

A Mixed-Method Examination of Multi-Level Contributors to Community Mental Health

Provider Burnout

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Abstract

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Community mental health providers (CMHPs) face high risk of experiencing burnout – an occupational syndrome characterized by emotional exhaustion, depersonalization and decreased personal accomplishment. CMHP burnout can lead to thwarted evidence-based practice efforts, staff turnover, worse quality care for clients, and poor provider well-being. However, it remains unclear what the full range of factors CMHPs’ perceive to be contributing to their burnout and which CMHPs are at most risk for burnout. Thus, the aim of the current study was to use qualitative and quantitative methods to examine multi-level factors that may contribute to CMHP burnout. Qualtrics surveys were completed by 197 CMHPs across 36 organizations across Washington State participating in a state-funded cognitive behavioral therapy training initiative for common youth mental health disorders. CMHPs reported on a 1-

item measure on burnout, provider- and organization-level characteristics, and answered an open-ended question on perceived contributors to burnout. Using thematic analysis, large caseloads, role overload (i.e., excessive responsibilities without sufficient time and resources), and poor provider well-being emerged as the most salient contributors perceived by CMHPs. Furthermore, multilevel random-intercept logistic regression revealed that CMHPs with 1-3 years of clinical experience were most at risk of experiencing burnout compared to CMHPs with other experience levels within their organization. Findings highlight key areas for targeted intervention to address CMHP burnout and suggest that organizations may need to especially support CMHPs with 1-3 years of clinical experience to mitigate burnout.

A Mixed-Method Examination of Multi-Level Contributors to Community Mental Health Provider Burnout

Approximately 40% of mental health providers experience feelings of burnout (Morse et al., 2012), an occupational syndrome due to unresolved chronic workplace stress characterized by emotional exhaustion, depersonalization and decreased personal accomplishment (World Health Organization, 2022). Community mental health providers (CMHPs) may be especially at risk for burnout (Evans et al., 2006), due to large caseloads, clients with higher need, and fewer resources compared to providers in private practices or hospital settings (Acker, 2010; Gattman et al., 2017; O'Connor et al., 2020). Burnout in the mental health workforce has far reaching impact on the organization, clients, and providers. Emotional exhaustion, one dimension of burnout, has been associated with employee's turnover intention (Green et al., 2013). Public mental health agencies in the US can experience a 24-40% turnover rate in 1 year (Brabson et al., 2020), with some agencies even experiencing 100% turnover in the span of 4 years (Beidas et al., 2016). High turnover rates are costly in terms of hiring and training new staff (Waldman et al., 2004), but also in terms of thwarted evidence-based practice (EBP) implementation efforts. Organizations invest time and effort to train staff on EBPs (Beidas et al., 2013), and when staff leave, their organizations lose that EBP knowledge and experience (Droege & Hoobler, 2003).

Mental health provider burnout also has negative implications for client and provider impact. Several studies have found that lower burnout among mental health providers was associated with better self-reported person-centered care (Fukui et al., 2021; Salyers et al., 2015), which involves treating a client with dignity, compassion and respect, offering coordinated and personalized care, and empowering clients to live an independent and fulfilling life (Health Foundation (Great Britain), 2016). Additionally, among school-based providers, higher burnout

was associated with less implementation of an evidence-based model (Camelford et al., 2017). Studies have also documented associations between burnout and employee impact, including internalizing symptoms such as depression and anxiety (Ahola et al., 2005; Peterson et al., 2008), physical symptoms (e.g., neck and back pain) (Peterson et al., 2008), and other health problems (e.g., flu symptoms) (Acker & Lawrence, 2009).

Despite existing quantitative studies on burnout among mental health providers, it remains unclear which CMHPs are most at risk. For example, findings on the relationship between gender and burnout in literature have been mixed (O'Connor et al., 2018), with some studies finding that women are more vulnerable to developing one dimension of burnout, emotional exhaustion (Ballenger-Browning et al., 2011), while others have found that women are less vulnerable to developing another dimension of burnout, depersonalization (Schadenhofer et al., 2018). Furthermore, associations between years of clinical experience and burnout has also been inconsistent. For example, one study found that less prior clinical experience was associated with more burnout (Sprang et al., 2007), while another study found no association (Malouf et al., 2023). Studies have however, demonstrated that that provider well-being can be a protective factor against burnout (Ahola et al., 2005; Lucas-Baptiste, 2022). Thus, based on the minority stress model, Black, indigenous and people of color (i.e., racial/ethnic minority) providers may be especially vulnerable to developing burnout due to exposure to discrimination and prejudice, which can create a chronically stressful environment and negatively impact well-being. However, there is limited research on racial/ethnic differences in burnout among mental health providers.

