.

Program Outcomes

- Long-term effectiveness in all but one outcome (social support), and the improvements lasted three years post intervention.
- Statistically significant reductions in work-related, client-related, and personal burnout, as well as psychological demands and effort-reward imbalance.
- Statistically significant increases in supervisor support, reward, and work quality.

Intervention to Improve Communication, Redesign Workflows, and Address Concerns

In this study, a primary care clinic implemented a series of workplace interventions aimed at improving communication among staff, redesigning workflows, and improving quality to address clinician concerns.[70]

Examples of Implemented Solutions[70]

- ✓ Scheduled standing meetings to discuss work life or difficult client care issues
- ✓ Altered workflow between medical assistants (MAs) and appointment coordinators and hired additional staff to ease task burden
- ✓ Removed bottlenecks to care by addressing medication reconciliation and improving screening processes
- ✓ Increased care visit time from 15 to 20 minutes to reduce time pressure
- ✓ Presented office and work-life data to staff and leaders to prompt discussions on changing clinic culture

Data on clinician perceptions of work conditions; stress, burnout, and intent to leave measures; and client quality of care were collected at baseline. Clinical staff reviewed the data and developed interventions to address adverse work conditions.

Workflow interventions such as changing call schedules or visit times had the strongest impact, while communication projects helped instill a culture of improved communication in the clinics.

Program Outcomes

- Statistically significant decreases in burnout and increases in satisfaction at 12 months post implementation.
- No effect on clinician reported stress or intent to leave.

Program to Address Work-Life Balance and Organizational Efficacy to Improve Well-Being

In this program, a primary care group instituted three components aimed at addressing physician work-life balance and organizational efficacy to improve well-being.[71]

Examples of Implemented Solutions[71]

- ✓ Implemented flexible work schedules with part-time options
- ✓ Customized work to meet physician goals
- ✓ Adopted the Institute for Health Improvements' "Idealized Design of Clinical Office Practice"[73]
- ✓ Emphasized clinical issues over administrative issues at site meetings
- ✓ Trained medical assistants to improve care quality

1. Following a period of practice change, clinic administrators identified high levels of distress among physicians. They aimed to improve organizational health and support leaders in prioritizing physician well-being at a level equal to care quality and financial responsibility. Physicians then identified individual and organizational factors affecting well-being.
2. The organization prioritized these factors under three principles: control (physician influence over their work environment), order (efficient office design and staff quality), and meaning (physician satisfaction).
3. Finally, leadership and staff developed and implemented organizational interventions grouped by the three principles.

Program Outcomes

- Statistically significant decreases in both emotional and work-related exhaustion (a component of burnout), which were sustained at three- and five-year follow-up periods.
- No effect on depersonalization, and the slight, not statistically significant increase in personal accomplishment (a component of burnout) was not statistically significant at five-year follow-up.

Pilot Program to Improve Well-Being

This national, multi-site pilot program aimed to remove or mitigate causes of staff distress in outpatient medical departments while simultaneously embedding evidence-based practices that evoke positive emotions.[72] An external team supported department leaders and project champions in implementing the intervention; however, it was designed for participation by all staff members.

The intervention was implemented over 9 to 12 months and involved three phases:

1. An assessment determined the sources of burnout, the ability of staff and leaders to bounce back from stress (emotional recovery), and whether they were doing their best work (emotional thriving).
2. Cultural transformation support was provided to departments through skills-based sessions with leadership; staff focused on human-design leadership, teamwork, and one-on-one interactions.
3. A redesign of daily workflows addressed challenges with inefficient policies and processes. This included an experience mapping exercise followed by user-centered design sessions customized to local environments that aimed to create positive emotion solutions (e.g., reserving time in team meetings to amplify expressions of gratitude between team members).

Program Outcomes

- Twelve months post intervention, statistically significant reductions in burnout across all roles including managers, nurse practitioners, physician assistants, nurses, and physicians.
- Statistically significant reductions in emotional exhaustion (a burnout component) and improvements in recommendation of departments as a good place to work.

Research Opportunities

The literature provides substantial evidence of burnout and its impact on healthcare staff (see Chapter 1). Studies show that organization-level factors (e.g., workload, individual role autonomy) are key drivers of burnout, but few studies examine organization-level *interventions* to address or reduce burnout, especially among behavioral health staff.[74]

Limitations of Research

There are many reasons for the lack of published research on burnout interventions. Burnout is multifaceted; small interventions may be more feasible to implement to mitigate a single driver of burnout, but may not show statistically significant improvements in burnout due to its many contributors.[53] Complex, multicomponent interventions require significant buy-in, time commitment, and resources. They usually result in interventions tailored to a specific organization, which in turn limits the intervention's generalizability. In complex interventions using multiple strategies (e.g., bundling an educational program, changing supervision styles, and redesigning break spaces), it is also challenging to isolate the relative contribution of each strategy to improvement in outcomes.

Beyond the challenges of implementing burnout interventions, there are also challenges in getting studies published.[74] Early studies of burnout interventions did not employ rigorous research methods (e.g., studies lacked a comparison group, had a small sample size), but those shortcomings have been improved in recent research (including the studies described in this chapter). Moreover, because implementing organizational strategies requires buy-in from many stakeholders, concerns about confidentiality or privacy can discourage publication. Many of these interventions also do not have manuals and detailed methodologies, or are site- or setting-specific, making them difficult to replicate.

Finally, current research only examines a limited set of outcomes related to burnout and often does not study the full range of outcomes relevant to an organization and its business operations.[72, 74] Additional outcomes associated with burnout, such as financial costs, disruptions to client care, employee turnover, and recruitment costs, critically impact an organization's functioning. Showing these types of quantifiable outcomes may better incentivize an organization to undertake interventions that address burnout. Furthermore, the studies included in this review are primarily focused on physicians; some intervention components may not be applicable to the drivers of burnout among the broader range of behavioral health providers described in Chapter 1.

Opportunities for Future Research

Although the body of research around organizational strategies to address burnout is growing, there continues to be limited evidence.[53] Research on programs addressing burnout that focus specifically on behavioral health providers, especially newer roles such as peer and recovery coaches, is particularly limited. The field would benefit from more research on organizational programs focused on behavioral health settings specifically, as small, community-based, typically under-resourced care settings where barriers to addressing burnout may be high.

Additionally, it is imperative that research include the differing impacts of burnout and the effectiveness of strategies among staff with diverse demographic characteristics and backgrounds (including, but not limited to, race, ethnicity, age, gender, sexual orientation, disability status, geographic location, socioeconomic status, position within an organization, and years working in the behavioral health field). Specific research focusing on the impact of systemic racism, intergenerational trauma, homophobia, and transphobia in the workplace, and other contributors to workplace stress are also important. Additionally, future research should seek to develop validated tools that can regularly assess, measure, track, and facilitate responses to burnout across settings, including behavioral health and telehealth.[53]

CHAPTER

3

Identifying and Implementing Emerging Strategies to Address Burnout

Organization-level interventions are more effective at reducing burnout and related outcomes than individual-level interventions alone.[62] Burnout is a complex issue with many key causes and drivers; thus, interventions to effectively target burnout must take a whole-organization approach. Burnout and its consequences (e.g., lost productivity, staff turnover, disruptions to client care) are associated with organizational culture—the way that work gets done based on shared norms—and organizational climate—the way employees perceive the overall work environment.[75]

Contributors to burnout have been distilled into six interrelated factors: workload, control, reward, community, fairness, and values.[11] Each factor affects employees in different ways (see Chapter 1 and sections below).

This chapter presents an approach for successful planning and implementation of organization-level strategies to address burnout. After a brief discussion of the steps needed to begin the planning process, the chapter then provides an overview of the six factors related to burnout and relevant considerations and strategies to address each one.

Organization-Level Processes to Address Burnout

Build a Planning and Implementation Taskforce

Conduct a Needs Assessment

- ❑ Determine organization's drivers of burnout
- ❑ Gather diverse input
- ❑ Understand contextual factors

Identify Resources and Strategies

- ❑ Identify implementation resources
- ❑ Ensure organizational and leadership support
- ❑ Select relevant implementation strategies from factors below to address burnout in your organization
- ❑ Identify a relevant implementation framework or model

Plan for Sustainability

Planning Processes to Address Burnout

Build a Planning and Implementation Taskforce

The prevalence of burnout across the healthcare workforce (discussed in Chapter 1) demonstrates the need for all behavioral health organizations to consider how to assess and address contributors to burnout. Change is often more successful when leadership instigates and endorses an intervention but allows staff to be central in its implementation.[76] When implementing interventions to address burnout, organizations should involve all levels of staff in planning and implementation, including staff in clinical and non-clinical roles. Alongside leadership, staff should participate in the development of needs assessments, identification of relevant strategies, and creation of implementation and evaluation plans.

Identifying a dedicated taskforce can help provide clear indication of leadership support and streamline planning and implementation processes. Engaging staff with diverse characteristics and experiences, based on age, tenure, social group, position within the organization, and other demographics, is key to taskforce success. Organizations should give appropriate support, including supervisor support, and time allowances for staff to be engaged in the taskforce. Otherwise, organizations may risk additional burnout. Some taskforces will have temporary functionality or rotating membership, while others may be semi-permanent or permanent entities. Consider that necessary skills of taskforce staff may change as the organization moves from initial planning to implementation and monitoring of change.

Outside consultants may bring useful expertise in industrial/organizational psychology or other fields and support and guide the work of a taskforce. Some organizations have implemented wellness offices, chief wellness officers, and other strategies to signal a focus on wellness and establish a more formal structure to reduce burnout and improve wellness. It is important to acknowledge that a taskforce may seek input from all staff at various times during the change process.

