



CITY OF PHILADELPHIA
Department of Behavioral Health and Intellectual disAbility Services
Promoting Recovery, Resilience & Self-Determination

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Title: Burnout and Bias: Protecting the Mental Health of Our Workforce

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Brief Type: Issue Brief

I. ISSUE OVERVIEW

Summary: Workforce burnout is at an all-time high, particularly in health, social service, and public sector settings. When compounded by bias, whether implicit, structural, or cultural burnout becomes not only a personal crisis but a systemic equity concern. Workers from historically marginalized communities often face "invisible labor," racial battle fatigue, and microaggressions that further erode psychological safety and job satisfaction. This brief outlines the urgent need to address workforce mental health through equity-informed strategies.

Background: The COVID-19 pandemic intensified burnout, but recovery efforts have largely ignored how identity, race, and bias shape the experience and outcome of burnout. Without protective mental health infrastructure, diverse workers face higher attrition, poorer outcomes, and limited advancement. Behavioral health organizations must now evolve their internal policies to center equity in employee wellness

Key Statistics & Data:

- 52% of healthcare workers report symptoms of burnout. Rates are higher among women, Black, and LGBTQ+ staff (KFF, 2023).
- 1 in 3 employees of color report experiencing racial microaggressions at work weekly (Catalyst, 2022).
- 40% of workers feel their workplace lacks adequate mental health support or accommodations (APA, 2024).
- High burnout correlates with decreased service quality, increased turnover, and greater liability exposure.

II. BIAS-AS-BURNOUT ACCELERATOR

Bias, especially when unaddressed, fuels burnout by:

- Forcing employees to engage in identity management or code-switching
- Undermining trust in supervisors and HR systems
- Overlooking the extra labor of "representation," mentorship, and equity work

Invisible Labor Examples:

- Being the only person of color expected to "speak for the community."
- Providing emotional support without formal recognition or compensation
- Constantly having to explain or defend lived experience.

III. POLICY AND PRACTICE RECOMMENDATIONS

Normalize Mental Health Support

- Provide no-cost, confidential counseling via Employee Assistance Programs (EAPs)
- Create “wellness hours” or flexible mental health leave.
- Train supervisors to identify and respond to mental health warning signs.

Conduct Equity-Centered Burnout Audits

- Track burnout and attrition rates by race, gender, and role
- Identify departments with high turnover or low engagement from BIPOC staff.
- Use surveys to assess experiences of bias, microaggressions, and organizational trust.

Institutionalize Cultural Humility

- Require ongoing training in bias, trauma-informed care, and equity.
- Incentivize diverse leadership pipelines and mentorship models to foster a more inclusive environment.
- Embed DEI competencies in job descriptions and performance evaluations.

Promote Peer and Community Healing Models

- Support affinity groups, healing circles, and peer support programs.
- Fund community-based mental health consultants and facilitators
- Integrate lived-experience voices into wellness programming.

IV. STAKEHOLDER ENGAGEMENT

Key Stakeholders:

- Employees across departments, particularly those in high-stress or underrepresented roles
- Human Resources and organizational leadership
- Union and labor representatives
- Peer support specialists and workforce wellness coordinators
- Mental health and DEI consultants

V. CONCLUSION

Protecting the workforce's mental health means more than offering wellness apps or burnout workshops. It requires acknowledging that bias is both a contributor to and an amplifier of burnout, and that healing must be both structural and personal. Mental health equity begins within our walls. To care for communities, we must first care for the caregivers.

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