Work-related factors have demonstrated a more consistent relationship to burnout. Factors including a large caseload size (Kim et al., 2018; O'Connor et al., 2018), working greater

number of hours (Ballenger-Browning et al., 2011; Luther et al., 2017), and treating patients with high symptom severity (Acker & Lawrence, 2009; Morse et al., 2012) have been associated with higher burnout. Furthermore, agencies in rural areas face more prevalent mental health provider workforce shortages (Washington State Department of Health, 2022) and more burned out providers compared to urban settings (Sprang et al., 2007). Labor unionization within an organization may impact provider burnout, as unions aim to improve working conditions and increase employee benefits. In recent years, there has been an increase in labor organization, particularly among healthcare workers. For example, in the Fall of 2024, 2,400 mental health providers in Southern California went on a 7-month long strike against the country's largest Health Management Organization, protesting staffing shortages, poor patient care, and low wages, which has become the longest mental health worker strike in United States history (Garcia, 2025). However, research on union participation and healthcare worker wellbeing is limited. One such study on this topic was with medical residents, who also face high rates of burnout, found that though surgical residents were offered more vacation time and housing stipends in unionized vs. nonunionized programs, they had similar levels of burnout (Brajcich et al., 2021). To our knowledge, no studies have examined whether unionization at an organization can help to mitigate CMHP burnout.

Changing mental health landscape

In addition to the usual stressors of working in the public mental health sector, the COVID-19 pandemic and related mitigation efforts (e.g., social distancing and academic disruptions) contributed to an increase in youth mental health service need (Leeb et al., 2020; Silk et al., 2022). At the same time, the ongoing workforce shortage in community settings (Fourfront Contributor, 2021) has required the youth mental health workforce to take on even

larger caseloads, creating a vicious cycle of burnout and staff turnover (Hallett et al., 2024). Given the drastic change in the community mental health landscape following the COVID-19 pandemic, it is essential to hear from providers themselves about what they understand to be driving their burnout, in order to better inform future strategies for remediation.

Current Study

Despite the abundance of research investigating burnout contributors among mental health providers, few studies have qualitatively examined CMHP perspectives on the full range of factors they perceive as contributing to their burnout. Furthermore, by identifying burnout contributors more broadly across CMHPs, we can examine which factors differentiate those who meet significant burnout thresholds from those who do not. Additionally, we sought to explore individual- and organizational-level characteristics associated with CMHP burnout to help identify CMHPs most at-risk. Thus, the aim of the current study was to use qualitative and quantitative methods to examine multi-level factors that may contribute to CMHP burnout. Specifically, we examined the following research questions (RQs): 1) What factors do CMHPs perceive to contribute to their own burnout? 1a) Which endorsed burnout factors differ between CMHPs that meet the threshold for burnout compared to those who do not? 2) What individual- (i.e., gender, race/ethnicity, clinical experience) and organizational-level (i.e., rurality, unionization) factors predict CMHP burnout?

Method

Setting

Data were collected as part of an evaluation of an ongoing Washington (WA) State-funded evidence-based treatment (EBT) training initiative called CBT+ (Dorsey et al., 2016). As part of the initiative, community mental health organizations in WA state can enroll CHMPs and

supervisors to be trained in the common elements of Cognitive-Behavioral Therapy (CBT) for depression, anxiety, trauma and behavior disorders. Virtual training consists of completing asynchronous modules, as well as attending synchronous trainings over 2 weeks. CMHPs then attend CBT+ expert-led video-based consultation calls offered twice a month for 3 months, then once a month for three months. CMHPs must attend 8 out of 9 consultation calls, present one CBT+ case during a consultation call, and enter de-identified client session information and scores on clinical measures into the initiative's online outcome measurement dashboard to receive CBT+ certification.

Participants

A total of 240 trainees completed the CBT+ pre-training evaluation survey. Responses excluded from analyses included responses completed *after* the training ($n = 24$) and completed by those whose primary role was not a provider (i.e., supervisor) ($n = 18$). Additionally, one CMHP was removed from analyses due to not completing questions on burnout. Participants in the final sample were 197 CMHPs from 36 organizations across WA State who were 1 of 5 CBT+ training cohorts from October 2022 - August 2023. CMHPs were majority White, non Latinx/e/a/o (59%), women (74.6%) and Master's level (93.9%). On average, providers had 2.52 years ($SD = 3.20$) of experience providing mental health therapy and had spent 1.53 years ($SD = 2.15$) at their current organization. Additionally, 22.2% of the organizations were from rural counties and 22.2% of organizations were unionized. Table 1 displays a full list of participant and organization characteristics.

Procedures

Yearly CBT+ trainings are announced via a listserv to trained CBT+ supervisors and providers. Trainings are also promoted to other community organizations by email. Providers

completed training and consultation during their workday as part of their organizations' expectations and thus were not financially compensated. Trainees received 18-20 hours of continuing education credits for participating in the CBT+ Initiative. For the current study, questions related to burnout were added to the pre-training CBT+ Initiative evaluation survey. All CMHPs enrolled in CBT+ training cohort completed the evaluation survey via Qualtrics prior to initiating training. The CBT+ Initiative also includes a second survey, following completion of CBT+ training and consultation, which was not included in this study.

Measures

Demographics and background

CMHPs reported on demographic and background information such as age (in years), gender (multi-select), race (multi-select), name of their organization and site, years spent conducting mental health therapy, and years spent at their current organization.

