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Improving support for mental health staff: a qualitative study*

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Abstract *Background*: High levels of both burnout and job satisfaction have been found in recent studies of mental health professionals. A qualitative methodology was used in a related study to explore reasons for these findings and to investigate staff's accounts of their strategies for coping with their work, and their views of support provided for them and how their jobs might be made less stressful and still more satisfying. *Method*: A semi-structured schedule was used to interview a purposive sample of 30 mental health staff drawn from three South London geographical sectors, selected to include junior and senior members of each profession in both hospital and community settings. Interviews were transcribed and analysed using QSR NUD.IST software. *Results*: Informal contacts with colleagues were the most frequently mentioned way of coping with the difficult and demanding aspects of work in both hospital and community settings, closely followed by time management techniques. The main formal sources of support described by staff were individual supervision and staff support groups. Accounts of the former were generally positive, but there was great variation in opinions about whether support groups are useful. Almost all the interviewees believed that their jobs could be improved by further training. For community mental health staff the main training gaps were the development of skills in various forms of clinical intervention, whilst ward staff identified the need for further skills in diffusing potentially confrontational and aggressive situations.

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Introduction

Results from several recent surveys of mental health professionals have suggested that their 'burnout' and poor mental well-being are at high levels compared with other occupational populations, although, perhaps paradoxically, job satisfaction also appears to be high (Carson et al. 1995a; Onyett et al. 1995; Prosser et al. 1996; Wykes et al. 1997). Particularly high levels of the 'emotional exhaustion' component of 'burnout' have been reported among staff based in the community rather than in hospital (Carson et al. 1995a; Prosser et al. 1996).

These findings are of considerable significance both because they suggest that the welfare of mental health professionals is adversely affected by their work, and because attempts to ensure delivery of high-quality mental health services and to develop more effective models of treatment are crucially dependent on the availability of skilled and highly motivated professionals. This need to integrate consideration of the well-being of the workforce into policy has been acknowledged by the Department of Health (1998) in the UK, where pressure to attend to the impact of services on their staff is particularly acute because of widespread staff shortages in the National Health Service. Thus there is a need to begin answering the questions that follow directly from reports of high burnout and poor well-being among mental health staff; namely, why the current tasks and working conditions of mental health staff appear to be affecting them adversely and how these adverse effects might be alleviated.

The qualitative study on which we report here is intended to address these questions. The companion paper

(Reid et al. 1999) describes staff's views about which aspects of their work they find rewarding and which difficult. This paper discusses staff's accounts of how they cope with the demands of their work and their opinions about support available to them and how this might be improved.

The potentially stressful nature of mental health work and the need to support and 'protect' staff have long been recognised (see Hawkins and Shohet 1989). However, the literature on how this can be done effectively is limited, and has focused mainly on the role of clinical supervision within professions such as psychology and social work (Hess 1980; Hill 1989) and, more recently, nursing (see Butterworth 1992; Everitt et al. 1996; Farrington 1997). Clinical supervision can take many forms depending on professional groupings, settings and specific theoretical orientations (see Dryden and Thorne 1991; Hawkins and Shohet 1993).

Whilst work describing and discussing a variety of forms of clinical supervision has been published, the literature as yet contains few evaluations of the effectiveness of supervision or of other interventions designed to support staff and alleviate stress and burnout. Exceptions include a description by Milne et al. (1996) of an intervention involving grouping all patients with similar problems on the same ward and providing nurses with training in behaviour therapy: this resulted in a reduction in staff absences on some of the wards. Carson and colleagues (Carson 1994; Carson et al. 1995b) investigated the effects of a form of structured group therapy which aims to formalise and intensify the positive effects of social support from colleagues. This appeared to have a beneficial effect over a 3-week period, although numbers were small. Ritter et al. (1995) review a number of studies regarding staff support groups as a means of trying to reduce stress among mental health nurses and argue that there is as yet little evidence about the general effectiveness of such groups or the elements that can make them helpful. A review of groups for mental health professionals within a large psychiatric hospital (Robertson and Davidson 1997) found that ambivalent reactions to such groups were very prevalent, with many staff feeling that they did not have a clear idea of their purpose. This was despite the fact that 73 staff groups were meeting regularly within the hospital surveyed.

Thus, the evidence about how mental health staff might be supported in their work and protected from its potential adverse effects remains limited. The aim of the present study was to begin to fill this gap by exploring staff's own views.