Conduct a Needs Assessment: Understanding Burnout in the Organization

An important initial step in addressing burnout is to conduct a needs assessment of both staff and leadership to understand the organization's specific issues. This step should also identify available resources, services, and opportunities that may facilitate implementation efforts. Organizations should tailor their needs assessment approach to organization size and capacity to conduct one.[75]

Understand the drivers of burnout facing the organization. There are multiple ways to identify drivers of burnout within the organization. A needs assessment should include questions related to identifying the scope and magnitude of each of the six contributing factors, as well as issues of organizational climate and culture. Organizations can create their own needs assessments to collect information from staff or adapt or use existing tools. For instance, there are validated scales for directly measuring burnout or the dimensions of culture and climate in relevant health services settings.[66, 75] There are also tools that assess the six factors of burnout[77] (see Multicomponent Frameworks and Manuals textbox and Chapter 5). Data collection can be in the form of surveys, questionnaires, focus groups, or interviews. Without understanding the causes of burnout within the organization, leadership runs the risk of implementing costly strategies that do not improve outcomes.

Gather input from across the organization. Each employee can have different needs and perceptions based on their personal identities, experiences, team/division culture, and relative position in the organization. The behavioral health workforce includes staff serving in diverse roles and at varying levels. This variability leads to differing levels of ability or opportunities to initiate change. Perceptions of practice change efforts can vary by organizational role.[78, 79] Employees' perceptions—as opposed to an external or objective view—of organizational climate, leadership transparency, independence, decision-making power, and other aspects of support contribute to burnout.[55, 80, 81]

Some evidence suggests that different populations experience burnout differently.[12] Including demographic questions (role, years of experience, gender, race/ethnicity, sexual orientation, etc.) in the needs assessments can help organizations understand both the diversity of their workforce and the intersectional issues at play. Collecting de-identified or anonymous data allows staff to be more honest in their feedback, so organizations should weigh the need for detailed demographics with maintaining confidentiality. A designated team outside of management could collect identifiable, confidential data from colleagues. At all junctures, organizations should be clear about why they are collecting data, how they will use it, and how they will maintain the confidentiality of staff responses.

Organizations should also consider the level of burden that data collection has on staff responding to surveys, attending focus groups, or contributing data in other ways. Organizations likely have access to internal or administrative data they can use to understand the magnitude of burnout-related issues at their organization without placing additional burdens on staff. Data related to staff turnover, hours logged on electronic health records (EHRs) outside of working hours, or client feedback can all provide relevant information. It is important to strike a balance between collecting the right data and not asking too much or too little. Collecting data in multiple ways and during existing staff meeting times can help ensure staff are able to contribute feedback in a way that works for them. Chapter 5 contains more information on relevant data sources.

Understand the contextual factors affecting employee burnout. Individual, organizational, cultural, and societal factors all drive burnout. In conducting a needs assessment, organizations may only want to include items they can directly influence and address with minimal cost (e.g., limited supplies in the breakroom, need for more staff social interactions). However, it is also important to include structural issues that involve the entire context under which staff operate. Emergent challenges—such as lack of childcare and caregiver support—may inform decisions around flexible schedules or explicitly including mention of mental health days in sick time policies. Recognizing the multifaceted needs of staff is important for gaining buy-in and creating a sustainable solution to address burnout.

Identify Available Resources and Strategies for Implementation

Explore what resources are available to implement change. In addition to dedicated staff time, documenting other available resources and existing capacities within the organization can help identify strengths and potential challenge areas for planning and implementation. Available resources could include financial resources or relevant in-house expertise. Analyzing the lessons learned from the needs assessment takes time and effort, and organizations may need to engage external expertise. Local universities, local health agencies, or provider associations may have capacity to partner with organizations and assist with these assessments.

Ensure organizational support and buy-in from executive leadership. Leadership buy-in from the needs assessment should translate to buy-in for the identification and implementation of strategies to address burnout. Leadership buy-in may take the form of financial or non-financial resources and should always include leadership's ongoing engagement and communication of support for the process. In large, hierarchical organizations, leadership buy-in may need to be sought or communicated early in the process, as well as throughout.

Select strategies to address burnout that are relevant to identified drivers. When organizations understand what drives their employees' burnout, they can identify the most appropriate strategies to address the identified challenges, their likelihood for success, and their feasibility (see Chapter 2).

Identify an appropriate framework for designing and implementing strategies to address burnout. Organizations can use a framework to design, implement, and evaluate their strategies. Identifying the best one to fit organizational needs and context provides structure to all aspects of the change process.

Multicomponent Frameworks and Manuals for Changing Culture and Climate

Multicomponent models and frameworks support efforts to identify and address burnout or drivers of burnout at the organization level, including resources for assessment, as well as interventions targeting multiple aspects of burnout and well-being. These interventions may require upfront costs to support planning and implementation, such as hiring consultants or providing staff time and resources to implement. Implementation costs may vary based on the project scope.

- Availability, Responsiveness, and Continuity (ARC) is a manualized intervention, described in Chapter 2. ARC is an organizational change strategy aimed at improving organizational culture and climate, reducing staff turnover, increasing job satisfaction, and improving outcomes for clients. ARC begins with an organizational needs assessment and staff-level assessment tool. More information can be found in *Building Cultures and Climates for Effective Services*.[82]
- The Stanford Model of Professional Fulfillment™ is a proprietary, organizational model that aims to mitigate burnout by promoting three interrelated dimensions: a culture of wellness, efficiency of practice, and personal resilience. The resources associated with the framework are available for use with permission and include a range of instruments to assess organizational well-being and professional fulfillment.
- The Mayo Clinic outlines a nine-step strategy to address physician well-being, beginning with assessing burnout, then identifying and implementing relevant strategies and institutionalizing organizational efforts. The Mayo Clinic reports that these efforts have led to reduced self-reported burnout of physicians and non-physicians across the organization.[83]
- The Institute for Healthcare Improvement's Framework for Improving Joy in Work identifies nine core components that contribute to a joyful, healthy, productive workforce. Similar to other models, this framework starts by assessing issues and needs, then identifies strategies that can best address those needs and monitors efforts through measurement.[84]
- The National Academy of Medicine released a set of recommendations in late 2019 for how healthcare organizations can take a systems approach to addressing clinician well-being. The recommendations provide practical considerations for organizations to achieve the goals of fostering a positive work environment, creating a positive learning environment, reducing the burden of administrative tasks, expanding or establishing technology solutions, and providing overall support to professionals and pre-professionals.[85]
- LISTEN-SORT-EMPOWER is an American Medical Association (AMA) framework adapted from the Mayo Clinic model for identifying and addressing professional burnout issues among physician teams or integrated care teams. The resource includes a practical guide, exercises, and examples for how to implement the framework into a clinical practice setting, which can likely be adapted to wider behavioral health settings.[86]

The University of Washington Implementation Science Research Hub has a useful website that includes information on process models, implementation theories, and evaluation frameworks.[87] Industrial/Organizational Psychology provides a relevant framework for understanding how individual staff members' behaviors impact the workplace and how to optimize performance.[88] Other methods, such as Appreciative Inquiry, may provide organizations with a helpful strengths-based approach for planning and implementing strategies to address burnout.[89] The resource section and Chapter 5 contain more information.

Plan for Sustainability

Organizational change can be a long, iterative process. Understanding the time and resources needed for lasting change is vital, as ending interventions too soon can lead to failure.[90] Implementing the wrong strategy for the specific issues an organization faces can also result in a lack of change. Implementation planning should include planning for how to evaluate, sustain, and continue to iterate upon chosen interventions. Organizations should consider how they may need to adapt strategies in the future as staff, clients, technology, funding, or social context changes.

Feedback systems can ensure the ongoing effectiveness of interventions and identify moments for adaptations. These systems can also include demonstration of returns on investments, particularly in savings associated with staff retention and appropriate training for assigned tasks. It may be weeks, months, or even years before organizations are able to see the full impact; creating a system that allows for periodic assessment, as well as examination of short-term and long-term outcomes, is key.

Where possible, explicitly identifying internal or external funding streams to support planning, implementation, and evaluation will help formalize the change process. Adapting internal budgets to include such funding streams can ensure initiation of the work as well as ongoing sustainability. Even without additional funding, organizations must ensure that relevant supporting policies and infrastructure are in place. Leadership support is a key aspect of the implementation process and can help ensure sustainability with ongoing commitment. Leadership should be adaptable to change, maintain a focus on the change at hand, and consider and communicate both the benefits as well as costs of failure to the organization, staff, and clients.[90]

By creating policies and infrastructure with the explicit purpose of codifying changes, organizations can continue to address burnout into the future. Chapter 5 provides information to support the design and implementation of an evaluation process for interventions addressing burnout.

Factors of Burnout and Strategies for Implementation

Six organizational factors—workload, control, reward, community, fairness, and values—contribute to burnout.[11] Guided by the needs assessment, the taskforce and organizational leadership can review the considerations and strategies below that are relevant to their organization's burnout issues.

Workload

Consideration:

Workloads, including caseloads, paperwork, and lack of administrative support, all contribute to burnout. Chronic excessive workload can include issues with both quantities and types of work, including working overtime, under time pressures, or for excessive hours. These tasks place additional, often uncompensated work on staff, who may feel it is outside their job description.

During staffing shortages, including those exacerbated by the COVID-19 public health emergency (PHE), staff may have taken on responsibilities outside their training or typical job description, engaging in work for which they do not have proper skills or training, adding additional burden.[32, 55, 63, 91] Workload pressures can be exacerbated by pre-defined caseloads or compensation structures built on burdensome measures of productivity.[92] Additionally, organizational disorganization and inefficiency can impede effective work and increase perceived workload.[63, 91] Key interventions to decrease workload—hiring more staff, improving technology—can be costly. When a needs assessment identifies issues related to workload, disorganization, and inefficiencies, opportunities may exist to address these issues through increased staffing or streamlining of existing workloads.