Gender. We initially intended to include gender in the model as an effect-coded variable where Woman = 1, and all other gender identities as = -1. However, after examining the all other gender identities category, which included individuals that identified as men ($n = 10$), cisgender only ($n = 22$), gender diverse ($n = 14$) and prefer not to say ($n = 4$), we decided to omit the gender variable from the multilevel random-intercept logistic regression model for a few reasons. First, due to the multiselect format of the demographic questions on gender, some participants selected only "cisgender", which appeared higher on the list, without also selecting a binary gender option (e.g., "woman" or "man"), which appeared lower on the list. Thus, the 22 participants that identified as only "cisgender" could likely be women or men. Second, categorizing men and gender diverse CMHPs into one category may further obscure associations

between gender and burnout. Thus, gender was not included in the final model described in this paper.

BIPOC status. Due to the small number of participants that identified as Native American ($n = 1$), Asian ($n = 15$), Middle Eastern or North African ($n = 1$), Native Hawaiian or other Pacific Islander ($n = 2$), Black or African-American ($n = 7$), Multiracial ($n = 44$), White and Latinx/e/a/o ($n = 4$) and Latinx/e/a/o only ($n = 32$), these participants were grouped together to form a BIPOC category. BIPOC status was effect-coded as BIPOC = 1 and all other racial/ethnic identities = -1. All other racial/ethnic identities included individuals that identified as White (non Latinx/e/a/o) ($n = 117$), an individual that selected “Prefer not to say” ($n = 1$), and another that selected “Self-Describe” ($n = 1$; “Unknown: Closed Adoption”).

Experience Level. A histogram of the provider’s years of clinical experience demonstrated a strong right-skew. Therefore, this variable was transformed into a multi-categorical effect-coded variable. CMHPs with less than 1 year of experience were determined to be “low” experience level ($n = 15$), 1-3 years as “medium” ($n = 141$), and more than 3 years as “high” ($n = 32$). These bins were selected because providers with less than one year of experience were typically attending the CBT+ training during their first few weeks of employment and, therefore, did not yet have a full caseload. Additionally, in WA State, having 36 months of full-time counseling experience is one of the eligibility criteria for obtaining a clinical license (RCW 18.225.090 Issuance of License—Requirements, 2024). As such, any CMHPs with more than three years of experience were categorized as having a "high" experience level, while those with 1–3 years of experience were designated as having a "medium" experience level. Two categorical variables were created for medium and high experience-levels, with low experience-level (< 1 year) designated as the reference group.

Medium Experience Level was effect coded as Medium = 1, High = 0, and Low = -1. High Experience Level was effect coded as High = 1, Medium = 0, and Low = -1.

Rurality. CMHP's organization was effect coded for rurality. Organizations may have several sites at different locations around the state. Site rurality was determined using the Counties Map by the WA State Department of Health (2022). If all sites within an organization were located in a rural county, the organization was determined to be Rural = 1, otherwise the organization was determined to be Not Rural = -1.

Unionization. Organization labor unionization was determined by examining the members list of local healthcare labor union websites (e.g., SEIU Healthcare 1199NW, OPEIU Local 8) and a Google search using the following search terms: [Organization Name] AND "union". Six organizations in the sample were identified as belonging to one of the local healthcare labor unions, and two organizations were identified through the Google search terms. These two organizations were represented by a school union and a non-local union. Unionization was effect-coded as Unionized = 1 and Not unionized = -1.

Burnout

Qualitative. To assess factors contributing to burnout, participants were asked an open-ended question "What, if anything, do you feel has contributed to your sense of burnout?", with instructions to list out the factors in no particular order. We used a modified free list technique (Bernard & Ryan, 2010), in which participants were asked to list up to 15 factors in no particular order, each in its separate entry box.

Quantitative. Participants reported on their level of burnout based on a non-proprietary single-item asking, "In the past 3 months, how would you rate your level of burnout?" (Dolan et al., 2015; Rohland et al., 2004). Responses are scored on a five-category ordinal scale and are

dichotomized as ≤ 2 (no symptoms of burnout) vs. ≥ 3 (1 or more symptoms). The item for our study specified a 3-month time frame, while the original item asked participants to rate burnout levels “overall”. Compared to the previously validated 1-item version of the Maslach Burnout Inventory Emotional Exhaustion subscale (West et al., 2009), this single non-proprietary item had a correlation of 0.79, sensitivity of 83.2%, specificity of 87.4%, and AUC of 0.93 (se=0.004) when tested in a sample of primary care staff (Dolan et al., 2015). Experience of burnout was dummy-coded in the model with 1 = Burnout and 0 = No burnout.

Data Analysis Plan

Qualitative and mixed-methods

Burnout factors were coded for themes using thematic analysis (Braun & Clarke, 2006). Factors describing the same theme (as determined by coders) were consolidated into a single code and organized into broader categories (e.g., client-related) using axial coding (Strauss & Corbin, 1997) (RQ1). We calculated the overall percentage of CMHPs endorsing each burnout factor and calculated percentages for CMHPs who met the threshold for burnout and those who did not. We then compared the percentage endorsement for each factor between the two groups of CMHPs (RQ2).

