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Implementing a Protocol to Address Risk for Burnout among Mental Health Professionals

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Abstract

BACKGROUND: The magnitude for potential burnout is enormous. The Centers for Disease Control and Prevention (2016), Centers for Addiction and Mental Health (2017) and Substance Abuse and Mental Health Services Administration (2015) reported diagnoses of psychiatric and substance use disorders are at an all-time high for physicians, psychiatrists, nurses, social workers and psychologists.

AIMS: Reduce the potential for burnout among outpatient mental health clinicians and staff.

METHOD: Develop an agency wellness protocol utilizing evidence-based interventions to reduce the potential for clinician and staff burnout.

RESULTS: Survey data indicated low to moderate levels of burnout and depersonalization. Staff and clinician recommendations provided during feedback sessions were incorporated with evidenced based interventions to establish a wellness protocol.

CONCLUSION: Implementing evidenced based interventions in a wellness protocol may reduce the potential for clinician and staff burnout.

Keywords: Stress, Staff Issues, Relationships, Roles, Self-management, Safety, Resilience
Implementing a Protocol to Address Risk for Burnout among Mental Health Professionals

Introduction

The magnitude potential for burnout is enormous. Mental health clinicians at each point of patient contact are prone to increased burnout and fatigue as a result of reduced resources, rising patient acuity related to suicide, and increase in substance usage, including opioids, alcohol, and stimulants (Luther et al., 2017). Burnout is defined as a complex state manifesting

in emotional exhaustion, diminished personal accomplishment, and depersonalization (Maslach, 1981). Percentages range from thirty to over fifty percent of mental health professionals reporting emotional exhaustion, depersonalization and increased stress levels (Johnson et al., 2018). Higher patient acuity diminished available resources and stress have placed clinicians at risk for compassion fatigue and burnout.

The National Alliance for the Mentally Ill (NAMI) State Mental Health Legislation 2015 Report highlighted significant reductions across the country in state reduction cuts for mental health funding. The resulting clinical concern is how to adequately address staff stress levels to reduce compassion fatigue and burnout in order to effectively provide needed mental health and addiction treatment. Garcia et al. (2015) concluded mental health staffs are at increased risk for burnout. Fatigue and burnout reduce the quality of patient care, increase patient safety concerns and contribute to turnover with clinical staff (Johnson et al., 2018).

The World Health Organization ([WHO], 2019) officially classified burn-out as an occupation phenomenon which has not been successfully managed. According to the International Classification of Diseases (ICD-11) symptoms are expressed as energy exhaustion, increased negativism and decreased professional effectiveness (WHO, 2019). Morse et al. (2012) identified limited research related to burnout involving mental health staff, critical issues surrounding prevalence, effects on organizations, staff and patients. Additionally, this study emphasized concerns related to research design, inability to replicate studies and methodological issues.

The Centers for Disease Control and Prevention (2016), Centers for Addiction and Mental Health (2017) and Substance Abuse and Mental Health Services Administration (2015), reported diagnoses of psychiatric and substance use disorders are at an all-time high for

physicians, psychiatrists, nurses, social workers and psychologists. Community providers are experiencing this epidemic at local levels and mental health professionals are struggling to deliver needed treatment (Luther et al., 2017). The National Institute for Drug Abuse (2016) and Centers for Disease Control & Prevention (2017) have noted tremendous increases in substance use and mental health concerns in individuals across the lifespan during the last 20 years. The collective reports indicate continued need for treatment for individuals diagnosed with psychiatric and substance use disorders. Multiple studies detailed escalated patient acuity and increased numbers of patients with improved access to healthcare have led to rising demands on limited staff (Dyrbye et al., 2017; Johnson et al., 2018; Luther et al., 2017). Johnson et al. (2018) highlighted international concerns of greater risk for burnout; describing issues by country, across disciplines and in various treatment settings. Researchers conducting a systematic review by the Center for Addiction and Mental Health (2017) noted a correlation between patient safety and burnout. Shively (2017) emphasized similar symptoms of burnout for mental health workers and correctional officers as fatigue, irritability and increased somatic concerns. Traumatic exposure and events such as patients overdosing, suicides and violence raise potential for lasting vulnerability (Shively, 2017). Dyrbye et al. (2017) detailed the relationship between physician burnout and increase in medical errors or malpractice claims. Researchers also found correlations between nurse burnout, increases in health care associated infection rates, and the decreased perception of teamwork quality (Dyrbye et al., 2017). The totality of the studies highlighted, indicates investigators are significantly concerned with evidence demonstrating mental health clinicians and staff are facing extended exposure to conditions that may place them at increased risk for burnout

Administrators at a mental health practice noted the increased and overwhelming demand for outpatient mental health treatment services, substance recovery care and intensified patient acuity. Proactively, they sought to identify if a need existed to address staff burnout.

