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ORIGINAL ARTICLE

Burnout among mental health professionals working in an inpatient setting within the Maltese NHS

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Background

The aim of this study was to quantitatively explore the prevalence of job related burnout in mental health professionals working in an inpatient setting. The phenomenon of burnout is understood as a process involving three core features: emotional exhaustion, depersonalisation and low personal accomplishment.

Method

The study population consisted of all the psychiatry doctors, nurses, occupational therapists, psychologists, psychotherapists and social workers working in an inpatient psychiatric setting in the Maltese Islands. A cross-sectional anonymous self report survey was administered, this included demographic and job related questions and the Maslach Burnout Inventory (MBI-HSS-MP).

Results

The response rate was 71%. The burnout levels in this cohort of healthcare workers were similar to those found in other countries. 13.9% of the study population reported all the core features of burnout. 70.4% appeared to be moderately to highly emotionally exhausted.

Conclusion

This study identified the need for services to start assessing and working to improve the mental wellbeing of the mental health service providers in Malta.

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Job related burnout emerged as a concept in the 1970s and extensive research has been conducted to understand its nature.[1] In the research community, burnout is viewed as a process by which the psychological resources of an employee are gradually depleted as a consequence of prolonged stress at work.[2]

For the purpose of this study, burnout is considered as a three-dimensional process consisting of three constructs:

1. Emotional exhaustion - feeling emotionally drained and exhausted by one's work;
2. Depersonalization - negative or very detached feelings toward clients or patients;
3. Reduced personal accomplishment - evaluating oneself negatively and feeling unsatisfied with positive job performance and achievements.

This model was proposed by Maslach and Jackson and is the basis for the widely used Maslach Burnout Inventory adopted in this study.[3] In this theory, the concept of burnout is understood as a continuous variable and the authors emphasized that the Maslach Burnout Inventory does not produce a total score for burnout. This means that the prevalence of burnout cannot be interpreted as clinical burnout but a research measure.

The causal order of the three dimensions depends on the theoretical perspective adopted but it appears that high emotional exhaustion precedes high depersonalisation whilst high depersonalisation leads to high emotional exhaustion and low personal accomplishment.[4]

It is well known that burnout is very much present in healthcare professions[5] and that it is almost inevitable in such professions.[6] Lyndon continues by explaining that the healthcare environment is conducive at putting healthcare workers at risk. Issues that contribute for such environment include time pressures, emotional intensity, role conflict and difficult relationships between groups and with managerial strata of the organisation.

At the same time burnout affects service provision and ultimately service users.[7] Mental health workers represent one of the categories of health workers at highest risk of burnout.[8] According to Lasalvia et al, high levels of job distress affected nearly two-thirds of the psychiatric staff whilst one in five staff members suffered from burnout.[9] Psychiatrists and social workers were found to be affected the most. In Malta, Galea reported that in a sample of Maltese nurses (including mental health nurses), working in three state hospitals, symptoms of burnout were noted to be high.[10] He noted that 94% indicated low personal accomplishment, 88% scored high on depersonalisation and 33% scored high on emotional exhaustion.

The presence of burnout in the healthcare professional community is thus an established phenomenon in published literature leading to the next question that need to be elucidated, namely what factors contribute to burnout. Maslach and Leiter proposed that burnout develops as the result of mismatches between professionals and their job contexts in several areas of working life.[11] They proposed a mediation model whereby, a worker-job mismatch results in increased possibility of burnout. A subjectively experienced weak fit or incongruence in one or more aspects of working life can operate as a stressor and thereby threaten employees' well-being. In this line, a job-person mismatch maybe defined in terms of organizational-, job- or individual-weakness.[12]

The purpose of this study was twofold. The first aim was to investigate burnout affecting mental health professionals in Malta. The prevalence of burnout in mental health professionals who work closely with inpatient service users namely: Psychiatry Doctors, Psychologists/Psychotherapists, Nurses, Social workers and Occupational Therapists was studies. The other objective was to increase awareness with regards to the mental health wellbeing of service providers within the national mental health services.

