Working Overtime in Community Mental Health: Associations with Clinician Burnout and Perceived Quality of Care

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Abstract

Objective—Funding cuts have increased job demands and threatened clinicians' ability to provide high-quality, person-centered care. One response to increased job demands is for clinicians to work more than their official scheduled work hours (i.e., overtime). We sought to examine the frequency of working overtime and its relationships with job characteristics, work-related outcomes, and quality of care in community health clinicians.

Methods—One hundred and eighty-two clinicians completed demographic and job characteristics questions and measures of burnout, job satisfaction, turnover intention, work-life conflict, and perceived quality of care. Clinicians also reported the importance of reducing stress and their confidence in reducing their stress. Clinicians who reported working overtime were compared to clinicians that did not on demographic and job characteristics and work-related outcomes.

Results—Ninety-four clinicians (52%) reported working overtime in a typical week. Controlling for exempt status and group differences in time spent supervising others, those working overtime reported significantly increased burnout and work-life conflict and significantly lower job satisfaction and quality of care than those not working overtime. Clinicians working overtime also reported significantly greater importance in reducing stress but less confidence in their ability to reduce stress than those not working overtime. There were no significant group differences for turnover intention.

Conclusions and Implications for Practice—Working overtime is associated with negative consequences for clinician-related work outcomes and perceived quality of care. Policies and interventions aimed at reducing overtime and work-related stress and burnout may be warranted in order to improve quality of care.

Keywords

overtime; burnout; quality of care; community mental health

Introduction

Improving access to high-quality, person-centered care has become a national priority. Indeed, the Patient Protection and Affordable Care Act (2010) established a National Strategy for Quality Improvement in Health Care, first published in 2011, that aims to make health care "more patient-centered, accessible, and safe" (U.S. Department of Health and Human Services, 2011, p. 6). At the same time, recent state funding cuts (Johnson, Oliff, & Williams, 2011; National Alliance on Mental Illness (NAMI), 2015) have jeopardized clinicians' ability to meet the objectives of high-quality person-centered care. This mismatch of demands outpacing resources puts clinicians at risk for burnout (Bakker & Demerouti, 2007; Green, Albanese, Shapiro, & Aarons, 2014), which in turn may negatively impact quality of care. Understanding the relationship between work demands, burnout, and quality of care has important implications for both policy and practice.

Despite calls for increases in mental health services (Corrigan & Watson, 2003; Honberg, Diehl, Kimball, et al. 2011; Johnson, Oliff, Williams, 2011), many U.S. states have experienced budget cuts or stagnant financial support for mental health services. Between 2009 to 2012, state budget cuts to mental health amounted to a staggering $4.35 billion dollars (NAMI, 2014), resulting in devastating declines to community and hospital-based mental health services. California alone suffered a $587.4 million loss, while Kentucky cut $193.7 million or 47% of its overall mental health budget between 2009 and 2011 (Honberg, Diehl, Kimball, et al. 2011). Budget cuts have not only impacted the availability and quality of services for clients but also affect clinicians themselves. Many community mental health service organizations have been forced to cut staff, reduce budgeted staff hours, and decrease administrative support (Honberg, Diehl, Kimball, et al. 2011), leaving the remaining clinicians to do more with less. As a result, clinicians are left with increased caseloads and other administrative demands. Further, state budget cuts have also forced many agencies to focus more on reimbursable and profitable services (Green, Miller, Aarons, 2013; Morse et al., 2012), leading to increased demands for productivity and efficiency for already taxed clinicians.