Strategies:

- **Identify existing staff workloads.** Organizations should consider time spent completing administrative tasks (e.g., documenting case notes or other charting), including activities conducted during personal time, as part of the workload. Concurrent documentation, while allowing for in-visit data entry, may not work for all providers or clients. When organizations cannot directly bill for certain activities or services, managers may need to consider ways to streamline other tasks to provide adequate resources.
- **Increase appropriate staffing.** In some instances, the most beneficial means to address burnout is to increase capacity by hiring and/or appropriately dispersing workloads. In these instances, it is important that organizations ensure new or existing staff are appropriately skilled and trained for the full requirements of the job. Determining the right staffing model and hiring for these roles may not always be simple but is imperative. Following staffing shortages, organizations should reassess whether staff are best allocated, based on their licensure and specialty training. This assessment includes ensuring appropriate staffing for non-clinical roles, so providers can focus their time on providing good clinical care to the full scope of their license or training.[33]
- **Improve efficiency** by reviewing overall organizational policies, workflows, and administrative tasks and ensuring policies are optimized in the best interests of staff and clients. Organizations may find they can simplify or eliminate some existing processes if they no longer serve an originally intended purpose. EHRs can be challenging to learn and may increase time spent documenting versus interacting with clients.[62] Organizations with some control over EHR programming can assess them for redundancies, inefficiencies, and unnecessary data entry points to increase efficiency.[62] The use of voice dictation or scribes for assistance with administrative tasks can allow providers to focus on client care and reduce administrative workloads.[62] While some aspects of patient portals may improve efficiency, providers have increasingly used them to communicate with or provide care to clients, with an influx during the COVID-19 PHE likely contributing to existing "inbox burden."[93] Where possible, organizations should ensure portals are integrated into EHR data collection in meaningful ways.

Change Fatigue and Addressing Burnout

Healthcare organizations have experience with practice change efforts from changing healthcare policies, clinical guidelines, and emergencies such as the COVID-19 PHE. Organizations should consider the impact of ***change fatigue***, which is a general sense of apathy for organizational change that can impact implementation in several ways.

- Change fatigue can decrease staff buy-in or ability to participate in a new effort, particularly when they perceive previous efforts as ineffective or without follow-through.
- Organizational leaders and staff may have limited capacity for developing and implementing plans for addressing burnout.[94] Additional change efforts without additional resources and support may further overextend staff who are leading the implementation.
- Staff experiencing the changing organizational landscape may feel a lack of control in their work life or disruptions to their work community, both of which can increase feelings of burnout. High levels of organizational change in community mental health centers during the COVID-19 PHE were associated with high levels of burnout, and indirectly, with higher reported intentions to leave the organization.[46]

Control

Consideration:

Another contributor to burnout in organizations relates to staff feeling in control of their job roles and decision-making.[55] Stressors can arise when staff do not have control of their workload or access to the resources needed to do their work. This lack of control relates to concepts of self-determination and autonomy and may have an impact on staffs' motivation, connection to work or the organization, and overall well-being and safety.

Strategies:

- **Maximize autonomy and control within staff roles**, including when crafting job descriptions, and by allowing different staff within a role to vary their tasks based on interests and needs. To the extent possible, encourage flexible and staff-created schedules to accommodate different working styles and circumstances. While this may be more complicated to implement in clinical positions, team-based care may allow for providers to maintain appointment schedules that are complementary to each other's schedules to support flexibility for each provider. Particularly as behavioral health settings expand hours to meet client demands, clinical teams will be required to have night and weekend coverage. Document these flexibilities in job descriptions and employee handbooks. Maximizing autonomy and appropriate decision-making within roles may support practicing to the full extent of one's scope or license.
- **Ensure staff have necessary resources and supports to provide high-quality care.** This can include access to ongoing education and financial or material supports for all resources and supplies necessary to perform job duties safely and effectively. Clinical supervision and consultation allow for staff oversight, support, and ongoing training by someone with more experience or a different perspective. Clinical supervision can enhance and maintain staff competencies, maintain fidelity to treatment models, and reduce unnecessary interventions.[95] Some studies also show the positive impact of quality clinical supervision on staff perceptions of work, burnout, and emotional exhaustion, though findings have been mixed.[96-98] Opportunities for peer consultation and discussion of cases can be another way to manage complicated cases and workload burden.[99] Providing staff with dedicated time to access such supportive resources will ensure they do not inadvertently increase work burden.

Rewards, Promotion, and Career Development

Consideration:

Rewards, recognition, pay, and benefits all contribute to staff feelings of belonging and well-being.[91, 100] Inconsistent or inequitably distributed rewards and recognition will contribute to an employee feeling their work is unimportant or undervalued, which can affect staff retention. Organizations should strive to create a culture where staff know that the organization recognizes and values them.

Strategies:

- **Create transparent avenues of promotion and increase pay.** By documenting and adhering to clear policies for promotions and raises, staff will have known and achievable goals for their careers, and the organization will convey a sense of transparency, equity, reliability, and fairness. Staff promotion ladders are important for staff retention and should be included for all clinical and additional staff, whether they wish to pursue management roles or not. Resources for staff should include avenues for professional development as well as individual growth.
- **Be transparent about pay and benefits**. Research suggests that employees believe they are underpaid even when they are not. Transparent communications about salaries can increase job satisfaction and contribute to job retention. In some industries or localities, this transparency is becoming the norm. Organizations can easily make salaries more transparent by including salary information on job descriptions or in company-wide or public-facing documentation.[101] Disclosing such information may be in line with a move toward state and local pay transparency laws.
- **Establish systems for genuine, meaningful, and equitable staff appreciation** to ensure staff feel motivated and rewarded in their roles. This appreciation can take many forms, both formal and informal, but should be both meaningful to the role and tasks and of appropriate value.[55, 62] While a monetary reward may not always be feasible, there may be ways to reward staff through professional development, flexible work

schedules when working overtime, or creation of a time-banking system that allows staff to be rewarded when they provide support to colleagues.[102]

- **Expand or offer additional benefits to mitigate stressors experienced by staff beyond the work environment.** Stressors related to staffs' home lives, such as child or elder care, can exacerbate feelings of burnout in the workplace. Organizations may be able to provide benefits that alleviate such external stressors. For instance, programs providing discounted or subsidized care options can help staff access care when needed to maintain their work schedule. Similarly, providing subsidized educational resources alleviates another stressor for both staff and their families.

Community

Consideration:

Organizations are communities of people with shared norms and complicated interpersonal dynamics. A shared sense of community creates an environment where staff feel supported. Lack of trust and unresolved workplace conflict can lead to feelings associated with burnout.[10] Organizations should strive to create a culture in which each role is respected for its unique perspective and where each member is free to contribute without retaliation.[103]

Strategies:

- **Create opportunities for building collegiality and shared community**, including meals, interdisciplinary rounds, and other opportunities to share work-life experiences.[62] Compensate staff for these opportunities by holding them during working hours.
- **Cultivate teamwork** by integrating team-based care models. Team-based care can support more effective care and allow all team members to practice to the top of their licenses.[62] Practicing at the top of their license means that each employee is utilizing the full set of skills and training allowed in their scope of work. It also includes allowing positions that do not require licensure, such as peers or community health workers, to practice within their full scope of work. These practices may be particularly beneficial in settings where certain clinician types are limited, but other staff with more availability can fulfill certain tasks. Creating job shadowing programs among colleagues of different roles or in different units can also improve teamwork and communication.[104]
- **Ensure development of and commitment to equity principles** both within the organization and in providing care to clients. Organizations should create a culture of care that fosters inclusion and belonging. Principles should both acknowledge the diverse personal experiences of staff and create policies that ensure equity practices are embedded throughout the organization.[62] Policies can include equitable hiring, leave, advancement, and pay policies, as well as anti-discrimination policies that protect both staff and clients in all interactions. Stating a commitment to these principles without enacting and adhering to policies and practices that demonstrate that commitment may create staff distrust and an unwelcoming organizational climate. For instance, organizations that create policies to diversify hiring should also consider the diversity of their executive leadership and how it is representative of the organization and surrounding community. Publicly tracking commitment to these principles over time may be one way organizations can prioritize equity (for example, see Kaiser Permanente's Annual Report[105]). It is imperative that organizations continue to build a more diverse workforce and ensure all staff and clients feel respected and valued, regardless of race, ethnicity, gender, sexual orientation, differences in abilities, or additional characteristics.
- **Address stigma within the organization to create a culture of support and belonging.** Organizations must address issues of stigma around mental health and substance use, which affect staff at all levels of the organization and in many different roles. Many within the organization likely have lived mental health or substance use experiences that are stigmatized, even if they have not disclosed that information to their colleagues or do not need to draw on that experience for their specific role. Peers and those hired for recovery support roles must divulge their history of substance use or behavioral health diagnoses because of their job role. Individuals often experience stigma for disclosing this type of information; this stigma exists both within and outside the organization. Organizations should

engage in thoughtful, comprehensive anti-stigma training with all staff, actively demonstrate the worth of staff with lived experiences and those in peer roles, and include peers as key members on care teams. Reducing stigma can benefit the organization by ensuring no staff feel ostracized for their experiences, and may reduce staff experiences of stigma-related stress and self-stigma.[106] Trainings that enhance empathy of providers or staff for people experiencing mental health or substance use issues may also be beneficial (such as NAMI's Provider training[107]). Organizations should also revisit policies that may deter staff from seeking help for mental health or substance use issues and create supports for staff seeking help. Organizations may consider trainings to recognize and support colleagues in distress (such as Mental Health First Aid[108] or QPR for suicide prevention[109]) and programs to support staff with current substance use issues or who are in recovery, such as the Workforce Supported Recovery Program,[110] whether or not they work in that capacity as part of their role.

- **Develop and retain leaders who encourage adaptive and supportive change.** One tactic to accomplish this strategy is to select and develop leaders who demonstrate a commitment to staff well-being, as well as evaluate leaders on associated traits.[62, 111, 112] Leadership development needs to be in line with the organizational goals of building and retaining a strong workforce. Supportive leadership with the skills to effectively manage their staff and navigate bureaucracy may be particularly beneficial to decrease burnout.[33] Executives may also benefit from shadowing staff at various levels to understand their day-to-day experiences and build trust and community.[113] Staff benefit when leadership has a realistic view of their everyday experiences, and may see it as demonstration of their value to the organization.