Coding. Participant responses were coded by the first author (Ph.D. student) and an undergraduate research assistant. The coders individually reviewed entries from the first 2 trainings (50 CMHPs) and used an open coding process (Strauss & Corbin, 1997) to develop a preliminary codebook. Coders separated clinicians’ entries into separate excerpts if an entry contained multiple themes (e.g., “low pay, high caseload”). Coders were instructed to assign only one code to each excerpt. Coders used the most recent version of the codebook to code survey entries. Coders engaged in an open discussion (Chinh et al., 2019) to resolve discrepant codes

during weekly consensus meetings, which helped inform the next iteration of the codebook. This process was repeated until all entries were coded. Once a final codebook was established, coders reviewed all excerpts and recoded them as necessary. A final consensus meeting was held to resolve remaining discrepancies. Coding was completed in Microsoft Excel and interrater reliability was calculated after final coding using kappa coefficients.

Quantitative

Descriptive statistics were calculated to determine the percentage of CMHPs experiencing burnout. A multilevel random-intercept logistic regression model was used to test whether burnout status was predicted by provider-level characteristics (Level 1; e.g., gender, level of clinical experience, BIPOC status) and organization-level characteristics (Level 2; rurality and unionization status) (RQ3). As is standard practice (Luo et al., 2021), intercept-only models were specified before formal analyses began in order to confirm the appropriate multilevel structure by assessing the degree of non-independence in scores due to clustering.

For ease of model results interpretation, all Level 1 variables (e.g., BIPOC status, Medium Experience Level and High Experience-Level) were cluster-mean centered. All predictors were effect-coded.

$$\begin{aligned} \text{LN(Burnout)}_{ij} = & \gamma_{00} + \gamma_{10} * \text{MediumExperience_eff_CMC}_{ij} + \\ & \gamma_{20} * \text{HighExperience_eff_CMC}_{ij} + \\ & \gamma_{30} * \text{HighExperience_eff_CMC}_{ij} + \\ & \gamma_{01} * \text{Rurality_eff_CMC}_{ij} + \\ & \gamma_{02} * \text{Unionization_eff_CMC}_{ij} + \\ & U_{0j}. \end{aligned}$$

In the model above, the natural log of the i^{th} outcome score for Provider within the j^{th} Organization is equal to the sum of the conditional mean (γ_{00}), the unique effects of Provider gender, experience level, BIPOC status, and Organization rurality and unionization ($\gamma_{10} - \gamma_{02}$), and the residual error due to Organization (U_{0j}).

An alpha of .05, 2-tailed, was used for all statistical tests. To assess the practical value of the results, approximate Cohen's d (Cohen, 1988) was computed as the effect size for each coefficient using the parameter estimate divided by the square root of the sum of the variance component estimates. Level 1 variance was approximated using $\pi^2/3$, which is the known variance of a logistic distribution. The approximate model total R^2 values were computed using `r2mlm` in *R* (Rights & Sterba, 2019; Shaw et al., 2020)]. Last, data visualization of model-predicted values was implemented using the 'ggplot2' package (Wickham, 2016); interaction term predicted values extracted with the 'effects' package (Fox & Weisberg, 2019).

Results

RQ1: What factors do CMHPs perceive to contribute to their own burnout?

Table 1 displays the full list of burnout contributors, as well as frequency and percent endorsement. Burnout contributors are organized below based on the following categories: provider-level, client-level, interpersonal, job-demands, organizational-level, and external. Across these categories, specific contributors endorsed most frequently by all CMHPs (at least 20% of CMHPs) regardless of burnout scores were: *personal issues* (e.g., childcare) (endorsed by 33% of participants), *large caseload* (26%), *challenging clients* (22%), *role overload* (22%), *own well-being* (e.g., sleep issues) (22%), *negative work environment* (22%), *schedule* (21%).

Provider-level

CMHPs noted that factors related to their lives outside of work and their own well-being contributed to burnout. Many CMHPs were managing their own *personal issues* outside of work, including childcare, relationship issues, or attending to the health and well-being of their family. Additionally, many CMHPs cited their *own well-being* as a major contributor to their burnout, for example their own feelings of depression, anxiety, and lack of exercise and sleep. Some providers noted that *secondary trauma*, or worrying about their client's outside of work, contributed to their burnout. A few others felt *self-doubt* in their jobs, perceiving that they were inadequate in their role.

Client-level

Factors related to their caseload or their clients were reported as contributors to burnout. Many CMHPs felt overwhelmed given their *large caseloads* which were sometimes even growing. Many CMHPs felt that they had especially *challenging clients*, who were difficult to treat given their high acuity (e.g., suicidality, trauma, psychosis, behavioral issues, crisis situations), multiple presenting problems, and high case management needs. Other factors that CMHPs reported contributing to their burnout included difficulty working with *parents* and *disengaged clients*, or seeing a lack of or *slow progress* with their clients.