One likely response to these increased demands is for clinicians to work more hours, and some evidence suggests that health care professionals are working longer hours to overcome staff shortages (Cleary, Horsfall, Muthulakshmi, Happell, & Hunt, 2013; Rogers, Hwang, Scott, Aiken, & Dinges, 2004). Among nurses, working overtime (i.e., more than the contracted hours for the position) is associated with reduced job satisfaction, increased turnover intentions, reduced quality of care, and reduced patient safety and satisfaction (Griffiths et al., 2014; Stimpfel & Aiken, 2013; Stimpfel, Sloane, & Aiken, 2012). Although little empirical research has addressed the impact of working overtime on community mental health clinicians, there is ample evidence demonstrating that a lack of resources coupled with workload pressures are a consistent concern among community mental health clinicians

(Paris & Hoge, 2010). Further, for health care providers, working overtime has been described as a trigger for burnout (Yoder, 2010), which is a response to chronic work-related stress (Leiter & Maslach, 1988; Maslach, Schaufeli, & Leiter, 2001) characterized by emotional exhaustion, depersonalization (e.g., detached or cynical attitudes), and a reduced sense of personal accomplishment. According to the Job Demands-Resources model of burnout (Bakker & Demerouti, 2007; Boyd et al., 2011), burnout can develop from a combination of high job demands (e.g., interacting with patients with intensive service needs, balancing competing priorities) that require sustained effort over time and lack of job resources (e.g., role clarity, job control, development opportunities). Specifically, job demands are posited to result in psychological and physiological costs to the staff person (e.g., emotional exhaustion), while lack of job resources contributes to difficulty meeting job demands, which leads clinicians to disengage or withdrawal from work. As clinicians become exhausted and disengaged, they likely conserve resources and pull back, leading to depersonalization and ultimately reduced quality care.

Empirical studies have demonstrated that clinician burnout is problematic in mental health care. A recent review suggested that 21–67% of mental health providers report high levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Further, burnout has been consistently linked with a myriad of problems for both clinicians and mental health organizations. For example, increased burnout has been linked with greater staff absenteeism (Borritz et al., 2006) and intentions to quit (Salyers et al., 2015) and reduced job engagement, employee morale, and job satisfaction (Maslach et al., 2001; Paris & Hoge, 2010). A few studies have also found that higher levels of burnout are associated with lower self-reported quality of care (Salyers et al., 2015; Shanafelt, Bradley, Wipf, & Back, 2002; Van Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013), with one study finding that burnout mediated the relationship between number of work hours and poor self-reported quality of care in physicians (Shirom, Nirel, & Vinokur, 2006). Similarly, working long hours has been associated with increased emotional exhaustion in psychologists working in independent practice (Rupert & Morgan, 2005), and working overtime hours has been found to be a contributing factor to burnout in community mental health nurses in Japan (Imai, Nakao, Tsuchiya, Kuroda, & Katoh, 2004). More recently, Kok, Herrell, Grossman, West, and Wilk (2016) found that working 45 hours per week or more was associated with greater burnout among military mental health providers.

Given the dearth of studies examining the impact of working overtime on community mental health clinicians and quality of care, our primary aims were to examine the frequency of working overtime and its relationships with job characteristics, job-related outcomes, and perceived quality of care in community health clinicians. Recognizing that working overtime has different ramifications depending on the type of position and payment for overtime work, we also examined the role of whether clinicians were exempt or non-exempt from overtime pay. Controlling for exempt status and any group differences on job characteristics, we hypothesized that clinicians who reported working more than their official hours would experience increased burnout and intentions to leave the job, as well as reduced job satisfaction, work-life balance, and quality of care. We also explored whether clinicians who reported working overtime would differ from those who did not report working overtime in

perceived importance of and confidence in managing work-related stress and life-work balance.

Methods

Participants and setting

Data for this study were obtained from baseline assessments (prior to any intervention) of participants in a comparative effectiveness trial aimed at reducing clinician burnout and examining its impact on patient-centered care. The parent study was a randomized, controlled trial comparing BREATHE—a burnout-reduction focused intervention (Rollins et al., 2016; Salyers et al., 2011)—to Motivational Interviewing (Miller & Rollnick, 2002), both offered in a series of 3 workshops. The study took place at two community mental health centers (CMHC), one in rural Indiana, and one in an urban setting in Missouri. The rural CMHC employs approximately 230 staff serving 6000 clients annually, whereas the urban site employs 262 staff and serves 4000 clients annually. Both agencies provide community-based programming, including case management, assertive community treatment, supported employment, home-based and school services, outpatient individual and group services, medication management, and residential programs. For the parent study, we recruited staff who were at least 18 years old, providing direct clinical care (to adults or children), willing to be randomly assigned to receive one of the two interventions, and willing to complete online assessments at baseline and then 3 months, 6 months, and 12 months after their initial assessment. Recruitment took place in three waves from January 2014 to January 2015. We distributed electronic and paper brochures describing the study to all staff at both agencies, and research assistants attended staff meetings to distribute recruitment materials and answer questions about the study. Clinicians were allowed administrative absence (i.e., paid time, not vacation) to attend the workshops and received continuing education credits. Clinicians also received a $10 gift card for each assessment. Study procedures were approved by the local Institutional Review Board.