MATERIALS AND METHODS

The method adopted for this study was a cross-sectional anonymous self-report survey. The Malta National Health System offers inpatient mental health services at Mount Carmel Psychiatric Hospital, Psychiatric Unit at Mater Dei Hospital and Short and Long stay wards at Gozo General Hospital. Managers in the respective units were contacted and informed of this study. Authorisation to contact the Human Resources department was obtained in order to identify the total population for this study and for the distribution of the survey.

The survey consisted of a questionnaire which entailed socio-demographics and job related questions together with the Maslach Burnout Inventory (MBI-HSS-MP). (Digital Supplementary File 1)

The survey was distributed to the different inpatient mental health locations as a pen and paper

questionnaire together with an information letter and a consent form. The choice to use a paper questionnaire was taken in an attempt to reach employees who do not use email or internet based surveys and hence to optimise response rate. The competition of the questionnaire was anonymous. Consent was understood as being present if the participant submitted the questionnaire. A collection checkpoint was established in a central area of the inpatient facility (Mount Carmel Psychiatric Hospital).

STATISTICAL ANALYSIS

Data collection was carried out over four weeks in the month of August 2018. The time period was chosen arbitrarily, taking into consideration the timeframe of the study. All data was stored in a password protected excel spread sheet.

Data collection was subjected to quantitative analysis and the results were compiled and evaluated in line with the literature review and objectives of the project. Statistical analysis was undertaken using IBM SPSS 20. Descriptive statistics together with Pearson co-relation and Analysis of variance (ANOVA) produced the results below.

These are structured according to the aims of the study. Statistically significant associations and correlations were considered at a p-value of 0.05.

The measure for burnout was attained by using the The Maslach Burnout Inventory Human services Survey for Medical Personnel (MBI-HSS-MP)

The Maslach Burnout Inventory (MBI), was initially published in 1981, and is considered to be a well-established tool for assessing burnout through a self-report survey. The MBI- HSS, adapted for Medical Personnel, also known as the MBI-HSS-MP, has slightly different wording. Instead of referring to "recipients", the MBI-HSS-MP, uses the term "patients".[13] It consists of 22 statements to be rated on a Likert scale assessing how often the statement occurs, ranging from 0 (Never) to 6 (Everyday). The 22 items are subdivided into three subscales measuring Emotional Exhaustion (9 items), Depersonalisation (5 items) and Personal Accomplishment (8 items). These represent the core components of burnout. The Cronbach Alpha co-efficient for the three subscales in this study were: emotional exhaustion α=0.91, depersonalisation α=0.64 and personal accomplishment α=0.82.

Previously defined cut-off scores by Maslach et al were used to determine low, moderate and high levels of each burnout feature:

- Emotional exhaustion: low ≤16, moderate 17 to 26, to high ≥27
- Depersonalization: low ≤6, moderate 7 to 12, high ≥13
- Personal accomplishment: low ≥39, moderate 32 to 38, to high ≤31

RESULTS

This survey included all the mental health professionals employed within the national health system whose work included inpatient care. The professionals included:

- Psychiatrists and trainees (N=42)
- Nurses (N=240)
- Occupational therapists (N=14)
- Psychologists/Psychotherapists (N=16)
- Social workers (N=10)

The total eligible number of employees was of 322 and 230 questionnaires were successfully completed and returned giving a response rate of 71%.

The response rates for the different professions were as follows:

- Psychiatry doctors (64.3%),
- Nurses (72.1%),
- Occupational therapists (85.7%),
- Psychologists/Psychotherapists (68.8%) and
- Social workers (70.0%).

57% were women and 43% males. The age distribution within the three categories (18-30, 31-50, 51 and over) was of 33%, 40% and 27% respectively. Thirty seven participants were of non-Maltese nationality representing 16.1% of the total population. 10.9% of the population were non-state employed, while only n=2.2 % worked on a part- time basis. 80.4% of the workforce constituted of frontlines, that is employees who deal directly with service users.

The mean scores for the three MBI sub scales are shown in **Table 1**. All the means fall within the moderate range for burnout as per Maslach et al.[14] **Table 2** shows the percentages in the study population falling within the different cut off categories. **Tables 3 - 5** illustrate the percentage scores within different professions for the three core burnout features.