Administrators were interested in measuring potential for burnout, developing processes and implementing procedures to reduce the potential for burnout. Developing an organizational protocol to address the risk for burnout was timely and significant to this outpatient mental health program. The objective of this DNP quality improvement project was to measure the potential for staff and clinician burnout; develop an agency protocol with evidenced based interventions; and provide resources to reduce the risk of burnout for clinicians and staff.

Protocol Development

Policies, procedures, and protocols are developed to standardize practices. The ultimate goals of standardization are to offer protection for patients and employee safety. Protocol development is a multi-step process to determine the purpose, understand employee expectation, ascertain resources required, and evaluate the benefits of implementation. Protocol development for an organization involves coordination amongst administrators, clinicians, and staff. Employee inclusion in decision making, staff sessions to discuss pending changes and highlighting envisioned effects on staff or patient safety are key (Irving, 2014). The outcomes for protocol development were: measure baseline data to determine a need for a wellness protocol; obtain clinician and staff recommendations to implement a wellness protocol; conduct a staff presentation on burnout risk factors; and provide a draft wellness protocol to administrators.

Wellness Interventions

Wellness interventions are activities by individuals or organizations that seek to reduce risk factors associated with burnout. Studies for physicians, nurses and first responders yield

common evidenced based interventions which include mindfulness, stress management, annual wellness assessments and small group discussions (West et al., 2016). Awa, Plaumann and Walter (2010) noted the best interventions for burnout integrated a combination of person and organization directed engagements. Organization efforts comprised of regularly scheduled trainings (resilience, trauma informed care and promoting self-care), expectation management and promoting a healthy environment for staff. Expectation management details how perceptions of roles, level of stress and responsibility affect the caregiver's reality. The American Medication Association (2016) and American Nurses Association (2014) have addressed burnout and fatigue along with specific organizational interventions to include establishing wellness quality indicators or annual wellness surveys.

Ossege and Sears (2017) specifically address peer consultation as an evidenced based intervention. They note peer consultation may reduce the isolation of clinical practice, provide support during stressful client interactions, and assist with professional development.

Methods

Institutional Review Board

Written approval was received from The Institutional Review Board. Signed consents were waived to protect the anonymity of participating staff and clinicians. No identifying information was gathered from clinicians and staff. The data collected was analyzed and reported in a summary format.

Data collection

All outpatient clinicians and staff associated with the practice were invited to participate in the opportunity to provide feedback on the proposed protocol and anonymously complete a baseline risk assessment tool. Twenty-one participants across mental health disciplines and

support staff anonymously completed the Maslach Burnout Inventory (MBI). Variables of employment type (clinician/staff), employment status (full-time/part-time), age range, and years in practice were gathered from questions also included with the MBI questionnaire. Clinicians and staff recommendations for protocol development were also requested.

Maslach (1981) developed the gold standard for measuring burnout via the Maslach Burnout Inventory. The MBI is a copyrighted 22-item survey which measures emotional exhaustion, personal fulfillment and depersonalization. This tool has been instrumental for identifying individuals across varying occupations who may be at risk for burnout (Maslach, 1981). Permission was received to include three example questions 1. I feel emotionally drained from my work. 2. I have accomplished many worthwhile things in this job. 3. I don't really care what happens to some recipients (Maslach & Jackson, 1981).

MBI has three factors: A: Burnout (a seven item, seven-point scale), B: Depersonalization (a seven item, seven-point scale), and C: Personal Achievement (an eight item, seven-point scale). Questions in A and B are worded negatively such that a high score indicates a risk for burnout and depersonalization, respectively. Questions in C are worded positively such that a low score indicates a lack of personal achievement. The responses to questions in each section were summed according to the authors' instructions, and statistics for each factor were computed.

Results

A bivariate, Pearson Correlation Matrix was conducted to evaluate the relationship among respondents' scores on the three MBI factors. Only one statistical relationship emerged: Burnout scores are significantly and linearly related to Depersonalization scores, $r = 0.729$, $p < 0.001$ (two tailed). Thus, respondents who suffered burnout also felt depersonalized, and vice-

versa. Personal achievement scores were statistically independent of burnout and depersonalization scores.