Fairness

Consideration:

Organizational fairness is impacted when employees do not trust their leadership (supervisors and executives) or feel that leadership does not maintain an appropriate level of transparency.[63, 80, 91] Challenges to fairness are most common when decision-making is not transparent or when employees are not engaged in decision-making that affects their roles.[10]

Strategies:

- **Create a commitment to transparency throughout the organization.** Transparency is important for the planning, implementation, and ongoing phases of the intervention to address burnout, as well as across the organization. Organizations should conduct decision-making related to hiring, salaries, promotion, and policy change in a transparent and clear way. Creating a culture of transparency may include organizations holding a set period for staff input before finalizing any practice or policy changes. Creating ongoing formal and informal opportunities for direct communication between leadership and staff at all levels will demonstrate a commitment throughout the organization to active communication and solicitation of staff feedback. Whenever possible, documenting planned changes and formalizing existing or planned policies and practices with staff input will generate staff buy-in in the short- and long-term.
- **Revise occupational health and safety policies** to include physical health and organizational climate factors that affect staff mental health and substance use.[80] Revisions to policies could include formal policies outlining supportive leadership styles and standards for maintaining collegial atmospheres with colleagues, particularly across different roles. It can also include documented support for staff seeking additional treatment or supportive services. Organizations should revisit and update policies periodically to address the current experiences of the workforce.

Values

Consideration:

A commitment to the value of the work and mission of the organization often draws behavioral health staff to their professions. When employees' and organizations' values are misaligned, employees may feel less connection to the organizational culture and their work.[33, 77] Affirming the value of the work that the organization does and the key role that employees play in the work can signal to employees that their values are aligned with those of the organization.

Strategies:

- **Align changes with organizational mission.** Aligning organizational changes with the organization's mission can help create and sustain motivation for change across the organization. Interventions that improve staff burnout also improve safety and quality of care.[61] Interventions to address burnout may signal an organizational commitment to the health of staff as well as clients, aligning the change effort with the organizational mission.
- **Align performance goals and metrics with values.** When productivity, documentation, and other performance metrics get in the way of the organization's mission, staff may be at risk for burnout and disengagement. It is important to ensure that the organization aligns stated commitments to health equity with how they measure quality of care, the way the organization delivers care, and how it protects staff in providing that care. Organizations can demonstrate a commitment to these values by dedicating resources and holding themselves accountable to providing mission-driven care, free from bias towards either clients or staff.

Individual-Level Interventions are Most Helpful When Implemented Alongside Organization-Level Strategies to Address Burnout

Individual-level interventions, such as mindfulness training, meditation apps or training, yoga classes, policies or programs promoting physical activity, and worksite programs to reduce alcohol and drug misuse and support staff struggling with substance use issues, are important for personal resilience and managing stress. These interventions may be most successful to address drivers of burnout when employed in conjunction with organization-level interventions that address the underlying causes, such as workplace culture and climate.[8, 63]

For example, mindfulness and meditation can support a healthy lifestyle, particularly when used with access to healthy food choices, exercise facilities, ergonomic offices (including supportive chairs and stand-up desks), no expectation that staff should complete work after hours, and role modeling of healthy habits (including work-life boundaries) by managers and executives.

Resources

The National Association of County and City Health Officials' (NACCHO's) Public Health Workforce Resilience Resource Library compiles resources produced by NACCHO and others to support resilience and well-being. Resources include written guides, webinars, and recorded talks.

The National Association of State Mental Health Program Directors' (NASMHPD's) recent report, Ready to Respond: Mental Health Beyond Crisis and COVID-19, identifies workforce challenges as a major potential barrier to developing a robust continuum of psychiatric care. The report includes recommendations for creating a diverse workforce to support this continuum of care.

The American Psychiatric Association has two toolkits aimed at improving physician well-being, reducing burnout, and creating a supportive work environment:

- Toolkit for Well-Being Ambassadors, which details opportunities for psychiatrists to support organization-level work to build awareness, identify issues, and select interventions to address burnout.
- Working Well Toolkit, which includes practical strategies, assessment tools, existing programs, and case studies for addressing workplace mental health stigma.

The SAMHSA-funded Mental Health Technology Transfer Center Network (MHTTC) Provider Well-Being Initiative brings together resources from across the network on organization-level strategies to support provider health and satisfaction.

The American College of Physicians has collated resources for institutional strategies to promote resilience and reduce burnout, including:

- How to Create a Clinician Wellness Committee to foster a culture of clinician wellness.
- Elevator speech for approaching organizational executives about the importance of physician well-being.

This guidance from the American Medical Association on Peer Support Programs for physicians aims to alleviate the effects of emotional stressors faced when providing care.

MindTools has a Burnout Self-Test for individuals to check their own levels of burnout.

Using data from surveys of healthcare professionals, a report from the Association of American Medical Colleges discusses how organizations can create and support wellness leaders and initiatives.

The National Academy for State Health Policy (NASHP) published two briefs on state and organizational strategies for mitigating primary care provider burnout and increasing diversity in the behavioral health workforce.

The Society for Industrial/Organizational Psychology (SIOP) white papers cover relevant topics for organizations, including: worker well-being; organizational development; diversity, equity, and inclusion; and others.

The National Academy of Medicine's Clinician Well-Being Collaborative is a network of 200 organizations working to reverse trends in burnout among the healthcare workforce. Their National Plan will be released in 2022, and their collection of resources addresses healthcare worker well-being at the organization and individual levels.

CHAPTER

4

Examples of Organizations Implementing Evidence-Based Interventions

This chapter highlights three examples of organization-level interventions to address burnout. The case examples vary by type of organization and setting.

1. **CopeColumbia Program at the Columbia University Irving Medical Center (CUIMC).** This example describes how the Department of Psychiatry implemented a peer- and faculty-led initiative to foster well-being and resilience in the wake of the COVID-19 public health emergency (PHE).
   - The creators identified a need to support the emotional well-being and mental health of the healthcare workforce.
   - They implemented a multi-pronged approach that included peer support, access to mental health treatment, and education and skill-building.
2. **Clinician Health and Well-Being Program (CHWB) at University of California Davis Health (UCDH).** This example describes how UCDH launched CHWB and institutionalized the leadership role of Chief Wellness Officer (CWO) to have a more centralized and coordinated approach to support the well-being and mental health of staff across the organization.
   - Wellness initiatives and activities were originally fragmented and siloed.
   - The CWO leveraged existing relationships to coordinate, communicate, increase capacity, and spearhead culture change across the organization.
3. **Mental Health America of Northern Kentucky and Southwest Ohio (MHANKYSWOH).** While the first two examples feature large healthcare organizations, this example describes how organizations can partner with local agencies, like MHANKYSWOH, for support implementing strategies to address burnout and promote workforce mental health.
   - MHANKYSWOH plays a unique role of "convener and connector" in its region and offers a menu of services that local agencies can select and have tailored to their organization's needs.

These case examples highlight various entry points for program implementation, as well as key themes:

- There is no one-size-fits-all approach to reducing and preventing burnout. Interventions need to be tailored to the unique context of a given organization (i.e., setting, organizational structure, current work culture, demographics of employees, and available resources). An intervention's success is dependent on customization and staff engagement.

- A multicomponent, whole-organization approach allows for deeper integration and opportunity to address the drivers of burnout, though robust interventions are not always feasible. As discussed in Chapter 3, organizations should conduct a needs assessment to understand which primary drivers and/or organizational factors should be targeted.
- Culture change within an organization requires buy-in from leadership and working across silos to establish long-term commitment and feedback mechanisms to monitor ongoing needs and improvement.

Organizations should do what they can with the resources available to create and sustain interventions. When a formal evaluation is not feasible, organizations should still identify outcome measures and assess impact over time. For example, organizations can use evaluation methods that have minimize individual-level burden (e.g., by leveraging existing administrative data as proxies for burnout, rather than collecting new data).

Columbia University Irving Medical Center – *CopeColumbia Program*

New York City, New York

Organization and Program

The Columbia University Irving Medical Center (CUIMC) Department of Psychiatry implemented the CopeColumbia Program in March 2020. CUIMC is a clinical, research, and educational healthcare organization in Manhattan, New York, that encompasses the Vagelos College of Physicians and Surgeons, College of Dental Medicine, School of Nursing, and the Mailman School of Public Health. CopeColumbia, co-founded by a team of psychiatrists and psychologists, is an ongoing initiative that fosters well-being and resilience by sharing evidence-based coping strategies, facilitating access to peer support, and contributing to an inclusive and compassionate culture for faculty and employees of CUIMC and the larger Columbia University community.

Challenge

New York City was deeply affected by the onset of the COVID-19 PHE in March 2020. Medical centers identified a critical need for organizational efforts to support the emotional well-being and mental health of frontline clinicians. At CUIMC, clinicians expressed concern over rising patient admissions, climbing death rates, lack of resources, no known treatment or vaccine, and shock at the magnitude of COVID-19. The CopeColumbia team initially focused on supporting the emotional well-being of frontline clinicians to help them cope with COVID-19-related stress, fear, and uncertainty.

Intervention

The Department of Psychiatry, in partnership with ColumbiaDoctors and CUIMC, developed CopeColumbia to provide immediate support to faculty and employees affected by the PHE. Residents, students, and other trainees also participated, though resources were already available to these groups. CopeColumbia sought to destigmatize mental health challenges, normalize conversations around stress and burnout, reinforce self-care, build resilience, and leverage the power of teams to equip individuals with resources to support each other on an ongoing basis. CopeColumbia also sought to validate the experiences and reactions of employees to the unprecedented circumstances, with stress manifesting in personal ways. CopeColumbia faculty used a peer support model to create a multi-pronged program, with activities and resources that were confidential and free of charge, including:

- **Peer support group** sessions (virtual, 30 to 45 minutes) to foster team support, identify coping resources, and explore department- and division-specific needs.
- **1:1 peer support** through individual meetings with a psychiatry faculty member to discuss challenges, enhance resilience and adaptive coping, and (as needed) make referrals to mental health services. The faculty or employee seeking 1:1 support calls a hotline or sends an email and is connected to a psychiatry faculty member as soon as the same day.
- **Educational sessions** via town halls, webinars, lectures, and grand rounds to accommodate larger audiences and address department- and division-specific needs. Example topics included stress, trauma, anxiety, loss, grief, and resilience.
- **Resources** (housed on a program website) that include tools and information on managing stress, fear, anxiety, trauma, loss, and parenting, and strategies for promoting well-being, including mindfulness, relaxation methods, and cultivating gratitude. The website provides links to relevant articles, videos, and guidelines for managing discussions on specific topics.