Two hundred and six clinicians consented to participate in the study, with each site consenting over 100 clinicians. One hundred and ninety two clinicians (93%) completed the study measures, but 10 participants were excluded from the current analyses because they were not currently seeing clients ($n = 3$) or worked less than fulltime (< 30 hours a week; Patient Protection and Affordable Care Act, 2010) ($n = 7$). The remaining 182 clinicians were grouped based on whether they reported working more than their official scheduled work hours ("overtime") or less than/equal to their official scheduled work hours in a typical week. Clinicians' job classification (i.e., exempt from overtime pay, nonexempt from overtime pay requirements) was obtained from each site's Human Resources Department. Additional background and job characteristics are listed in Table 1.

Measures

Participants completed an online survey hosted on SurveyMonkey. Demographic information included age, gender, race, education level, field of education, marital status, tenure at the agency, and tenure in the mental health field. We also assessed self-reported job demands, including official work hours and actual hours worked in a typical week, the

number of clients participants interacted with in a typical week, and the percent of time spent on specific task domains (e.g., direct care, supervision). Working overtime (yes or no) was identified based on participants' reported official work hours and actual hours worked in a typical week.

Burnout was measured by the Human Service Provider version of the widely used Maslach Burnout Inventory (MBI-HSS; Maslach, Jackson, & Leiter, 1996). Participants were asked to report how often they felt each of the 22 items on a 7-point scale (0 = *never* to 6 = *every day*). The MBI-HSS contains three subscales: emotional exhaustion, depersonalization, and personal accomplishment. These subscales have previously demonstrated good convergent validity and internal consistency (Maslach et al., 1996). In the current sample, the subscales had acceptable internal consistency (emotional exhaustion $\alpha = .92$; depersonalization $\alpha = .72$; personal accomplishment $\alpha = .72$).

Job satisfaction was assessed with a single self-reported item: "Overall, I am satisfied with my job." Participants were asked to rate this item on a 1 (*strongly disagree*) to 7 (*strongly agree*) scale. Single-item measures have been found to be an efficient, yet valid approach to assessing overall job satisfaction (Nagy, 2002; Wanous, Reichers, & Hudy, 1997).

Turnover intention was assessed by a single self-reported item: "How often have you seriously considered leaving your job in the past six months?" The item is rated on a 6-point scale from 1 (*never*) to 6 (*several times a week*) and has been used in several studies with community mental health clinicians where it has been found to correlate with burnout and job satisfaction (Salyers et al., 2015; Salyers et al., 2011; Salyers, Rollins, Kelly, Lysaker, & Williams, 2013).

Work-life balance was measured using six items adapted from the 18-item Work-Family Conflict measure (Carlson, Kacmar, & Williams, 2000). Three of these items specifically assess conflict resulting from work interfering with life outside of work (work conflicts with life). An example item is: "Due to all the pressures at work, when I come home, I am too stressed to do the things I enjoy." The other three items assess the degree that life interferes with work (life conflicts with work) for example, "The time I spend on family/home responsibilities interferes with my work responsibilities." Participants are asked to rate each item on a 5-point scale (1 = *strongly disagree* to 5 = *strongly agree*). The two subscales demonstrated acceptable internal consistency in the current sample: for work conflicts with life ($\alpha = .76$) and for life conflicts with work ($\alpha = .71$).