Table 1 *Mean scores per MBI subscales and cut off scores as per Maslach et al.*[14]

MBI Subscales	Burnout Cut off scores			Results	
	Low	Moderate	High	Mean	SD
Emotional Exhaustion	≤16	17-26	≥27	23.79	12.31
Depersonalisation	≤6	7-12	≥13	8.04	5.49
Personal Accomplishment	239	32-38	≤31	33.93	8.62

Table 2 *Percentages Population per MBI Subscale*

MBI Subscale	Low (%)	Moderate (%)	High (%)
Emotional Exhaustion	29.6	30	40.4
Depersonalisation	42.6	39.1	18.3
Personal Accomplishment	30.4	41.3	28.3

Table 3 *Percentage Scores for Emotional Exhaustion by Profession*

Profession	Low (%)	Moderate (%)	High (%)
Social Workers	0	14.3	85.7
Psychology	15.7	57	27.3
Occupational Therapists	33.3	33.3	33.3
Nurses	27.1	33	39.9
Doctors	19.3	40	40.7

Table 4 *Percentage Scores for Depersonalisation by Profession*

Profession	Low (%)	Moderate (%)	High (%)
Social Workers	13	58.4	28.6
Psychology	63	97	0
Occupational Therapists	70	21.7	8.3
Nurses	38.9	40	21.4
Doctors	55	37.6	7.4

Table 5 *Percentage Scores for Personal accomplishment by profession*

Profession	Low (%)	Moderate (%)	High (%)
Social Workers	13	58.4	28.6
Psychology	63	97	0
Occupational Therapists	70	21.7	8.3
Nurses	38.9	40	21.4
Doctors	55	37.6	7.4

13.9% of the responders scored high on emotional exhaustion, high on depersonalisation and low on personal accomplishment and this can be considered as the prevalence of burnout in this cohort. On the other hand, 8.7% scored low on emotional exhaustion and depersonalisation and high on personal accomplishment. These could be considered as fully engaged employees. 15.2% scored high on both emotional exhaustion and depersonalisation while 14.3% scored high on emotional exhaustion and low in personal accomplishment.

DISCUSSION

Burnout levels found in this cohort of Maltese mental healthcare workers were comparable to results found in other published studies carried out in other European countries as summarised in Eurofound.[15] 13.9% of this study population scored up for all the three core features of burnout. These can be considered to be at the extreme end of the burnout continuum. At the other end of the spectrum 8.7% can be described as fully engaged at work with low emotional exhaustion, low depersonalisation and high personal accomplishment. Furthermore, although 71% responded to the questionnaire, 29% of the study population chose not to partake in the study. It could be hypothesised that people who are disengaged due to burnout contributed to a degree of nonresponse bias considering burnout as a subject matter.

When considering these results it is important to keep in mind that as Doulougeri et al[16] pointed out, calculating burnout using all the three core features (of burnout) is considered as a conservative approach. This can be understood depending on the perspective or paradigm used. If a one-dimensional concept of burnout is adopted, then this study would underestimate the prevalence of the phenomenon

under investigation. On the other hand, this study employs a multidimensional approach to remain truthful to Maslach and Leiter concept of burnout.[11] Nonetheless, it is valuable to investigate individual features of burnout to better understand the present wellbeing of service providers.

A key finding from this study was the high level of emotional exhaustion reported (40.4%). Emotional exhaustion is given particular attention in the literature and is considered by various authors as the core component of burnout and this is in line with the findings of this study.

Maslach and Leiter describe exhaustion as the first reaction to the stress of job demands or major change.[11] Some studies even measure emotional exhaustion to represent the existence of burnout and others measure emotional exhaustion in conjunction with either depersonalisation or low personal accomplishment as indicators of burnout.[16] Taking this into consideration and the fact that burnout is understood as a continuous variable and not a distinct phenomenon, people scoring high in one of the three components, particularly in emotional exhaustion, are at a higher risk of experiencing burnout.[17] This could mean that in this study there is a high proportion of the workforce who is at risk of becoming burnt out.