Implementation

To meet the needs of faculty and employees at all levels and to address the need for broad expertise (i.e., peer support, evidence-based mental health, trauma, grief, loss, and burnout), CopeColumbia recruited 10 to 12 faculty from Columbia Psychiatry to launch the program and build the capacity to reach all CUIMC faculty and employees on an ongoing basis.

With leadership support, CopeColumbia faculty developed virtual and in-person programming (events, guest speakers, time-limited support groups) to reduce their own burnout and stress experienced while supporting others across CUIMC. Guest speakers on topics, such as complicated grief, physician suicide, substance use, trauma, and post-traumatic stress disorder, educated program staff so they could more effectively support employees.

Columbia University Irving Medical Center – *CopeColumbia Program*

New York City, New York

The team collaborated with other CUIMC groups that promote well-being, such as Human Resources and Faculty Affairs, to increase program reach and learn from experts. The team closely listened to emergent needs in real-time to support their colleagues compassionately and effectively. For example, the program created spaces for dialogue and developed materials to help guide discussion in response to challenging events that further compounded stress (e.g., national outrage over racial and social injustice in summer 2020).

Faculty volunteers supported the first six months of the program; some continue to volunteer their time. Philanthropic funds and support from ColumbiaDoctors helped sustain efforts.

Outcomes and Other Benefits

Over the course of two years, program staff conducted 272 peer support groups (2,603 attendees), 304 1:1 peer support sessions, and 103 educational sessions (5,336 attendees). Panel discussions, such as *I'm (Not) Fine: Persevering During Persistently Challenging Times* and *Bold Conversations for Healing and Reshaping our Medical Center Community,* had a combined total of over 700 attendees.

CopeColumbia faculty earned the trust of physicians and other frontline workers, contributing to the removal of silos and building of new collaborations across the institution, as demonstrated by informal, qualitative feedback from post-session debriefing surveys, leadership groups, and departmental representatives proactively reaching out to the CopeColumbia team.

CopeColumbia's work led to an increased system-wide awareness of the importance of well-being. In June 2021, CUIMC institutionalized a Chief Well-Being Officer and established a well-being leadership group composed of clinical and other faculty (Human Resources, Communications, and Office of Work-Life) to develop partnerships, expand the platform, and broaden the reach of the program. This leadership group developed a well-being survey and will collaborate with CopeColumbia on more formal evaluation efforts.

Lessons Learned

- Peer support was an important and underutilized process that was extremely powerful in supporting the healthcare workforce.
- Program success required earning the trust of Medical Center colleagues (i.e., to speak freely and be more vulnerable with peers) across departments/services and gaining buy-in from organizational leadership to support and sustain the program.
- Diverse offerings and services created opportunities for supporting a resilient healthcare workforce, both by decreasing stigma and providing increased pathways for outreach and formalized mental health treatment when needed.
- As programs evolved, especially those in academic health centers, it was critical to have scholarly products to communicate about programs, formalize outreach and access to mental health treatment, and create surveys/collect data to inform future developments.

Related Resources

- CopeColumbia website (additional resources embedded)
- Coping in Crisis: Program Offers Free Resources for CUIMC Faculty and Staff
- COVID-19 News: CopeColumbia: Helping Each Other
- Supporting the Well-Being of Healthcare Providers During the COVID-19 Pandemic: The CopeColumbia Response

University of California Davis Health – *Clinician Health and Well-Being Program*

Sacramento, California

Organization and Program

The University of California Davis Health (UCDH) is an academic medical center serving northern California, including the Sacramento region. UCDH encompasses UC Davis Medical Center, UC Davis School of Medicine, the Betty Irene Moore School of Nursing at UC Davis, and the UC Davis Medical Group.

The UCDH Clinician Health and Well-Being Program (CHWB) was initiated in 2017 by the UC Davis Department of Psychiatry and Behavioral Sciences to support the well-being and health of clinicians at the organizational level. The Chief Wellness Officer (CWO) leads the program and reports directly to the Chief Medical Officer of UCDH. Since 2018, it has been run out of the UCDH Department of Clinical Affairs.

Challenge

Two challenges led to the initiation of CHWB:

1. The existing initiatives supporting staff wellness across UC Davis were fragmented and siloed, with no core funding or coordinated direction. The initiatives included a well-being committee, multiple clinician education and support initiatives, an employee assistance program (EAP), and a nurse-led peer responder program.
2. Burnout and physician engagement surveys over several years demonstrated high physician workloads, lack of work-life balance, and concern about well-being.

These challenges emphasized the needs for 1) a more unified and strategic approach; 2) mechanisms for early identification and prevention of burnout; and 3) culture change to reduce drivers of burnout and promote wellness in the workplace.

Intervention

The mission of CHWB was to broaden the impact of both pre-existing and new initiatives and activities through a centralized and coordinated approach, thereby enabling better quality of life for clinicians as they provide high quality care for patients.

UCDH created the CWO position as a new leadership position in 2018 to centralize the responsibility and expand the available budget for well-being and wellness programs across UCDH. The CWO's overarching responsibility was to develop a work culture at UCDH in which staff can thrive; more specifically, to translate UCDH's vision—*that physician and medical staff wellness is a critical and essential business component of UCDH*—into a detailed, tangible, and attainable strategic plan.

The scope of the CHWB program expanded over time. Though this program primarily supports physicians, UCDH is committed to supporting the overall well-being and mental health of all staff, faculty, and trainees.

Implementation

To implement and expand CHWB, the team identified existing resources, challenges, and areas for targeted improvement to enhance work culture at UCDH. The CWO used existing relationships to coordinate, communicate, and increase capacity across UCDH.

Over the course of three years, CHWB used the following strategies to drive culture change at the organization level:

1. **Develop a critical mass of interest and expertise among staff to create momentum for culture change.** CHWB identified and engaged physician faculty and nursing and psychology staff who were interested and knowledgeable in workforce wellness. CHWB launched a six-month fellowship program to train and support physicians, residents, and other clinical staff (all healthcare disciplines) and promote organizational change initiatives. Fellows developed practice change and well-being projects within their own units, and most have since remained involved with UCDH initiatives. To date, the fellowship program has enrolled 85 fellows over three cohorts, including over 30 UCDH clinicians.

University of California Davis Health – *Clinician Health and Well-Being Program*

Sacramento, California

2. **Establish multiple paths to care for clinicians and normalize help-seeking behaviors to reduce stigma.** UCHD expanded existing programs, including EAP services (adding of two clinical psychologists dedicated to physicians) and the peer responder program, which was administratively supported and scaled across disciplines. To date, almost 600 multidisciplinary staff, such as nurses, physicians, pharmacists, and janitors, have been trained as peer responders; all wear badges that identify them as peers prepared to support and refer colleagues to available resources. In addition, UCDH launched programs to facilitate connection to care, including 1) a self-assessment tool for suicide prevention with a built-in referral system; 2) professional coaching; and 3) confidential faculty psychiatry services for physicians.
3. **Leverage the Stanford Model of Professional Fulfillment as a framework to create a culture of wellness, efficiency, and resiliency that is outcomes-based.** CHWB supported very popular and well-utilized physician and resident lounges. Leadership provided "care packages" to frontline, clinical, and non-clinical staff; peer responders delivered the packages, which included a personal thank-you note as a token of recognition and appreciation, as well as free meals on holidays. Recognition awards and efficiency improvements have been implemented, especially around inbox and electronic health record management. A "Help Make Us Better" website has been well-utilized for fielding suggestions and making improvements within the health system. The CWO sends a biweekly "Good Stuff" message to all staff that highlights well-being activities and tips, achievements by staff and units, and well-being resources.

The CWO role, 0.5 full-time equivalent (FTE), is funded through the CHWB core budget (~$1M annually). Multidisciplinary staff include two full-time coaches, a full-time educational analyst, a part-time administrative officer, and five part-time physicians (0.6 FTE total). Some programs are run at no cost (e.g., fellowship); others are paid in full by the core budget (e.g., care packages, coaching, and peer support). Limited funding is offset by ongoing, active participation of collaborating staff, especially department-appointed faculty well-being champions, many of whom participated in the fellowship.

Outcomes and Other Benefits

- UCDH is in the process of establishing metrics and analytics to evaluate the performance of wellness programs and resources. Staff well-being is an outcome in UCDH's strategic plan. Moving forward, the organization plans to analyze available administrative data (EHR information, patient complaints, medical errors, turnover and leave data) rather than administer burnout surveys. New programs and initiatives have been developed and continued based on input and feedback from staff.
- The CHWB program has inspired an organization-wide commitment to workforce wellness; though culture change is difficult to measure, there is now widespread involvement of staff in well-being activities.

Lessons Learned

- Leadership buy-in was critical to support culture change.
- The most important and challenging component to driving culture change was developing a critical mass of knowledgeable employees interested and engaged in workforce wellness.
- The CWO role by itself was insufficient to spearhead change; a whole-organization approach, with continued support from leadership and ongoing collaboration and feedback from employees, was essential to creating and sustaining meaningful change.

Related Resources

- UCDH Physician Health and Well-Being Resources
- UC Davis Staff and Faculty Health and Well-Being (SFHWB) Program and Resources
- UCDH Clinician Health and Well-Being (CHWB) Program

Mental Health America of Northern Kentucky & Southwest Ohio

Newport, Kentucky

Organization and Program

Mental Health America of Northern Kentucky and Southwest Ohio (MHANKYSWOH) is an affiliate of Mental Health America (MHA), a nonprofit organization dedicated to promoting mental health and working to prevent mental health and substance use disorders through education, advocacy, and service.

MHANKYSWOH serves as a "convener and connector" of local agencies, schools, and healthcare and other organizations across their regions. It also serves as a "gap filler," to address organizations' needs (e.g., providing mental health awareness and education). It is uniquely positioned to identify workforce needs and improve mental health (prevention and treatment) at the community and organization levels.

MHANKYSWOH receives its funding from local, state, and federal government, local foundations, United Way, private donors, and program fees from partner organizations. Through a Health Resources and Services Administration (HRSA) grant received in January 2022 ($2,280,666 over three years), it will expand its capacity to assist community partners in reducing burnout and promoting mental health through a range of programs, services, and resources (described below).