Importance and confidence in managing stress were assessed by two questions that were created for this study to assess the importance of stress reduction for participants and their confidence in stress management skills: "How important is it for you to reduce your work-related stress right now?" and " How confident are you that you can reduce work-related stress in your life?". Following the importance/confidence rulers used in motivational interviewing (Miller & Rollnick, 2002), the rating scale ranged from 1 (*not at all*) to 10 (e*xtremely*).

Perceived quality of care was evaluated by a modified version of the self-report Quality of Care scale (Salyers et al., 2015), which was created to specifically assess mental healthcare

quality from the clinicians' perspective. The original version contained 25 items, and 20 out of the 25 items were used in the current study after making small modifications to improve clarity and readability. An additional 11 items developed through focus groups with clinicians and clients asking about the potential impact of burnout on quality of care (Author, 2016) were also added. For each of the 31 items, participants are asked to report how frequently each item had occurred in the past six months on a 6-point scale ranging from 0 (*never*) to 5 (*always*). The original 25-item version demonstrated good internal consistency and convergent validity with measures assessing provider's expectations of consumer recovery (Salyers et al., 2015). For the 31-item version, after removing nine poor functioning items, the internal consistency for the remaining 22-items was good in the current sample (α = .84); the 22-item version was used in analyses.

Analyses

First, we examined the frequency of working overtime and compared those who reported working overtime to those that did not on site location and demographic and job characteristics using chi-square tests for categorical variables and *t*-tests for continuous variables. Second, job-related outcomes and quality of care were compared between groups using one-way analysis of covariance tests (ANCOVAs), controlling for exempt status and any group differences found in step one. We followed Cohen (1988) in categorizing effect sizes (*d*) of 0.2 as small, 0.5 as medium, and 0.8 as large.

Results

Background and Job Characteristics

Ninety-four clinicians (52%) reported working over their official hours, ranging from 1 hour to 20 overtime hours in a week (mode = 5 overtime hours). The remaining eighty-eight clinicians (48%) reported working their official hours or less in a typical week. Specifically, there were 83 clinicians who reported working exactly their official hours and five people who reported working less than their official hours, which ranged from a reported 25 hours to 2 hours less than their official hours in a week (mode = 2 hours less than official hours).

Background information, site location, and job characteristics for the overall sample and each group are shown in Table 1. The majority of participants were White, female, married or living as married, and had a mean age of approximately 40. Most had a bachelor's degree or less, with the most degrees being in psychology or social work, saw an average of 24 primarily adult clients a week, and spent an average of 25 hours a week interacting with clients. Participants had worked at their agency an average of 5 years and in the mental health field for an average of 8.8 years. Those who reported working overtime did not differ on background characteristics or site location from those who did not report working overtime, but the two groups did differ on two job characteristics. First, those who reported working overtime were more likely to be in jobs classified as exempt from overtime than those who reported working their official hours or less ($p < .001$). Second, those who reported working overtime also reported spending a greater percentage of their time supervising others ($p = .03$) than those who reported working their official hours or less. We

included both of these variables as covariates in comparisons of those who reported working overtime to those that did not on work-related outcomes and quality of care.

Work-Related Outcomes and Perceived Quality of Care

Consistent with hypotheses, after controlling for exempt status and reported percent of time spent supervising others, participants who reported working overtime experienced significantly more burnout on all three indices: greater emotional exhaustion ($p = .002$) and depersonalization ($p = .001$) and significantly lower personal accomplishment ($p = .05$) (See Table 2). Those who reported working overtime also perceived greater work conflicts with life ($p = .03$) and lower job satisfaction ($p = .048$) and quality of care ($p = .01$) than participants who reported working their official hours or less. In exploratory analyses, the overtime group also reported significantly greater importance in reducing their work-related stress ($p = .03$), yet less confidence in being able to do so ($p = .002$). All group differences were small to medium effects. Contrary to hypotheses, there were no significant differences between groups on turnover intention ($p = .14$). There were also no group differences on life conflicts with work ($p = .66$).