Subjects and methods

The method is described in greater detail in the companion paper (Reid et al. 1999). Briefly, a purposive sample of 30 members of staff, representing a range of disciplines, settings and levels of seniority, was drawn from three geographical mental health sectors in South London and interviewed using a semi-structured format. Interviews were taped and transcribed verbatim, and QSR NUD.IST software used in carrying out a content analysis of the data (Richards and Richards 1998). The initial sections of the interview, reported in the companion paper (Reid et al. 1999), investigated which areas of work staff found most rewarding and which most difficult or demanding. In the subsequent sections of their interview, discussed in this paper, we asked staff to describe their main sources of support at work and strategies for coping. We also made specific enquiries about experiences of supervision and of staff groups as means of support and whether these might be improved, and about the adequacy of training available and whether any changes in training might lead to work becoming less stressful and more rewarding.

Results

Principal sources of support and ways of coping among ward and community staff

Staff were asked to describe their main ways of coping with difficult or stressful situations at work (Table 1) and to identify their main sources of support at work (Table 2).

The most frequently mentioned coping strategy among both community and ward staff was talking to colleagues (see Table 1). In response to questioning about principal sources of support (Table 2), other team members were most commonly mentioned as an important source of support at work for staff both in hospital and in the community. Doctors and psychologists identified colleagues within their own discipline as a central source of support (Table 2).

> *Colleagues are pretty important in being able to sit down and say exactly how you are at the time when it's happening and it's nearly always possible to do that in the office. There's no one I work with who I wouldn't feel comfortable doing that with. That's*

Table 1 Current ways of coping with work demands

	No. of references (among 30 subjects)
Talking to colleagues	19
Time management techniques	11
Supervision	8
Stress reducing activities (exercise, walks, music)	7
Working overtime	6
Taking a break	5
Talking to partners/friends/family	4
Other	6

Table 2 Most important sources of support at work

	No. of references (among 30 subjects)
Other team members	21
Friends/family/partner	11
My supervisor	10
My consultant	5
My registrar/senior registrar	3
Colleagues of the same discipline	3

how I deal with it within work. (Community Psychiatric Nurse; CPN)

We all get on well together, so there's a lot of ongoing support, informal and official. (CPN)

Strategies for time and workload management were also frequently cited as important ways of coping with the demands of work. These strategies involved organising the caseload, prioritising and planning ahead, and doing work on the spot and not allowing it to pile up. Doctors and psychologists were the groups who most often mentioned these strategies, but two CPNs also referred to them.

I'm very organised, so I look at the organisation of what is going on, I try to ensure that I am prioritising correctly, making time for the work that I have to do and leaving aside the work I do not have to do. (psychologist)

It's best to work on your time management really. Its quite important, especially because you are quite autonomous in your job, your days are your own, nobody tells you what to do. You have to manage your time. (CPN)

Clinical supervision, involving one-to-one meetings with a more senior member of staff, was mentioned by almost one-third of the staff interviewed as a way of coping with the demands and pressures of the work, and one-third identified their supervisors as one of their most important sources of support. Supervision was most frequently mentioned as an important way of coping with difficult or stressful situations by CPNs. Among the ward staff, supervision was mentioned as a way of coping only by two of the ward managers. The other ward staff appeared more often to discuss difficult or stressful situations with other colleagues on the shift, whereas ward managers did not feel they could discuss their anxieties with the rest of the team.

Another way of coping with difficult situations mentioned was taking a break from the work, a strategy least likely to be used by ward staff. It was felt by some on the wards that there was a pressure to deny oneself a break. Six community-based staff described working unpaid overtime as a way of coping with work demands. Strategies for coping outside the workplace included various stress-reducing activities, such as taking exercise, going for a walk or listening to music ($n = 7$) and talking to partners, friends or family ($n = 4$). Just under half of the staff interviewed mentioned friends, family or partners as important sources of support in their work.

Staff's experience of supervision

All staff except for the consultant psychiatrists and clinical psychologists received regular one-to-one supervision. For ward staff, its frequency varied from once a fortnight to every 6 weeks, while for community staff it generally took place every 2 weeks. Staff were asked whether and in what ways supervision helped them to do their jobs. All but three staff (one CPN, one social worker and a ward nurse) felt that it did help them do their jobs. Table 3 shows the most frequently occurring categories derived from content analysis of responses about how supervision helps staff do their jobs.

The following descriptions indicate in more detail the types of comments within each of these categories:

Supportive: Over two-thirds of staff who received supervision said that it provided support as a setting in which anxieties about work could be discussed and reassurance obtained. Respondents who described supervision fulfilling this function were eight out of nine community psychiatric nurses (CPNs), two of the three occupational therapists, four of the six ward nurses and one out of three junior psychiatrists. For example:

It helps me know I have the support to make a decision. If something goes wrong I know I can fall back on that support... I can always draw on that resource...it helps to ease some of the stress. (team leader)

It's somebody to talk to. They can sit and listen, and say they are there for you...it's the support aspect of it. (ward nurse)

Educational: The educational aspect of supervision involved being helped to develop skills in assessment and management by a more experienced colleague, to obtain feedback on work, and to set future objectives. This aspect was mentioned by four of the nine CPNs, four out of six ward staff, all the occupational therapists, and all three junior psychiatrists:

It's always constructive and helpful to have a second opinion and to get advice on how my time management skills are going at any one time...it's time to reflect. (team leader, CPN)

Managing the caseload: The use of supervision to discuss specific clinical problems in managing particular caseloads was described by all social workers, five of the nine CPNs and two medical staff.