Challenge

Organizations face significant issues related to supporting staff through traumatic experiences, addressing burnout, and eliminating barriers to behavioral health supports. Organizations need guidance on identifying resources or strategies to address these needs, building internal capacity, and facilitating connections across the community. Organizations continue to identify issues of staff burnout and a lack of capacity and resources to address burnout.

Intervention

MHANKYSWOH's role as a community convener and content expert has allowed it to provide organizations a range of resources, including content and organizational expertise for trainings, technical expertise, and establishing peer support within organizations.

MHANKYSWOH coordinates and serves as a resource hub for the community. It networks with local agencies, identifies organizational strengths and areas of need, and establishes partnerships to connect with other organizations to provide direct and indirect support for various need-based initiatives.

MHANKYSWOH's services are available to local organizations, its employees, and other community members. The HRSA grant will expand its capacity to serve the healthcare workforce, including first responders and rural and medically underserved communities.

MHANKYSWOH's menu of services and resources includes those provided directly and others available through the national MHA, as follows:

- **Awareness** efforts, including education, community outreach, and research. Awareness activities may occur during one large event or be rolled out over a year-round calendar of events, depending on the organization's awareness plan. MHA's Center for Research and Innovation works with companies, researchers, and advocates to understand community and workplace trends on mental illness, trauma, disparities, and access to supports. MHA also developed a May Is Mental Health Month toolkit with practical tools to help improve mental health and resiliency among staff within local organizations.
- **Training** and community education programs designed to increase knowledge of mental health, substance use disorders, trauma, recovery, resiliency, and wellness. Mental Health First Aid is a nationally recognized training program that teaches individuals how to assist someone experiencing a mental health or substance use crisis by applying a targeted action plan. Certified peer support specialist training is offered locally and utilizes resources via MHA's Center for Peer Support. MHANKYSWOH also offers customized trainings for employers and employees on topics related to mental health, including burnout and stress, and on implementing trauma-informed care within organizations.

Mental Health America of Northern Kentucky & Southwest Ohio

Newport, Kentucky

- **1:1 Consultation**, including peer support meetings and other services (e.g., supported employment, counseling, mental health screening/referral). MHA developed an online mental health screening tool for individuals and organizations (Workplace Mental Health Survey). The Screening-to-Supports (S2S) program helps individuals find support following a screening.

Implementation

Organizations may reach out to MHANKYSWOH with specific needs that it has identified (i.e., through internal trend or anecdotal data) or with a request to help identify needs. Requests can be related to a specific mental health issue, general community mental health needs, or direct support to establish peer support position(s). For example, MHANKYSWOH collaborated with St. Elizabeth Healthcare on the implementation of a program (Activating Hope) to expand access to suicide prevention services and evidence-based treatment among populations with special needs (e.g., individuals with a dual diagnosis of mental health and substance use disorders). This collaboration allowed MHANKYSWOH to build connections and better understand community needs.

MHANKYSWOH is committed to meeting organizations “where they are.” If an organization is unsure of how to proceed, MHANKYSWOH provides potential assessment tools and a range of activities related to awareness, training, and individualized support.

A formal partnership between MHANKYSWOH and an organization is established through a memorandum of agreement that outlines each organization’s responsibilities and the services and resources that it will provide.

Organizations were traditionally responsible for covering the cost of the selected services, though MHANKYSWOH has provided some services at no cost when funding was available. With receipt of HRSA grant funds, MHANKYSWOH hopes to provide most services to partner organizations for little to no cost. It will provide services not funded by the grant using a program fee structure. Organizations with target populations outside of the grant's scope will be encouraged to secure funding to cover program fee costs.

Outcomes and Other Benefits

- MHANKYSWOH developed and strengthened partnerships in the community that can be leveraged for larger-scale change initiatives (i.e., under the new HRSA grant).
- MHANKYSWOH became a resource hub and can tailor resources and services offered by national MHA to local needs.
- MHANKYSWOH provides services and supports to local organizations that may not otherwise have the capacity to address burnout at the organization level.

Lessons Learned

- It was important to meet organizations “where they are” when supporting the mental health of their workforce. MHANKYSWOH found that removing barriers and building capacity are the major challenges facing local organizations in change efforts.
- Organizations must consider sustainability and recognize that culture change requires long-term commitment, especially from organizational leadership.
- Organizations may improve their capacity to address burnout and mental health among staff by partnering with local agencies.

Related Resources

- MHANKYSWOH website and MHA website
- MHA's Workplace and Mental Health Program Resources for Employers

CHAPTER

5

Resources for Evaluation

Evaluating an intervention can answer key questions related to whether implementation has been successful and what aspects of the intervention may or may not be working. This chapter provides an overview of approaches to evaluate implementation and impact of organization-level approaches to address burnout.

Organizations should evaluate both the process of implementing the intervention and its outcomes. Ideally, staff will be able to document a reduction in burnout symptoms because of the intervention, as well as high acceptability, uptake, and trust in the process of implementation. This chapter focuses on approaches discussed in Chapter 2 to evaluate the strategies to prevent and reduce burnout.

Types of Evaluations

Evaluation is an integral part of the planning and implementation process and should be considered from the start. Evaluation components can be formative (conducted to provide information to guide the effort) or summative (conducted to evaluate the outcomes and impacts of the intervention). Different evaluation types are used to:

- Determine the intervention's feasibility or likelihood of success (formative evaluation)
- Understand implementation fidelity to a particular evidence-based intervention, barriers to implementation, and factors that support successful implementation (process evaluation)
- Understand short- and long-term outcomes (short- and long-term outcomes evaluation)
- Understand short- and long-term impacts (short- and long-term impact evaluation)

Each type of evaluation is useful in assessing an intervention designed to prevent or reduce burnout. However, when evaluating strategies to address burnout, it is important to remember that outcomes may not be observable immediately. Interventions need to be ongoing to ensure that organizations continue to support staff in ways that minimize and prevent burnout. Therefore, evaluation should be continuous. Evaluations can inform organizations about needed modifications to the current intervention or whether additional interventions may be required. Both qualitative and quantitative methods, as well as participatory approaches, are important when evaluating interventions to address burnout.

Formative evaluation assesses the readiness of an organization to implement the intervention, articulates a theory of change (often illustrated in a logic model), and determines the extent to which evaluators can assess an intervention's implementation and outcomes. Staff can also use what is learned during formative evaluations to make mid-course corrections to the intervention to achieve desired results.

Process (implementation) evaluation collects data about implementation of an intervention. This type of

evaluation enables leaders or project managers to assess whether they have implemented the intervention as planned and whether and to what extent it reached the intended audience. Process evaluation will also document factors that support implementation and challenges or barriers. Process evaluation may be concurrent with an outcome or impact evaluation.

Outcome evaluation collects baseline data and data at defined intervals (e.g., annually) during and after full implementation of the intervention to assess short- and long-term outcomes. These outcome data provide leaders or project managers with information to assess changes or improvements in attitudes and behaviors that can be associated with the intervention.

Impact evaluation assesses whether outcomes can be attributed to the intervention. Impact evaluations seek to establish a causal relationship between the intervention and the outcomes. Impact evaluations can be challenging to implement because causal relationships are difficult to determine.

Culturally Responsive and Equitable Evaluation

As discussed in Chapter 3, it is essential to engage staff at all levels of the organization in the planning and implementation phases of interventions to address burnout. Similarly, plans for evaluation must address equity. Burnout may affect staff differently, depending on position within the organization, demographic characteristics, and other factors. It is important for the evaluation to examine whether the intervention is equitably implemented to benefit all individuals and whether it has differential effects.

Equitable evaluation is a type of culturally responsive evaluation. Equitable evaluation does not consider culture as a subjective factor that needs to be controlled; instead, it explicitly acknowledges culture and context when assessing program effectiveness. Equitable evaluation relies heavily on engaging the very participants with whom the evidence-based practice is implemented and from whom evaluation data are collected. According to the Equitable Evaluation Initiative (EEI), evaluation efforts should be in service of equity, and evaluators should consider the following aspects when developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences of team members
- Cultural appropriateness and validity of evaluation methods
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

Developing An Evaluation Plan

The Centers for Disease Control and Prevention (CDC) has identified six key steps to program evaluation that implementation teams should consider at the beginning of any evaluation and include in an evaluation plan:

1. **Engage stakeholders**. The program planning, implementation, and evaluation of a burnout prevention intervention will require involvement of multiple stakeholders with diverse backgrounds. As discussed in Chapter 3, it is important to include people from diverse roles and identities to provide unique insights and viewpoints.
2. **Describe the intervention.** The implementation team needs to reach a common understanding of what the intervention is, its goals, and its intended outcomes. It can be helpful for providers and stakeholders to develop a logic model that articulates the components of the program they are evaluating, what the intended outcomes are, and how they hypothesize the program will achieve the intended impact. Also consider potential unintended consequences of the program.
3. **Focus the evaluation design.** As described above, there are several types of evaluations that implementation teams can use. It may be necessary to conduct multiple evaluations to fully understand how the intervention was implemented and what impact it had. Once the types of evaluation have been selected, it is necessary to identify evaluation questions and indicators (more on this below).

Qualitative and quantitative data are complementary. Each provides critical insight into if and how the intervention is operating and achieving the intended objectives.

Qualitative data include any non-numeric, text-based information, such as verbal, visual, or written data. Qualitative data collection methods include interviews, focus groups, clinical observations, gathering data from documents and images, and open-ended survey questions and polling responses.

Quantitative data are any numeric data that can be processed by mathematical or statistical analysis. Quantitative data collection includes close-ended survey questions and polling responses, services and utilization data, and claims and encounter data.

4. **Gather credible evidence.** There are five questions that can help guide data collection:
   a. What do you need to know to answer the evaluation questions?
   b. In what timeframe will you collect data, and how often?
   c. What is the evaluation budget? What is your staff capacity and ability to do data collection?
   d. Are there ethical considerations, such as anonymity or privacy, that affect your data collection?
   e. Are the data reliable and valid?