Discussion

Given recent concerns regarding funding cuts, coupled with increased job demands and focus on quality of care for community mental health clinicians, this study is timely in addressing potential consequences of working overtime. Among 182 clinicians, approximately half of the sample reported working more than their scheduled hours. Those who reported working overtime were more likely to be exempt from overtime pay and reported spending a greater portion of their time supervising other employees than those who did not report working overtime. After controlling for these factors, as hypothesized, reported working overtime was associated with greater burnout and work conflicts with life, as well as lower job satisfaction and quality of care. Further, those who reported working overtime felt that reducing work-related stress was important but were less confident in their ability to reduce stress. While these findings are consistent with previous studies that have identified that working overtime is linked to increased burnout and reduced job satisfaction for health care providers (Kok et al., 2016; Stimpfel et al., 2012), our study extends prior work by specifically examining clinicians in community mental health settings and demonstrating links to perceived quality of care.

We found potential detriments of working overtime for clinician work-related outcomes and their self-reported quality of care. This is especially important given that 52% of the sample reported working overtime in an average week. In our sample, 5 hours overtime was the modal response. These findings are in line with Kok et al. (2016) who found that military mental health service providers who worked at least 45 hours a week were at increased risk for elevated levels of burnout. Thus, it appears that working even a few extra hours in a typical week may be a risk factor for burnout as well as for negative consequences to perceptions of work-life balance, job satisfaction, and quality of care. We note, however, that the direction of these relationships remains unclear. It may be that those who are the most burned out find the need to work extra time (e.g. out of a reduced sense of personal

accomplishment). Conversely, there may be alternative variables responsible; for example, those who report working overtime may be more conscientious and engaged at work, which could lead to reduced work-life balance and in turn burnout and reduced job satisfaction. Similarly, given that those who were classified as exempt and who had supervisory responsibilities were more likely to report working overtime than not, it may be that burnout may be caused by the added responsibilities they undertake, and overtime itself may be another consequence of those responsibilities rather than a root cause. These are intriguing possibilities for future research studies to examine by modeling relationships over time and extending the examination by including other key constructs.

Regardless of the direction of the relationships, our findings highlight that working overtime is a potential risk factor (or at least a signal) for a number of other negative consequences. One implication may be to consider policies to monitor and restrict the number of hours clinicians work over their official hours in a typical week. Although these practices may be happening informally within organizations, there are no professional or state standards we are aware of that regulate working overtime for mental health providers. There are current mandatory restrictions for resident physicians set forth by the Accreditation Council for Graduate Medical Education (Nasca, Day, & Amis, 2010), and several states are implementing work hour regulations for nurses (Page, 2004). Our findings suggest that it may be beneficial to implement similar policies for mental health clinicians. At the organizational level, it may be helpful for human resource departments or supervisors to monitor clinicians' hours to identify those who are working overtime. Identification could lead to corrective measures to help reduce work demands and/or to help employees develop strategies to work more efficiently. For example, although clinical documentation is essential, clinicians have expressed strong desires to spend more time in direct client care as opposed to completing "paperwork" (Salyers, Rollins, Kelly, Lysaker, & Williams, 2013). Anecdotally, clinicians mentioned note-writing as a frequent activity they completed after hours. Implementing polices that aim to streamline regulatory requirements that are outdated or duplicative would certainly be a worthwhile starting point. Concurrent documentation practices (or co-writing treatment records with clients) have been proposed as a way to both increase client involvement and to improve efficiency (Stanhope, Ingoglia, Schmelter, & Marcus, 2013). Similarly, although controversial, some companies, and even countries, have instituted policies to restrict email after regular work hours (Schofield, 2016), which if implemented, could help to reduce overtime work and encourage a greater work-life balance for community mental health clinicians.

We may also need to more closely examine the corporatization of health care and professional services and the underlying emphasis on "efficiency" and "productivity" (Ivey, 2012), as measured by activity. Reimbursement strategies that are being discussed within health care reform, such as paying for quality of services or for outcomes, could help focus attention away from working "more" to working "better" and could perhaps help counter the current emphasis on productivity that is measured by activity completion. Similarly, reimbursement strategies for clinical supervision are also at odds with other regulations and with calls for person-centered, higher quality care. Presently, many payer sources require some level of clinical supervision but do not reimburse organizations for clinical supervision. This may force those who supervise others to work additional hours to meet

their productivity requirements. We found that clinicians who reported working overtime also reported a greater amount of time supervising others, possibly reflecting this inconsistency.