It helps me to manage the caseload. We also develop new strategies for dealing with difficult clients. That helps me being here on a day to day basis. (CPN)

To clarify problems you may be having with a particular patient, and how to move forward... (OT)

Table 3 Ways in which supervision helps staff to do their work

	No. of references (24 respondents)
Supportive	15
Educational, e.g. gaining advice, feedback	14
Managing caseload	10
Career/professional development	7

Career/professional development: Four CPNs and all the junior psychiatrists described using supervision to discuss development of their careers and progress of their training.

One of the team leaders summarised a variety of the positive aspects of supervision that emerged from the interviews:

> *It helps me to check things out, that I am doing things correctly, it helps me to release some of my frustrations. I think I learn as well from supervision, I get ideas. I get support...sometimes when I feel that I don't care about anything, there is actually somebody there who is giving me support saying "I can understand how you feel, it must be really frustrating" and I know that somebody recognises. Things like that give you the will to continue and gives you a surge of energy to do the job.* (team leader)

The majority of staff ($n = 18$, 75%) who received supervision were satisfied with its frequency and structure. Three of the CPNs thought it would be improved by a more structured approach and a greater focus on new ways of working with clients. Two social workers felt that their supervision was too case orientated and would have liked it to cover training and development issues, with a greater focus on assessment and feedback. Consultants and psychologists did not receive formal supervision and tended to rely on their peer group for support. For psychologists this took the form of peer supervision in which individual clients could be presented and discussed with colleagues.

The experience of staff support groups

Staff were also specifically asked whether they had access to staff support groups and whether these supported them in their work.

All the community teams had access to a psychodynamically facilitated staff support group, with a frequency varying from weekly to monthly. Only one ward had a facilitated staff group, as well as a nursing care group, in which they had the opportunity to discuss patients. One ward had a group that staff had decided should be unfacilitated, and in another the staff support group had previously collapsed due to unpopularity. Staff had found it ineffective and had decided to have in its place an informal staff meeting.

Staff in both settings had greatly varying views as to the usefulness of the staff groups. Amongst the 27 staff interviewed who had had experience of support groups 12 responses were predominantly positive and 15 negative. The negative responses were most frequent among ward staff and doctors. The views of one team leader summed up the mixed responses of staff regarding the helpfulness of these groups:

> *Some find it helpful and a useful medium or forum and then others find it a complete waste of time…I must say I have never understood why it was necessary.*

Two of the three team leaders, all ward managers and five of the six medical staff tended to feel that the support group was not a forum in which it was appropriate for them to discuss day-to-day problems or anxieties related to their work. They identified their roles within the team as provision of support and encouragement to other members, and felt that it would be unhelpful to moan or appear negative.

Amongst other staff, five felt that many people were unsure how to use support groups and five reported that they themselves felt unsafe discussing their real concerns and anxieties in it. Two of these felt intimidated by the size of the group, whilst for the other three the fact that their group was so very poorly attended by their team made them feel that it was ineffective and inconsistent. Many resented the time taken up in a very busy schedule, and would rather have had the time to 'grab some lunch'. The following comments reflect some of these themes:

> *It's far too large. I don't feel safe talking in it. It has not reached a level of safety for me to disclose anything…I don't think anything is ever resolved in a group. People are not honest and there is a lot of pussyfooting around.* (OT)

> *It's not helpful. I've found that generally they do not work…the best support is socially, i.e. in the pub, people are more open there…I think people are not used to working psychodynamically…it's the formality of it, people do not want to talk.* (OT)

Twelve of the 27 staff with experience of support groups did, however, make more positive comments about them. These professionals described finding it useful to have the opportunity to discuss personal or professional difficulties and individual concerns as part of a team, to be able to discuss difficult patients, and to take a break from the demands of the day-to-day work:

> *It's time for us as a team. A chance to say how you feel about working here, any problems with clients or other team members, a way of coping with your stress...it makes you feel part of the team...it's a problem shared.* (CPN)

> *The way other members interact with each other... what the areas of conflict were... I feel also it is a venue where I can discuss anything that bothers me. I feel very supported and that's very important.* (psychologist)

It was evident from the responses of staff in our sample that the same staff support group could provoke very different reactions in different individuals.