Interpersonal

CMHPs also cited a general *negative workplace environment* as a source of burnout, for example feeling generally unsupported in their role as a clinician, not being valued at their organization, and experiencing negative interactions with other staff. Some CMHPs specifically cited *supervisor issues*, including inadequate clinical supervision, lack of communication from their supervisor, and poor supervisory relationship. Other CMHPs specifically cited *issues with the administrators* at their organization, including lack of communication around policy changes,

feeling undervalued by administrators, and having lack of leadership that understands the demands of providing mental health care.

Job Demands

Role overload, or having too many responsibilities for the time and resources available, was a frequently reported contributor. CMHPs felt “stretched too thin” across all their responsibilities. Relatedly, CMHPs felt burnout from their *schedules*, which were filled with back-to-back clients, leaving them unable to take breaks throughout the day, unable to take allotted vacation time, or having to work long hours. *Administrative work* associated with insurance, county, and mandated reporting requirements was another frequently reported contributor. Other CMHPs felt that being new and having to *develop competency* in their role contributed to burnout. Some CMHPs felt that having a lack of *professional autonomy* in caseload size, clinical decision-making, type of treatment delivered, or population of interest contributed to burnout. *Role ambiguity*, such as having unclear job expectations or having unexpected tasks come up was another cited contributor. Some CMHPs reported that the amount of time spent *travelling* for work contributed to their burnout.

Organization-level

Many CMHPs cited that their lack of appropriate *compensation* was a source of burnout. Other CMHPs reported that *trainings*, either a lack of training or having too many trainings, contributed to burnout. Other contributors included a *lack of resources* at the organization, including a lack of referral services that connect families to care not offered by the organization, medical services, and consultation on cases. Other contributors included *staff shortages* and *turnover*, which in turn led to CMHPs taking on more work to cover for absent team members.

External

Some CMHPs cited external factors outside of the organization that contributed to their burnout. For example, the *state of the world*, including the economy, capitalism, negative news coverage, and inflation were reported as contributors. Other CMHPs felt that *seasonal changes*, such as the cold weather or decreased amount of sunlight contributed to their burnout.

RQ 1a: Which endorsed burnout factors differ between CMHPs that meet the threshold for burnout compared to those who do not?

Table 1 also displays the percentage of CMHPs that endorsed each burnout factor separated by burned out CMHPs (BO) vs. not burned out (NBO) CMHPs. Across all categories, specific contributors endorsed most frequently by BO CMHPs (at least 20% of BO CMHPs) were: *large caseload* (40%), *role overload* (35%), *negative work environment* (33%), *own well-being* (32%), *administrative work* (30%), *schedule* (30%), *compensation* (28%), *challenging clients* (25%), and issues with administration (20%). For parsimony, this section describes differences in burnout factors only for factors endorsed by at least 10% of all CHMPs. Burnout factors that were about three times as likely to be endorsed by burned out (BO) CMHPs vs. not burned out (NBO) CMHPs were *role overload* (35% of BO; 13% of NBO) and *compensation* (28% of BO 8% of NBO). Factors that were about twice as likely to be endorsed by BO vs. NBO CMHPs included *own well-being* (32% of BO; 17% of NBO), *large caseload* (40% of BO; 20% NBO), *negative work environment* (33% of BO; 15% of NBO), *administrative work* (30% of BO; 14% of NBO), and *schedule* (30% of BO; 16% of NBO). Factors that did not differ much by CMHP burnout status included *personal issues* (33% BO; 30% NBO) and *challenging clients* (25% of BO; 20% of NBO).

RQ2: What individual- (i.e., BIPOC status, years of clinical experience) and organizational-level (i.e., rurality, unionization) factors predict CMHP burnout?

Descriptives and Correlations

Sixty CMHPs met threshold for burnout (32%). N's, percentages, and zero-order correlations among all variables in the model are provided in Table 2. As displayed in Table 2, Medium Experience Level was positively correlated ($r = 0.17, p = .021$) with burnout. CMHPs that had medium experience level (i.e., 1-3 years of professional experience) were more likely to endorse burnout. Additionally, BIPOC status was *negatively* correlated with burnout ($r = -0.16, p = .026$). CMHPs that identified as BIPOC were *less* likely to endorse burnout. No other correlations, including those between predictors were significant. Inspection of the ICCs revealed that organizations explained 4% of the variance in the outcome variable of burnout. Additionally, organizations explained 14% of the variance in provider medium experience level (1-3 years of clinical experience), 2% in provider high experience level (> 3 years of clinical experience), and 0% of the variance in BIPOC status.

Model Results

Model 0 Results Overall. Due to missing data, 186 providers from 34 organizations were ultimately included in the models. An intercept-only (or “empty”) model was specified to examine intraclass correlations. As shown in Table 4, the probability of a provider endorsing burnout was -0.82 log odd units (logits), which was significantly different from zero ($p < .001$). The total variance explained by the model was 0.126.