   The next section includes examples of potential data sources that can help answer the evaluation questions. Because the risk of staff burnout is ongoing, it is important that data collection maintains a regular schedule. This will provide organizations with data to assess whether the intervention is still having the desired effects or if further intervention is needed.

5. **Justify conclusions**. Once data collection is complete, the team should present the data in a way that is meaningful and understandable to stakeholders, including staff and leaders within the organization. Stakeholders identified earlier in the evaluation process should have an opportunity to provide guidance and input on data interpretation. Consider using this opportunity to look at and present your data through an equity lens, analyzing outcomes by different subpopulations (e.g., different roles within the organization, different racial/ethnic groups, populations with different socioeconomic characteristics).

6. **Ensure use and share lessons learned.** Organizations can use evaluation results both internally (for continuous feedback on an intervention's implementation) and externally (to provide information on the effectiveness of the program, increase the evidence base, and/or increase awareness about the program). For each audience, consider detailing what your communication objectives are, what the format is to communicate the results, and what the key focus is. Then, look at other considerations specific to that target audience, such as what their priorities are, whether background information is needed, and how much time they have to review results.

Outcomes

An important but often challenging step in the process of implementing interventions is determining whether they have yielded desired outcomes. An outcome is the intended change resulting from an intervention's implementation. In any type of evaluation, it may take time to assess the full impact of an intervention; burnout is a complicated issue and multiple steps are needed to address its drivers.

The table below provides a list of potential measures, example outcome indicators, and qualitative and quantitative data sources that implementation teams may use to evaluate evidence-based strategies identified in Chapter 2. These measures are in two sections:

1. Six organizational factors that drive burnout (discussed in this guide)
2. Burnout and other related measures that may be of use

Evaluations do not need to use all of these measures. Choosing which measures to use will depend on the goals of the evaluation, available data sources, and time and feasibility of collecting your own data.

Measures, Indicators, and Data Sources		
Measure	**Illustrative Indicators**	**Illustrative Data Sources**
Organizational Factors that Drive Burnout		
Workload	• Work hours, hours logged into systems, denied or canceled leave, untaken annual leave, lost leave (leave time not carried over) • Perceived work-life balance • Degree to which work is within job description, which accurately captures the entirety of a role • Access to training needed to successfully complete job activities	• Administrative data (hours worked, time logged into systems outside of set hours) • Survey instruments (develop own measures or use or adapt existing measures, quantitative or qualitative) • Qualitative interviews/focus groups (staff and leaders)
Control	• Perceived autonomy in role • Ability to make decisions about work and work-life • Perceptions that staff have the resources necessary to fulfill their roles • Perceptions that staff feedback is wanted and used within the organization	• Survey instruments (develop own measures or use or adapt existing measures, such as NIOSH Worker Well-Being Questionnaire Section 1, quantitative or qualitative) • Qualitative interviews/focus groups (staff and leaders)
Reward	• Equitable pay or other fringe benefits, such as leave, professional development funds (by race/ethnicity, gender, other categories) • Availability, staff knowledge, and perception of accessibility of career and promotion pathways • Perceptions that organization, leaders, colleagues acknowledge work	• Administrative data (pay equity, fringe benefits provided, applications for and use of benefits) • Survey instruments (develop own measures or use or adapt existing measures such as NIOSH Worker Well-Being Questionnaire Section 1, quantitative or qualitative) • Qualitative interviews/focus groups (staff and leaders)

Measures, Indicators, and Data Sources		
Measure	**Illustrative Indicators**	**Illustrative Data Sources**
Community	• Perceptions of supportive organizational climate and culture • Perception that staff are valued within the organization • Perception of teamwork and communication within the team and organization • Perception that leaders are supportive of staff well-being and adaptive to change • Perception that the supervisor is supportive and knowledgeable about your work • Perception of importance and commitment to equity principle at all levels of the organization • Perception that staff are protected from harassment, prejudice, and stigma • Perception that staff are supported in their lived experiences related to mental health and substance use	• Qualitative interviews/focus groups (staff and leaders) • Structured quantitative scales and assessments (e.g., NIOSH Worker Well-Being Questionnaire, Organizational Social Context Measurement System, Workplace Mental Health Survey) • Survey instruments (develop own measures, quantitative or qualitative)
Fairness	• Policies protecting and supporting staffs' physical and mental health • Awareness of policies and perceptions that policies are transparent and clear • Perceptions that policies are implemented consistently across staff • Frequency of organizational communication related to policy change	• Survey instruments (develop own measures, quantitative or qualitative) • Qualitative interviews/focus groups (staff and leaders) • Policy document review
Values	• Perception that the organization and staff have shared values • Perception that organization is upholding its values • Degree to which organizational metrics of success are aligned with organizational values	• Survey instruments (develop own measures or use or adapt existing measures such as NIOSH Worker Well-Being Questionnaire Section 1, quantitative or qualitative) • Qualitative interviews/focus groups (staff and leaders) • Policy document review
Burnout and Related Outcomes		
Burnout	• Percent of staff who report symptoms of burnout by roles and demographics • Changes in symptoms of burnout • Perceived impact of burnout on work and self	• Qualitative interviews/focus groups (staff and leaders) • Structured quantitative scales and assessments (e.g., Maslach Burnout Inventory, Single Item Burnout Measure (embedded in the Mini-Z), Oldenburg Burnout Inventory (OLBI), Copenhagen Burnout Inventory)
Job Satisfaction	• Percent of staff who report low scores on work engagement, professional fulfillment, or well-being outcomes • Perceived satisfaction with work, work-life, colleagues	• Structured quantitative scales and assessments (e.g., NIOSH Worker Well-Being Questionnaire, Mayo Well-Being Index, Stanford Professional Fulfillment Index, Well-Being Index, Utrecht Work Engagement Scale) • Qualitative interviews/focus groups (staff and leaders)

Measures, Indicators, and Data Sources		
Measure	**Illustrative Indicators**	**Illustrative Data Sources**
Turnover	• Percent of staff who have left the organization by roles and demographics • Percent of vacant positions • Time needed to fill vacant positions • Percent of staff who have transitioned to new positions internally • Reasons why staff have left the organization	• Administrative data • Qualitative exit interviews (staff)
Absenteeism	• Frequency of staff using sick, vacation, paid time off, or personal time	• Administrative data
Engagement in Burnout Intervention	• Percent of staff who participated in a needs assessment (response rate) • Representativeness of staff who participated in the needs assessment compared to all staff • Number and percent of staff who participated in particular components of the intervention • Representativeness of staff who participated in the intervention compared to all staff	• Administrative data
Patient Safety	• Number of adverse events and serious adverse events, including trends over time	• Administrative data

Evaluation Resources

The American Medical Association's STEPS Forward Planning and Implementation Guide focuses on physician burnout, with specific tools and resources to improve satisfaction and patient outcomes.

Center for Public Health Systems Science at the Brown School at Washington University in St. Louis has developed a Program Sustainability Assessment Tool (PSAT) and a Clinical Sustainability Assessment Tool (CSAT) to measure progress towards sustaining new implementation efforts.

The Centers for Disease Control and Prevention (CDC) developed A Framework for Program Evaluation summarizes essential elements of program evaluation. Additional evaluation resources from CDC are also available.

The National Institutes of Health has a webpage with tools and guidance for evaluation.

The Rainbow Framework provides tools that organizations can use in monitoring and evaluation.

The Urban Institute has a report called Understanding Good Jobs that includes job elements and outcomes.

Resources on Culturally Responsive and Equitable Evaluation

The Equitable Evaluation Initiative's Equitable Evaluation Framework™ seeks to provide foundations and nonprofit organizations an understanding of equity and how to use an equity lens while performing evaluations.

The Handbook of Practical Program Evaluation's Culturally Responsive Evaluation: Theory, Practice, and Future Implications provides a foundation for culturally responsive evaluation, from preparation for evaluation to disseminating and utilizing results.

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Glossary

Behavioral health provider: A professional who helps individuals to address mental health and substance use disorders. Professionals include psychologists, psychiatrists, nurses, peers, patient navigators, therapists, addiction and mental health counselors, recovery coaches, case workers, social workers, psychiatric aides and technicians, psychiatrists, and paraprofessionals working in psychiatric rehabilitation and addiction recovery fields, as well as other medical and non-medical professionals who manage and support behavioral health issues.

Burnout: An occupational condition resulting from chronic workplace stress that has not been successfully managed and is typically characterized by three dimensions: sustained feelings of exhaustion, depersonalization, and professional inefficacy.

Community: One of the six organizational factors that impact burnout. It concerns the quality of the social environment at the workplace (e.g., one's sense of mutual support, cooperation, and mutual expression of positive feelings by team members).

Compassion fatigue: The decreased capacity to care for clients because of repeated exposures to their suffering and trauma.

Control: One of the six organizational factors that impact burnout. It includes the ability to make independent decisions and choices, and to have control or autonomy over one's work and work-life.

Depersonalization: One dimension of burnout characterized as being detached from oneself and emotionally distant from one's clients and work in general.

Evidence-based practices: Interventions for which there is consistent scientific evidence showing that they improve individual-level or organization-level outcomes.

Exhaustion: One dimension of burnout characterized as sustained feelings of fatigue, depletion, and overextension.

Fairness: One of the six organizational factors that impact burnout. It refers to the sense of whether staff are treated in a just way and concerns aspects of work such as clear rules, trust in leadership, and opportunities for promotion.

Fidelity: The extent to which an intervention is delivered as conceived and planned.

Impact evaluation: An evaluation that assesses an intervention's effectiveness in achieving its ultimate goals. Impact evaluations determine whether, and sometimes the extent to which, the newly implemented intervention led to changes in desired and unexpected outcomes.

Implementation science: The scientific study of the methods to promote the systematic uptake of clinical research findings and other evidence-based practices into routine practice and improve the quality and effectiveness of health care.

Inefficacy: One dimension of burnout characterized by reduced sense of professional accomplishment or productivity.

Intervention: A program, initiative, service, or policy designed to address burnout or its contributors.

Moral injury: The psychological, social, or spiritual distress caused by committing or failing to prevent or stop an act that is inconsistent with an individual's values.

Organizational climate: The way employees perceive their work environment and culture of their organization.