A series of independent *t*-tests was conducted to evaluate possible difference in the three MBI factors with respect to job type (staff vs. clinician). Only the Depersonalization Factor approached significance, $t = 1.75$, $df = 19$, $p = 0.097$ (two-tailed). Clinicians showed marginally greater depersonalization ($M = 8.3$, $SD = 5.30$) than did staff ($M = 4.25$, $SD = 4.95$). It is noteworthy that the mean depersonalization score for clinicians is considered moderate burnout, whereas the mean depersonalization score for staff is considered low-level burnout.

Because the sample sizes are small for both staff and clinicians ($n = 8$ and $n = 13$, respectively), statistical power was lacking ($1 - \beta = 0.49$). Thus, the effect size was computed for the difference between the two groups with respect to depersonalization. The effect size, $d = 0.785$ is very close to the generally accepted benchmark for a “large” effect (0.80). Thus, the differences in depersonalization, although statistically marginal, appear to be practically meaningful.

Table 1 highlights twenty-one participants completed the Burnout Self-Test (Maslach Burnout Inventory). Approximately 62% of the respondents were clinicians (vs. staff), 50% had fewer than 5 years in practice, and 81% were full-time employees. A plurality of respondents (33.3%) were between the ages of 35-44 years; the distribution of age categories is relatively uniform. Table 1 provides frequency distributions for these categorical variables.

Table 1
Categorical variables

<i>Job Type</i>		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	staff	8	38.1	38.1	38.1
	clinician	13	61.9	61.9	100.0
	Total	21	100.0	100.0	
<i>Years in Practice</i>					
Valid	no practice	8	38.1	40.0	40.0
	less than 5 years	2	9.5	10.0	50.0
	6-9 years	4	19.0	20.0	70.0
	10-14 years	4	19.0	20.0	90.0
	more than 15 years	2	9.5	10.0	100.0
	Total	20	95.2	100.0	
Missing	5.00	1	4.8		
Total		21	100.0		
<i>Job Status</i>					
Valid	full time	17	81.0	81.0	81.0
	part time	4	19.0	19.0	100.0
	Total	21	100.0	100.0	
<i>Age</i>					
Valid	25-34	3	14.3	16.7	16.7
	35-44	6	28.6	33.3	50.0
	45-54	5	23.8	27.8	77.8
	55+	4	19.0	22.2	100.0
	Total	18	85.7	100.0	
Missing	5.00	3	14.3		
Total		21	100.0		

Table 2 reveals a mean for Burnout of 10.86 (SD = 9.00), which indicates low-level burnout (below the threshold of 17 for moderate burnout). The mean for Depersonalization is 6.76 (SD = 5.43), indicates moderate burnout (6-11 inclusive). Ten respondents (47.6%) indicated a level of burnout greater than low-level for Section B: Depersonalization (i.e., scores greater than 5). Four of these respondents (about 19% overall) indicated high-level burnout for this factor. Finally, the mean for Personal Achievement is 40.67 (SD = 7.95), indicates low-level burnout (above the threshold of 40 for moderate burnout).

Table 2
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Burnout	21	.00	35.00	10.8571	9.00159
Depersonalization	21	.00	19.00	6.7619	5.43051
Achievement	21	17.00	51.00	40.6667	7.95194
Valid N (listwise)	21				

A closer look at the distribution of scores shows that, overall, only three respondents (14.3%) indicated a burnout greater than the low-level for Section A: Burnout (i.e., scores greater than 17). Two of these respondents (about 10% overall) indicated a high level of burnout with scores greater than 30.

Discussion

The protocol was developed as a standardized process to address employee wellness. A draft protocol of common evidenced based interventions was completed prior to feedback sessions. Post feedback sessions yielded comments which included personal and organization changes required to reduce the potential for burnout. Initial evidenced based interventions were primarily focused on employee personal modifications of actions and behaviors. Employee and agency actions to promote wellness and reduce potential for burnout were grouped by timeframes. Monthly activity recommendations included: case conferences for complex patient concerns; staff sessions to review administrative concerns; and share community low cost or nominal fee recreation activities for employees and their families. Quarterly, semi annually and annual actions included educational/training sessions; participating in a community support activity as an agency; staff retreat, wellness assessment and organization climate survey. The feedback for employee and agency actions highlight a need for a combined systems and individual focused approach (West et al., 2016). The protocol will require additional modifications before being accepted or implemented by practice administrators.