Model 1 Results Overall. Level 1 and Level 2 predictors were added for Model 1 to examine main effects. As can be seen in Table 4, only Level 1 predictors of provider BIPOC status and Medium Experience Level cluster-mean-centered within organization were significant predictors of the variance in burnout status. The total variance explained in Model 1 was 0.430, which is .304 greater than the intercept-only model (Model 0). The likelihood ratio test (LRT)

comparing this model to the previous indicated significance ($p = .030$) and the AIC dropped by 1.9 points. However, the BIC value increased by 17.5 points. Taken all together, the model with the predictors was improving model-data fit.

Model 1 Coefficients. When examining the coefficients in Model 1 (see Table 4), the intercept of the model predicts that across organizations, the probability of a provider endorsing burnout is 27.2%, ($\beta = 0.98$, $OR = 0.37$, 95% CI [0.21, 0.67], $p = .001$). Additionally, cluster-mean-centered provider Medium Experience Level significantly *positively* predicted provider burnout. Providers with a medium level of experience (i.e., 1–3 years of providing mental health therapy) had significantly higher odds of endorsing burnout compared to the organizational average provider, calculated as the grand mean likelihood of burnout endorsement across all categories of experience levels within an organization ($\beta = 0.97$, $OR = 2.77$, 95% CI [1.23, 6.24], $p = .014$), holding all else constant. This means that, on average, medium-experience providers were 2.77 times more likely to report burnout than their peers at their organization. Additionally, cluster-mean-centered provider BIPOC status significantly *negatively* predicted provider burnout. BIPOC providers had significantly lower odds of endorsing burnout compared to the organizational average provider, calculated as the grand mean likelihood of burnout endorsement across BIPOC and other racial/ethnic CMHPs within an organization, ($\beta = -0.52$, $OR = 0.60$, 95% CI [0.40, 0.89], $p = .012$), holding all else constant. This indicates that, on average, BIPOC CMHPs were 40% less likely to report burnout than their peers at their organization. No other provider- or organization-level variables significantly predicted CMHP burnout (p 's > .05).

Discussion

The current study examined perceived contributors to burnout of CMHPs in WA state, as well as individual- and organizational-level characteristics that predict burnout. Given the

abundance of quantitative studies on predictors of burnout, it was important to examine this topic using qualitative methods to understand the top problems facing CMHPs that they perceive to contribute to burnout. Though CMHPs endorsed a wide array of contributors, the most endorsed contributors across all CMHPs regardless of burnout status included *personal issues* (e.g., childcare, relationship issues, or attending to the health and well-being of their family), *large caseload*, *challenging clients* (e.g., high acuity, multiple presenting problems, high case management needs), *role overload*, and their *own well-being* (e.g., provider's own anxiety, depression, lack of sleep/exercise). However, despite being some of the most endorsed contributors by all CMHPs, *personal issues* and *challenging clients* were endorsed by BO and NBO CMHPs at similar rates, suggesting that endorsement of *personal issues* and *challenging clients* is not necessarily an indicator of burnout. In contrast, *large caseload*, *role overload*, *schedule*, *negative work environment* and *own well-being* were endorsed by BO CMHPs at higher rates compared to NBO CMHPs, suggesting that these factors could be key targets for intervention to reduce burnout.

By identifying the top contributors to burnout as reported by CMHPs, we can better focus intervention efforts in these areas to address burnout, which may be particularly useful in low-resource settings such as community mental health. For example, though CMHPs' wellbeing may be difficult to tackle directly, CMHPs' clinical supervisors at the organization could check in on their CMHPs well-being and encourage CMHPs to practice self-care or seek out their own mental health services if warranted. Though policies have attempted to increase productivity requirements of agencies to serve more youth and to justify compensation, the resulting impact may be counterproductive, as CMHPs are spread too thin as they try to meet requirements. Systemic changes are needed to build capacity in the mental health workforce, particularly by

incentivizing people to enter the field. However, this is currently difficult due to the high cost-benefit barrier of being a CMHP. Master's-level programs are expensive, and compensation can be relatively low for those working in community mental health centers. Expanding the workforce would improve access to care, ensuring that no single provider is overwhelmed with too many clients. Community mental health centers also face a heavy administrative burden, often having to manage multiple levels of requirements (insurance, city, county, state, and federal). Streamlining communication between these levels and creating streamlined workflows, such as standardized progress note templates within agencies, could help reduce administrative strain.

Quantitative results demonstrated that a substantial portion (32.3%) of CMHPs in the current sample met criteria for burnout. Additionally, results suggest that CMHPs who have medium clinical experience (i.e., 1-3 years) were much more likely (2.77 times) to endorse burnout compared to the average CMHP within an organization, across experience levels. This period in a CMHP's career may be a particularly challenging time where they are experienced enough to take on a full caseload, but may not have yet developed the professional coping strategies that their more seasoned colleagues have. Clinical supervisors may want to focus on especially supporting medium-experience CMHPs to help them navigate the increased demands that accompany transitioning into this stage in their career.