Organizational culture: A system of shared assumptions, values, and beliefs that governs how people behave in organizations. The culture of an organization provides boundaries and guidelines that help members of the organization know the correct way to perform their jobs.

Outcome evaluation: An evaluation that collects baseline data and data at defined intervals (e.g., annually) during and after full implementation of the intervention to assess short- and long-term outcomes related to the targeted behaviors.

Process (implementation) evaluation: An evaluation that assesses the quality of an intervention's implementation and conditions that facilitate or create barriers to successful implementation. Process evaluation enables program managers and policymakers to assess whether they have implemented the intervention as planned, and whether and to what extent it reached the intended audience.

Reward: One of the six organizational factors that impact burnout. It is the degree of satisfaction with rewards one acquires for one's work. Reward includes both material rewards and opportunities for promotion as well as social rewards (recognition and respect from colleagues, superiors, and clients).

Second victim syndrome: Suffering that a provider experiences when traumatized by a client's unexpected event, feeling personally responsible for the client's outcome, and doubting their clinical skills, knowledge base, and career choice.

Secondary trauma: The emotional stress resulting from an individual hearing about another individual's firsthand traumatic experience.

Stakeholders: Individuals, organizations, or communities that have a direct interest in the process and outcomes of a project, research, or policy endeavor/initiative.

Sustainability: The process of building an adaptive and effective system that achieves and maintains desired long-term results.

Values: One of the six organizational factors that impact burnout. It includes whether there is a conflict of values within the organization or a conflict between the employee's values and the values supported and promoted by the organization.

Vicarious trauma: The compounding impact on behavioral health staff of working with patients who have experienced traumatic life events.

Workload: One of the six organizational factors that impact burnout. It includes the sense of being loaded with work: whether they can tackle their situation at work and the tasks entrusted to them or if they feel overwhelmed or overburdened by excessive work.

APPENDIX 1: Acknowledgments

This guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel on Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies from October 2021 through June 2022. Two expert panel meetings were convened during this time. A series of guide development meetings was held virtually over a period of several months.

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APPENDIX 2: Literature Review Process

STEP 1. This systematic literature review began with developing a search strategy to conduct in research databases. The team selected the following databases, which are standard for searches of medical, health, and psychology studies: MEDLINE (medicine), PubMed (medicine), CINAHL (nursing), PsycINFO (psychology), and SSCI (social sciences).

STEP 2. The team conducted an abstract review with every citation captured from the database search, a total of 2,269 abstracts. The team reviewed the abstracts for the three inclusion criteria:

- The article describes an intervention, program, or policy that was implemented in an organizational setting (e.g., health center, psychiatric hospital).
- The intervention is intended to address burnout or related topics (emotional exhaustion, compassion fatigue, moral injury).
- The article was published after 2002, was written in English, and was conducted in the United States, United Kingdom, Canada, Australia, or New Zealand.

The team also identified studies from other sources (e.g., systematic reviews, references in identified papers) for inclusion. Twelve programs met inclusion criteria and were moved to STEP 3.

STEP 3: The team reviewed and extracted information into a systematic literature review table (see Appendix 3). Extracted information related to the citation, intervention, setting, study design, outcomes, findings, and lessons learned.

STEP 4: The team synthesized findings for each intervention that demonstrated statistically significant outcomes and was focused on a behavioral health or comparable audience. These findings are reported in Chapter 2.

APPENDIX 3: Reviewed Interventions

Intervention	Reference, Year	Country	Study Design, Methods	Population and Setting	Outcomes	Timing of Assessment	Lessons Learned	Included in Ch. 2? If not, why?
Psychologist-facilitated reflective practice groups	O'Neill et al., 2019	UK	Observational; interviews	Psychiatry nurses (n=13) in emergency departments	Thematic analysis of interviews: sharing and learning; grounding and perspective on value and impact of work; safe and protected space; supporting relationships (NS)	Post-intervention	Reflective practice groups provided an opportunity for learning, sharing, and building relationships.	No statistically significant findings
Clinical supervision, individual versus group	Livni et al., 2012	Australia	Cohort study; survey	Alcohol and Other Drug staff (n=52); Area Health Service	Burnout (NS), well-being (NS), job satisfaction (NS)	Post-intervention	The differences between group and individual clinical supervision did not result in statistically significant differences in burnout, well-being, or job satisfaction.	No statistically significant findings
Guided e-learning program for managers focused on six management domains: Change, Control, Demands, Relationship, Role, and Support	Stansfeld et al., 2015	UK	Experimental, control group; survey, interviews	Employees and managers (intervention n=330, control n=80); NHS Mental Health Trust	Well-being (NS), sickness absence (NS), psychological distress (NS), psychosocial work characteristics (NS)	Baseline; 3-months	Well-being decreased in both arms. No effect on psychological distress or supervisor relationship and support. Managers did not fully engage with interventions indicating this type of education alone is insufficient to change behavior.	No statistically significant findings
7-day whole system intervention to improve teamwork and leadership	Onyett et al., 2009	UK	Uncontrolled pre-post; survey	Mental health providers (n=230); community, inpatient, and primary care teams	Job satisfaction (NS), Burnout (NS)	Post-intervention	The 7-day intervention had no impact on job satisfaction or burnout.	No statistically significant findings
"Buddy Care" peer-to-peer intervention: addresses occupational fatigue, compassion fatigue, caregiver stress, and burnout	Villaruz Fisak et al., 2020	US	Uncontrolled pre-post; survey	Navy active-duty hospital corpsmen and registered nurses (n=40); Military hospital	Resilience (NS), patient safety (NS), horizontal cohesion (bonding between peers) (NS), stress (NS), burnout (NS)	Baseline; 3-months; 6-months	Medium effect size for burnout measure from baseline to 3 months. Small sample size and missing data limit ability to identify reliable changes.	No statistically significant findings
Civility, Respect and Engagement at Work (CREW) program – facilitator trainings and civility activities	Oore et al., 2010	Canada	Quasi-experimental; survey	Health professionals (n=361); 17 care-giving units across three district health authorities	Mental health symptoms: workload,* job control (NS) Physical health symptoms: workload (NS), job control (NS)	Baseline; 6-months	All regressions showed reduced relationship between job stressors and mental and physical health outcomes.	No; study was not specifically focused on burnout

Intervention	Reference, Year	Country	Study Design, Methods	Population and Setting	Outcomes	Timing of Assessment	Lessons Learned	Included in Ch. 2? If not, why?
Interdisciplinary (Schwartz) rounds: case-based, interactive discussion to provide different perspectives on psychosocial topics	Lown and Manning, 2010	US	Observational, Uncontrolled; pre-post, survey	Medical providers at hospitals (n=222) that had implemented (retrospective) or were about to implement (pre-post)	Retrospective: Compassion for patients/families,* Energized about work* Pre-Post: Supported in work,* Stressed at work,* Isolated in work*	Retrospective: 1-time post Pre-Post: before sessions; 1-time post (after 6 sessions)	Schwartz Rounds improved outcomes related to energy, support, stress, and isolation at work.	No; study was not specifically focused on burnout
Availability, Responsiveness, and Continuity (ARC) intervention: team-based, manual-guided process aimed at creating the organizational social contexts necessary for successful innovation implementation	Glisson et al., 2012	US	Experimental, control group; survey	Social workers, psychologists, psychiatrists (intervention n=89, control n=109); Youth community mental health programs from a service system for economically disadvantaged populations	Work attitudes: morale,*** job satisfaction,** and organizational commitment*** Organizational climate: role conflict,* personalization,* growth and advancement* Organizational culture: rigidity,* centralization***	Baseline; 18-months	ARC intervention improved multiple dimensions of organizational culture, organizational climate, and work attitudes. Longer intervention period was key in changing organizational social contexts and culture.	Yes
Participatory intervention focused on reducing adverse psychosocial work factors and their mental health effects	Bourbonnais et al., 2006a, 2006b, 2011	Canada	Quasi-experimental, control group; survey interviews, observation	Care providers (intervention n=248, control n=240); Acute care hospital	1-Year: Psychosocial demands,* supervisor support,*reward,*** effort-reward imbalance,** work-related burnout,* client-related burnout (NS), personal burnout (NS) 3-Year: Psychosocial demands,** supervisor support,** reward,** effort-reward imbalance,*** work-related burnout,*** client-related burnout,** personal burnout**	Baseline; 1 year; 3 years	3 years post-intervention all but one adverse psychosocial factor reduced and all health indicators improved in experimental group. Long-term effectiveness of intervention with significant reduction in burnout sustained over 3 years.	Yes
Quality improvement projects to improve communication between clinicians, workflow design, and chronic disease management	Linzer et al., 2015	US	Experimental, control group; survey	Primary care clinicians (intervention n=67, control n=72); clinics	Burnout,** stress (NS), satisfaction,* intent to leave (NS)	Baseline; 12-18-months	Targeting a range of interventions can lead to improvements in clinician outcomes, including burnout and satisfaction.	Yes
Senior management supported physician well-being program that identifies and addresses individual and organizational stressors	Dunn et al., 2007	US	Uncontrolled, prospective; survey	Physicians (n=32); primary care group	Emotional exhaustion,** work-related exhaustion,* depersonalization (NS), personal accomplishment (NS)	Baseline; 1 year; 2 years; 3 years; 5 years	Efforts to increase physicians' control over their work environment likely contributed to significant decreases in exhaustion indicators.	Yes

Intervention	Reference, Year	Country	Study Design, Methods	Population and Setting	Outcomes	Timing of Assessment	Lessons Learned	Included in Ch. 2? If not, why?
Organizational pilot program to improve well-being, including an assessment, cultural transformation through leadership and team development, and workflow redesign.	Pierce et al., 2021	US	Uncontrolled, prospective; study	Healthcare workers; Four departments (adult primary care, urology, pediatric primary care, and gastroenterology) across three healthcare organizations.	Emotional exhaustion,* likelihood to recommend workplace to friend or relative,* emotional recovery (NS), emotional thriving (NS)	Baseline; 12-months	Program focusing on integrating positive emotions into daily work led to a decline in emotional exhaustion across all roles.	Yes

Note: * <.05, ** <.01, *** <.001; NS = not statistically significant

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