Limitations

There were several limitations for the project. The MBI is copyrighted and could be costly for organizations to administer. Weaknesses are widely recognized with self-reported questionnaires. Additionally, data from the project may not be generalizable to other outpatient mental health settings.

Strengths

Prior research has focused on professional clinicians only. This quality improvement project offered all agency clinicians and staff multiple opportunities to participate and have their

recommendations considered in developing a wellness protocol. Administrators were eager to gather the data to determine if a need existed to create a wellness protocol.

Implications for Practice

Burnout impacts patients, providers, staff, and organizations. Whether globally, nationally or locally, it's evident that in order to provide care for patients with higher acuity, engage with individuals attempting to maintain sobriety and ensure access to mental health services, burnout must be addressed for staff and clinicians. Preventative efforts and interventions must be considered before having to manage the high personal and organizational cost consequences of reduced patient safety, employee mental health concerns, compassion fatigue and staff turnover. Obtaining staff and clinician feedback is vital before implementing evidence-based wellness protocols to reduce burnout. Organization administrators seeking to reduce the potential for burnout among staff and clinicians must establish metrics to measure wellness and address system constraints noted by employees.

Conclusion

The combination of improved access to care, increased patient acuity, limited inpatient treatment resources, and reduced outpatient mental health providers has created the perfect storm of risk for burnout amongst clinicians and staff. Previous findings have been geared towards physicians, medical residents and first responders. Research must be expanded to include staff and providers across the spectrum of healthcare. Outpatient mental health clinicians are caring for patients with substance abuse concerns, extensive trauma histories and acute mental health needs. Support staff engage directly with patients seeking treatment during acute psychiatric episodes. They are aware of personal and systematic transformations required to occur in providing for the complex needs of patients. Mental health professionals nor staff are immune to

the stress brought about attempting to care for or treat patients entrusted to their practice.

Avoiding difficult conversations related to potential for burnout places clinicians and staff at greater risk for their own mental health concerns. Healthcare administrations that fail to include staff wellness, develop specific policies or protocols to ensure the protection and wellbeing of staff employees will risk the consequences of clinician and staff burnout.

References

- Awa, W., Plaumann, M., Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling*, 78(2), 184-190.
- American Nurses Association. (2014). *Nurse Fatigue*. Retrieved from <https://www.nursingworld.org/practice-policy/work-environment/health-safety/healthy-nurse-healthy-nation/nurse-fatigue/> on November 1, 2019.
- American Medical Association. (2016). *Physician Burnout Improve Physician Satisfaction and Patient Outcomes*. Retrieved from <https://edhub.ama-assn.org/steps-forward/module/2702509> on November 1, 2019.
- Center for Addiction and Mental Health. (2017). Understanding of Quality of Care (The relationship between resident burnout and safety-related and acceptability-related quality of healthcare: a systematic literature review. *Health & Medicine Week* (Dec 1), 127.
- Centers for Disease Control and Prevention. (2017). *Health, United States, 2016*. Retrieved from <https://www.cdc.gov/nchs/data/abus/abus16.pdf#050> on November 22, 2018.
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.), New Jersey: Lawrence Erlbaum Associates
- County Health Rankings and Roadmap. (2018). *Talbot, Maryland*. Retrieved from <http://www.countyhealthrankings.org/app/maryland/2018/rankings/talbot/county/outcomes/overall/snapshot> on November 1, 2019.
- Dyrbye, L., Tait D., Shanafelt, C., Sinsky, A., Cipriano, P., Bhatt, J., Ommaya, A., West, C & Meyers, D. (2017). Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. *NAM Perspectives*. Retrieved from <https://nam.edu/burnout-among-health-care-professionals-a-call-to>

[explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/](#) on

November 1, 2019.

Garcia, H., McGeary, C., Finley, E., Ketchum, N., McGeary, D., & Peterson, A. (2015). Burnout among psychiatrists in the Veterans Health Administration. *Burnout Research*, 2108-114.

Gauthier, T., Meyer, R., Grefe, D., & Gold, J. (2015). An on-the-job mindfulness-based intervention for pediatric ICU nurses: A pilot. *Journal of Pediatric Nursing*, 30, 402-409.

Irving, A. (2014). Policies and procedures for healthcare organizations: A risk management perspective. *Patient Safety & Quality Healthcare*. Retrieved from <https://www.psqh.com/analysis/policies-and-procedures-for-healthcare-organizations-a-risk-management-perspective/>

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, 27(1), 20-32. <https://doi.org/10.1111/inm.12416>

Konstanzer, R. (2017). Mental health crisis in Maryland: A lack of hospital beds for the mentally ill presents Maryland legislature with concerns about the legality and practicality of detainment, *Journal of Legislation*, 44(1),84-106.