In contrast to depersonalisation and personal accomplishment, most demographic and work related factors in this study did not show statistical differences with regards to emotional exhaustion. This suggests that emotional exhaustion is experienced similarly across professions. The results of this study show that 70.4% of participants who responded appeared to be moderately to highly emotionally exhausted. Considering that emotional exhaustion is defined as 'wearing out, loss of energy, depletion, debilitation, and fatigue', further investigation is warranted to elucidate how widespread it is in the Maltese mental health inpatient services, whether this extends to community and out-patient services and ultimately how this affects the provision of healthcare services and patient care. Research shows that community mental health service workers exhibit higher scores of burnout when compared to those working in specialised community services and it would be informative to assess Malta's present situation.[18] High emotional exhaustion levels are related to heavy workloads, low supportive relations, and personal engagement, less quantity of staff members, professional development and understanding of burnout.[19] It would be valuable for the worker and the organisation alike to investigate these factors in relation to burnout within the mental healthcare services.

The depersonalisation and personal accomplishment components show a more complex relationship within the study population. As shown in the results, 18.3% and 30.4% of responders scored high for depersonalisation and low for personal accomplishment respectively. Depersonalisation and personal accomplishment show significant differences across a number of factors.

Of note were the higher levels of depersonalisation in males as compared to the female employees; and higher depersonalisation scores and lower personal accomplishment in non-Maltese employees and non-state employed. Depersonalisation is described in literature as starting off as a self-preserving mechanism from job stress, where a person utilises psychological withdrawal in the face of chronic stress. Ultimately this becomes a dysfunctional mechanism. As a result, depersonalization manifests itself as a negative, cynical attitude towards the service users or work in general.[20] It is interesting to note a gender difference in this aspect that was also documented in a meta- analysis by Purvanova and Muros.[21] It is valuable to research further this gender difference since if depersonalisation can be considered as a maladaptive coping mechanism to prolonged stress, males could benefit from coping skills training to improve their mental wellbeing. At the same time, it is difficult to ascertain whether gender differences are an attribution to the gender of the individual or the possible differing work environment or expected roles within a particular culture.

During the COVID pandemic and therefore, whilst this questionnaire was being filled out, ongoing changes were being carried out to the mental health system and its structure. This included closure of the psychiatric unit at Mater Dei Hospital and of long-stay wards at Mount Carmel Hospital. Furthermore, re-structuring of the acute wards was carried out and staff was functioning as ward-based rather than consultant-base. All of these changes were being implemented during the pandemic, hence adapting to a new working structure might have possibly added to the burnout being experienced.

Following this study, we formulated some recommendations to help tackle the issue of burnout amongst professionals.

Psycho education on burnout and its ramifications is essential at all organisational levels.[22] Employees

need to become more aware of their mental well being and the way the organisational environment affects them and their ability to offer reliable and safe service provision.[23] Workers who are already suffering from burnout or are at risk of burnout need to have the ability to recognise their situation and rectify their situation in an environment that fosters self-improvement and understanding.

Managerial awareness of employees' mental health and the possibility to provide organisational support is also crucial if burnout is to be reduced [24,25] Employee mental wellbeing needs to be integrated in organisational policy both for the employees' ability thrive in an organisation and for better service provision.[25]

Another recommendation is to invest more in further research into care provider wellbeing. Understanding the employees' needs and strengths will ultimately benefit the patient and service provision.

CONCLUSION

When analysing job related burnout, Eurofound report in 'Burnout in the workplace: A review of data and policy responses in the EU' that "The evidence pointed to increased risk of sickness absences, turnover intention, decreased work ability, lower performance in work and premature exit from the labour market".[15]

This study offers the possibility to initiate a discussion on the wellbeing of the service provider in an important health sector. It shows that the Maltese context follows closely international burnout levels and needs addressing to improve the workers' wellbeing and ultimately help in sustaining a safe environment for the service users.

Finally, it suggests areas where further research can be undertaken to better understand the health of the Maltese psychiatric services, and hopefully to initiate a brainstorming process of how to improve the present condition, both at an individual level and on the organisation plane.

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