Results from this study also suggest that BIPOC CMHPs are *less* likely to endorse burnout compared to the average CMHP within their organization, across BIPOC and other racial identity groups. This finding could be interpreted in various ways. First, it could be a spurious finding. Research in this particular topic is still in its early stages, though one study among workers in a related profession found that BIPOC social workers had lower levels of

burnout compared to White social workers (Acker & Lawrence, 2009). However, another study concluded that Black therapists may be especially susceptible to burnout (Acker, 2010). Whereas another study found no differences in burnout between Black and White mental health professionals (Borden, 2024). Future research should explore whether these disparate findings are a result of actual burnout *experience* or differences in *response styles* between BIPOC and non-BIPOC CMHPs.

This study did not demonstrate a significant impact of organization rurality or unionization on CMHP burnout. Due to the distribution of sites and organizations, we were constrained to model organizations as the Level 2 factor rather than sites in the multi-level models to achieve model convergence. This approach categorized seven organizations as “Not Rural,” even though they included a mix of urban and rural sites, potentially obscuring differences based on rurality. Similarly, we found no evidence that unionization affected CMHP burnout. This may suggest that while labor unions aim to improve workplace conditions, they remain constrained by broader systemic under-resourcing in the youth mental health sector. However, more research is needed to determine whether these findings replicate. Additionally, pre-post studies examining CMHP burnout before and after unionization can provide further clarity on the direct role of unionization in mitigating burnout.

Another limitation of the study was the use of a single-item measure, which is not as reliable as a full-scale measure and could have reduced statistical power. However, this decision was made given financial restraints and to be mindful of CMHPs’ potential burden if we used time-consuming measures given their existing time demands. Additionally, we made the decision to group all BIPOC CMHPs in the statistical model in order to conserve statistical power and for model convergence. However, providers of different racial and ethnic backgrounds within

BIPOC communities likely have different experiences that may relate to burnout, but their experiences could not be uncovered in the present study.

Conclusions

This study used qualitative and quantitative methods to examine factors contributing to CMHP burnout. Large caseloads, role overload (i.e., excessive responsibilities without sufficient time and resources), and poor provider well-being emerged as the most salient contributors. Additionally, CMHPs with 1–3 years of clinical experience were identified as particularly at risk for burnout. Centering CMHPs' own perspectives on the most pressing contributors to burnout highlights key areas for targeted intervention. Systemic changes will likely be necessary to make lasting improvements, including expanding the public mental health workforce to limit caseload sizes. To ensure effective and sustainable solutions, it is critical that researchers and policymakers alike engage CMHPs directly in decision-making processes, whether for designing interventions targeting CMHP burnout or devising legislation relevant to youth mental health services.

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Table 1
Participant and Organization Characteristics

Variable	<i>M (SD)</i>	<i>n (%)</i>
<u>Providers</u>		
Age	33.63 (9.16)	
Years of Clinical Experience	2.52 (3.20)	
Years at Current Organization	1.53 (2.15)	
<u>Race/Ethnicity</u>		
Native American/Indigenous/Alaska Native	-	1 (1%)
Asian	-	15 (8%)
Black or African-American	-	7 (4%)
White (only)	-	117 (59%)
White and Latinx/e/a/o, Hispanic, or Spanish	-	4 (2%)
Middle Eastern or North African	-	1 (0.5%)
Native Hawaiian or other Pacific Islander	-	2 (1.0%)
Latinx/e/a/o, Hispanic, or Spanish	-	32 (16%)
Mixed race, Multiracial, or Biracial	-	11 (6%)
Self-Describe ("Unknown: Closed Adoption")	-	1 (0.5%)
Prefer not to say	-	4 (2%)
<u>Gender</u>		
Woman	-	147 (75%)
Cisgender only	-	22 (11%)
Man	-	10 (5%)
Gender-diverse (e.g., genderqueer, two-spirit, nonbinary, etc.,)	-	14 (7%)
Prefer not to say	-	4 (2%)
<u>Degree</u>		
Bachelor's (BA/BS)	-	8 (4%)
Master's in Social Work (MSW)	-	90 (46%)
Other Master's Degree (e.g., MA/MS)	-	95 (48%)
Doctoral Degree (PhD, PsyD)	-	3 (1.5%)
Other ("PhD Candidate")	-	1 (0.5%)
<u>Organization</u>		
Unionization	-	8 (22%)
Rurality	-	8 (22%)

Note. *N* = 197 community mental health providers (CMHPs) from 36 organizations. Women and men CMHPs may be cisgender or transgender. Due to the multiselect format of the demographic questions on gender, some participants selected "cisgender," which appeared higher on the list, without also selecting a binary gender option (e.g., "woman" or "man"), which appeared lower on the list.