Luther, L., Gearhart, T., Fukui, S., Morse, G., Rollins, A. L., & Salyers, M. P. (2017). Working overtime in community mental health: Associations with clinician burnout and perceived quality of care. *Psychiatric Rehabilitation Journal*, 40(2), 252–259.

Maryland Department of Health. (2018). Report on Statewide Review of Behavioral Health Workforce and Capacity. Retrieved from [http://www.mdcbh.org/files/manual/169/Joint%20Chairmen's%20Report%20\(p.%2084\)-](http://www.mdcbh.org/files/manual/169/Joint%20Chairmen's%20Report%20(p.%2084)-)

%20Review%20of%20the%20Behavioral%20Health%20Workforce%20and%20Capacit
y%20(1).pdf on April 29, 2019.

Maryland Department of Planning. (2016). *Maryland State Data Center*. Retrieved from
<http://planning.maryland.gov/msdc/Pages/default.aspx> on November 22, 2018.

Maslach C, Jackson SE. (1981). The measurement of experienced burnout. *Journal of
Occupational Behavior*, 2(2), 99-113.

Moran, K. J., Burson, R., & Conrad, D. (2017). *The Doctor of Nursing Practice Scholarly
Project*. Burlington, Massachusetts: Jones & Bartlett Learning.

Morse, G., Salyers, M., Rollins, A., DeVita, M., & Pfahler, C. (2012). Burnout in mental health
services: A review of the problem and its remediation. *Administration and Policy in
Mental Health and Mental Health Services Research*, 39(5), 341-352.

National Alliance on Mental Illness. (2015). *State mental health legislation 2015: Trends,
themes and effective practices*. Retrieved from [http://www .nami.org/About-
NAMI/Publications-Reports/Public-Policy-Reports/StateMental-Health-Legislation-
2015/NAMI-StateMentalHealthLegislation2015.pdf](http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/StateMental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf)

National Institute on Drug Abuse. (2017). *Overdose Death Rates*. Retrieved from
<https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates> on
November 1, 2019.

Ossege, J. M., & Sears, R. W. (2017). *The Resilient Mental Health Practice: Nourishing Your
Business, Your Clients, and Yourself*. New York, NY: Routledge. Retrieved from
[https://searchebsohostcom.libdata.lib.ua.edu/login.aspx?direct=true&db=nlebk&AN=146
3460&site=eds-live&scope=site](https://searchebsohostcom.libdata.lib.ua.edu/login.aspx?direct=true&db=nlebk&AN=1463460&site=eds-live&scope=site) on November 1, 2019.

Shively, R. (2017). BURNOUT: Managing staff burnout and vicarious trauma in the workplace.
Corrections Today, 79(6), 44.

Stillwell, S. B., Fineout-Overholt, E., Melnyk Mazurek, B., & Williamson, K. M. (2010).

Evidence Based Practice - Step by step: Asking the clinical question: A key step in evidence-based practice. *American Journal of Nursing*, (3), 58-61.

Substance Abuse and Mental Health Services Administration. (2015). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf> on November 1, 2019.

Tsai, P. (2003). A middle-range theory of caregiver stress. *Nursing Science Quarterly*, 16(2), 137-145.

Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*, 23(2), 172–185.

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *The Lancet*, 388(10057), 2272–2281. [https://doi-org.libdata.lib.ua.edu/10.1016/S0140-6736\(16\)31279-X](https://doi-org.libdata.lib.ua.edu/10.1016/S0140-6736(16)31279-X)

Wiederhold, B. K., Cipresso, P., Pizzioli, D., Wiederhold, M., & Riva, G. (2018). Intervention for physician burnout: A Systematic Review. *Open Medicine* 13, 253–263. doi:10.1515/med-2018-0039

Wood, A., Prins, A., Bush, N., Hsia, J., Bourn, L., Earley, M., ... Ruzek, J. (2017). Reduction of Burnout in Mental Health Care Providers Using the Provider Resilience Mobile Application. *Community Mental Health Journal*, 53(4), 452–459. <https://doi.org/10.1007/s10597-016-0076-5>

World Health Organization (2019). *Burn-out an "occupational phenomenon": International Classification of Diseases*. Retrieved from

https://www.who.int/mental_health/evidence/burn-out/en/ on June 6, 2019.