Our findings are particularly relevant to organizations that may be affected by the recent federal Final Rule to update the regulations for those who are entitled to overtime pay (U.S. Department of Labor, 2016). In the U.S., workers have been classified as exempt (and are not entitled to overtime pay) if they make over $23,660 per year. However, starting December 1, 2016, the new national regulations substantially increase the cut-point base salary to $47,476 for determining if someone is eligible for exempt status. Once this policy is enacted, the shift in exempt status eligibility could lead organizations to either pay higher base salaries to keep current clinicians exempt or shift employees to a non-exempt status, requiring a combination of additional pay for overtime or rules and stopgaps in place to prevent overtime employment. Although we do not have salary levels for our participants, given that 23% of our sample are currently classified as exempt, these federal policy changes may have wide-reaching financial implications for community mental health.

Our findings also have implications for intervention strategies that may reduce clinician work stress and burnout. Specifically, those who reported working overtime also reported greater importance in reducing their work-related stress, but less confidence in being able to do so. This suggests that interventions aimed at enhancing self-efficacy in managing work-related stress could be important to reducing burnout (c.f., Salyers et al., 2011), particularly for clinicians who are working overtime. However, given the high job demands of community mental health clinicians, it is likely that interventions that also target organizational variables, such as work overload and lack of resources for workers (c.f., Ewers, Bradshaw, McGovern, & Ewers, 2002), may also be beneficial to prevent or reduce burnout and ultimately improve quality of care.

There are several limitations that should be considered when interpreting the results from this study. First, the number of official and overtime hours, as well as proportion of time in supervision, was self-reported by the clinicians. Although previous work has found that staff members' self-report of work hours was very close to their workplace records (Fox, Dwyer, & Ganster, 1993), we do not have objective reports in this study. Second, the cross-sectional nature of this data limits our ability to speak to the direction of relationships. As noted above, future work could examine causal models over time. Similarly, future longitudinal work is needed to identify the point at which working overtime is most likely to lead to increased burnout and reduced quality of care. Also, while a strength of this study is that we assessed clinicians' perceived quality of care, future studies could build on these findings by assessing additional indices of quality of care, for example, through reports from clients or supervisors. An additional limitation, which could be addressed in future work, is that we did not assess whether clinicians were working multiple jobs, which has been linked to increased stress in non-mental health workers (Zeitinoglu, Zeytinoglu, Lillevik, Seaton, & Moruz, 2004) but to our knowledge has yet to be explored in community mental health clinicians. Future work may also benefit from exploring the impact of peer-support providers and mental health care technology aids (i.e., decision support centers, mobile behavioral sensing (Ben-Zeev, Scherer, Wang, Xie, & Campbell, 2015; Deegan, Rapp, Holter, & Riefer,

2008)), which may help to reduce clinician job demands, clinician overtime, and burnout, as well as improve quality of care.

Overall, findings from this study demonstrate the need for policies and interventions aimed at reducing overtime and work-related stress and burnout. Further, this study points to overtime work as a potential risk factor for negative job-related outcomes (increased burnout and work conflicts with life and reduced job satisfaction) as well as for poorer quality of care. The ever-increasing concerns of funding restrictions combined with increased administrative demands for community mental health clinicians (Johnson et al., 2011; Paris & Hoge, 2010) also raise the potential for longer workdays. Our findings suggest that in order for clinicians to continue to provide quality person-centered care, creating regulations and supporting organizational efforts that resolve working overtime may be critical steps.