Table 2
Burnout Contributors Endorsed by Providers

Code	Frequency	n (%)			Kappa
		Overall	NBO	BO	
Provider-level					
Own well-being	66	43 (22%)	23 (17%)	19 (32%)	.82
Personal issues	112	65 (33%)	41 (30%)	20 (33%)	.90
Secondary trauma	17	14 (7%)	7 (5%)	6 (10%)	.84
Self-doubt	17	15 (8%)	11 (8%)	3 (5%)	.78
Client-Level					
Challenging clients	51	44 (22%)	28 (20%)	15 (25%)	.91
Disengaged clients	12	11 (6%)	8 (6%)	2 (3%)	.97
Large caseload	53	51 (26%)	27 (20%)	24 (40%)	.91
Parents	11	10 (5%)	4 (3%)	6 (10%)	1.00
Slow progress	4	4 (2%)	4 (3%)	0 (0%)	.75
Interpersonal					
Issues with administration	27	19 (10%)	7 (5%)	12 (20%)	.64
Negative work environment	47	43 (22%)	21 (15%)	20 (33%)	.80
Supervisor issues	22	18 (9%)	9 (7%)	9 (15%)	.93
Job Demands					
Administrative work	47	38 (19%)	19 (14%)	18 (30%)	.93
Developing competency	16	15 (8%)	9 (7%)	6 (10%)	.82
Professional autonomy	16	12 (6%)	5 (4%)	7 (11%)	.74
Role ambiguity	11	10 (5%)	4 (3%)	6 (10)%	.71
Role overload	55	43 (22%)	18 (13%)	21 (35%)	.78
Schedule	47	41 (21%)	22 (16%)	18 (30%)	.82
Travel	6	6 (3%)	5 (4%)	1 (2%)	.83
Organization-level					
Compensation	34	30 (15%)	11 (8%)	17 (28%)	.92
Lack of resources	7	6 (3%)	3 (2%)	3 (5%)	.82
Staff shortage	7	7 (4%)	4 (3%)	3 (5%)	.92
Staff turnover	7	7 (4%)	1 (1%)	5 (8%)	.91
Trainings	15	13 (7%)	6 (4%)	6 (10%)	.96
External					
Seasonal changes	7	5 (3%)	4 (3%)	1 (2%)	.92
State of the world	13	11 (6%)	3 (2%)	7 (12%)	.87

Note. Total $N = 197$. No burnout providers (NBO) ($n = 137$). Burned out providers (BO) ($n = 60$).

Table 3
Zero-Order Disaggregated Correlations of Model Variables

Variable	<i>n</i> (%)	<i>ICC</i>	1.	2.	3.	4.	5.
<i>Outcome</i>							
1. Burnout	60 (32%)	0.04	--				
<i>Predictors</i>							
2. Experience-level – Medium ^{ec}	141 (76%)	0.14	.17	--			
3. Experience-level – High ^{ec}	31 (17%)	0.02	.07	.11	--		
4. BIPOC ^{ec}	74 (40%)	0.00	-.16	.11	-.01	--	
5. Rurality ^e	8 (24%)	--	.03	.00	.00	-.02	--
6. Unionization ^e	8 (24%)	--	-.02	.00	.00	.01	-.08

Note. 11 providers were excluded from the model due to missing data. *N* = 186 providers (L1) within 34 organizations (L2). ^e = effect coded. ^c = cluster mean-centered. BIPOC = Black, Indigenous, People of Color. Pearson's *r* reported. Observed values in boldface indicate

Table 4*Multilevel Random-Intercept Logistic Regression Model Results*

<i>Fixed Effects</i>	Model 1: Random Intercept Only							Model 1: Main Effects						
	<i>Coeff</i>	<i>(SE)</i>	<i>z</i>	<i>p</i>	<i>OR</i>	95% CI for OR		<i>Coeff</i>	<i>(SE)</i>	<i>z</i>	<i>p</i>	<i>OR</i>	95% CI for OR	
						Lower	Upper						Lower	Upper
Intercept (Mean)	-0.82	0.18	-4.48	<.001	0.44	0.31	0.63	-0.99	0.30	-3.28	.001	0.37	0.21	0.67
Experience-level – Medium ^{ec}								1.02	0.42	2.45	.014	2.77	1.23	6.24
Experience-level – High ^{ec}								0.42	0.46	0.91	.365	1.52	0.61	3.79
BIPOC ^{ec}								-0.52	0.21	-2.51	.012	0.60	0.40	0.89
Rurality ^c								-0.02	0.27	-0.09	.930	0.98	0.58	1.64
Unionization ^c								-0.12	0.24	-0.49	.623	0.89	0.56	1.42
<i>Random Effects</i>	<i>Var</i>							<i>Var</i>						
Intercept (L2)	0.14							0.23						
<i>Model Fit</i>	<i>Value</i>							<i>Value</i>	<i>p</i>					
Pseudo Total R^2	0.126							0.430						
AIC	230.6							226.5						
BIC	237.0							249.1						
Deviance (-2LL)	-113.3							-106.3						
Residual <i>df</i>	184							179						
LRT Chi-square test	--							14.1	.015					

Note. $N = 186$ providers (L1) within 34 organizations (L2). All values in log-odds units (logits). BIPOC = Black, Indigenous, People of Color. OR = Odds Ratio. CI = Confidence Interval. LRT = Likelihood Ratio Test. ^c = effect coded. ^{ec} = cluster mean-centered. All lower-level predictors were cluster-mean centered. All categorical predictors were effect-coded. Models estimated with maximum likelihood using binomial link in R lme4. Observed p -values reported; values in boldface indicate significance at the .05 level.