Acknowledgments

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Table 1

Overall and group background, site, and job characteristics

	No Overtime (*n* = 88)	Overtime (*n* = 94)	Test of Significance	Total Sample (*n* = 182)
	M (SD)	M (SD)		
Age	38.5 (11.7)	41.2 (12.5)	$t(180) = -1.50$	39.9 (12.2)
Gender (*n*, % Female)	72 (82%)	73 (78%)	$X^2(1) = .49$	145 (80%)
Race (*n*, % White)	70 (80%)[a]	85 (90%)	$X^2(2) = 3.66$	155 (86%)[a]
Education level (*n*, % with masters degree or above)	33 (38%)[a]	41 (44%)	$X^2(1) = .60$	74 (41%)[a]
Education field (*n*, % with degree in psychology or social work)	38 (43%)	47 (51%)[a]	$X^2(1) = .98$	85 (47%)[a]
Marital status (*n*, % married or living as married)	44 (51%)[a]	38 (41%)[a]	$X^2(3) = 5.04$	82 (46%)[b]
Tenure at agency	4.5 (5.8)	5.5 (6.6)	$t(180) = -1.00$	5 (6.2)
Agency location (*n*, % working in rural agency)	42 (48%)	49 (52%)	$X^2(1) = .35$	91 (50%)
Tenure in mental health	7.7 (8.0)	9.8 (9.5)[a]	$t(177) = -1.55$	8.8 (8.9)[a]
Exempt status (*n*, % exempt)	8 (9%)	33 (35%)	$X^2(1) = 17.63$ ***	41 (23%)
Clients interact with weekly	24.2 (27.5)[a]	24.4 (15.9)[a]	$t(178) = -.07$	24.3 (22.2)[b]
Weekly client contact hours	25.7 (8.4)	24.4 (9.6)	$t(180) = 1.02$	25 (9.1)
% of time spent in				
Direct care	61.7 (25.1)[a]	58.6 (27.2)	$t(179) = .79$	60.1 (26.2)[a]
with adults (18 years)	71.9 (40.8)[a]	77.4 (36.5)	$t(179) = -.95$	74.7 (38.6)[a]
Clerical work	17.9 (18.8)[a]	16.2 (12.9)	$t(179) = .70$	17 (16.0)[a]
Other administrative duties	10.4 (12.3)[a]	13.5 (17.1)	$t(169) = -1.40$	12 (15.0)[a]
Teaching	4.9 (11.9)[a]	4.1 (11.2)	$t(179) = .47$	4.5 (11.5)[a]
Supervision of other employees	2 (9.7)[a]	6.1 (15.0)	$t(160) = -2.21$ *	4.1 (12.9)[a]

[a] missing *n* = 1;

[b] missing *n* = 2.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 2

Group comparisons on work-related outcomes and quality of care[a]

	No Overtime (*n* = 88)	Overtime (*n* = 94)	*F*	*d*
	M (SD)	M (SD)		
Emotional exhaustion	19.1 (12.2)[b]	24.9 (12.1)	$(1,177) = 9.60$**	−.48
Depersonalization	4.9 (5.3)[b]	7.7 (5.3)	$(1,177) = 11.71$**	−.53
Personal accomplishment	39.5 (6.1)[b]	37.7 (6.1)	$(1,177) = 3.88$*	.30
Job satisfaction	5.7 (1.5)[c]	5.2 (1.5)[d]	$(1,163) = 3.98$*	.33
Turnover intention past 6 months	2.1 (1.6)[b]	2.5 (1.5)	$(1,177) = 2.22$	−.26
Work conflicts with life	7.8 (3.0)[b]	8.9 (3.0)	$(1,177) = 5.05$*	−.37
Life conflicts with work	5.6 (2.2)[b]	5.5 (2.2)	$(1,177) = .19$	.05
Importance of reducing stress	6.0 (2.9)[b]	6.9 (2.9)	$(1,177) = 4.89$*	−.31
Confidence in ability to reduce stress	7.1 (2.5)[b]	6.0 (2.5)	$(1,177) = 9.46$**	.44
Perceived quality of care	3.8 (.5)[e]	3.6 (.5)	$(1,175) = 6.12$*	.40

[a] adjusted means are reported, controlling for exempt status and % of time spent supervising other employees.

[b] missing *n* = 1;

[c] missing *n* = 7;

[d] missing *n* = 8;

[e] missing *n* = 3.

* *p* .05.

** *p* < .01.