Suggestions for improvement of support groups

Improvements suggested were more consistent attendance by members of the team, a more structured format, training in how to use groups effectively, a more active facilitator, and the introduction of a facilitated group for discussion of patients. One community team had previously had a facilitated clinical support group in which patients could be discussed, and generally comments about this were positive:

> *The clinical support group, everybody really enjoyed that and found it helpful. That involves talking about difficult patients or anything clinical. That was very popular and I think in the other support group people are left with people they would like to discuss and cannot*. (junior psychiatrist)

Several people felt that their facilitators took too passive a role, and that a more active approach would be helpful:

> *If the facilitator took a more active role, if he had set or it had been agreed at the outset with the staff what his remit was, what the parameters were. It seems to me more of a meditation exercise*. (team leader)

Several staff members felt that a more structured forum, perhaps resembling that on 'team building' days that they had experienced, would be more useful to them:

> *Some people who find it difficult to deal with things on an emotional level can deal with it on a more practical level...it may be more effective, rather than exploring the issues and asking people what they feel, actually getting down to work and saying, 'what can we do to change this?...Unstructured groups are OK for people who have had a lot of experience of support groups and are accomplished at using them, but for others a structured group can provide more, in that people feel they are doing something*. (team leader)

The adequacy of training

Staff were asked whether they felt they had the right training for their jobs and whether there were any forms of extra training that they believed would help them cope better with the demands of their work. Twenty-four of the 30 staff interviewed identified gaps in their training and indicated areas of training that they felt would support them in doing their work. Only six staff felt that they had just the right training for the job. Table 4 shows the areas identified by staff as ones in which they would like to have further training.

Table 4 Areas in which staff felt they would like more training

General clinical skills, e.g. counselling, family therapy, risk assessment, cognitive-behavioural therapy
Specialist clinical skills, e.g. working with forensic patients, individuals with dual diagnosis of substance misuse and severe mental illness
Mental Health Act legislation, e.g. supervised discharge, keyworking responsibilities under Care Programme Approach
Social welfare needs, e.g. housing, benefits
Crisis management
Managing violence/aggression on wards
Management skills
Computers and information technology skills generally
Research skills
Supervision

Having the opportunity to learn new clinical skills was the type of training staff more frequently felt would enable them to deal more effectively with their current work: this was mentioned by 16 of the 30 subjects. Particular areas mentioned included counselling skills and family therapy:

> *I think it will help my interactions and interventions with clients, and help to set boundaries and work more efficiently with them*. (CPN)

> *I have a lot of dysfunctional families...I feel unsupported and out of my depth often..there only seems to be one course in the whole country*. (CPN)

The following extract from an interview with a CPN sums up the frustration staff felt in relation to their lack of training in specific clinical skills:

> *It feels like it has been left behind really. You cope with what you need to do day to day to keep people safe and working. You don't get an opportunity to develop your own skills that much...there seems to be little around that is relevant to what I do and there are few places on the courses that are on offer...it's like getting into Oxbridge*. (CPN)

Staff who felt that they had received adequate training in particular clinical skills described the increased confidence that this provided in working with patients. The following quotations describe the benefits of effective training:

> *Well you have the training to do the job really. I think particularly assessing suicidal depression, it's very useful, you're less frightened of that area, and better able to deal with the situation*. (OT)

> *I did a depression and suicide risk training which has been very useful, it's made me feel more confident about my clinical work... I mean if I didn't go on any of these courses it would be really easy to stagnate and get stuck in your ways, and not challenge your ideas*. (CPN)

There were also certain groups of 'difficult' patients for whom staff felt they lacked the required skills. Those groups included patients with a forensic history and those with a dual diagnosis of severe mental illness and substance abuse. The lack of skills in this area were particularly emphasised by doctors, one social worker and a community team leader in our sample.

A lack of training in management skills was identified by two ward managers, two team leaders and two

medical staff:

As far as managing, I've just learnt the hard way really, very much trial and error... I would have liked more training, because there have been times when things have gone wrong, and when I have been blamed for things when in fact I didn't have any training in how to do them. (team leader)

Those who had received some management training had found it highly valuable in performing their role, feeling better equipped to deal with aspects of their job such as the financial management of finite resources.

Three-quarters of community nurses and one psychologist felt that their training had not prepared them for working with patients in the framework of the new community care legislation. Important deficits in skills were identified in relation to the keyworking responsibilities set out in the UK Care Programme Approach legislation, which requires community staff to take certain lead responsibilities in organising and monitoring clients' care, and to the implementation of recent legislation on supervised discharge from hospital. Two occupational therapists and one CPN felt that their training had not prepared them for dealing with the social welfare aspects of their clients' needs.

I've had to apply for grants and stuff like that, that I do not feel trained for really... you're never quite sure if you have done it correctly. Dealing with housing, housing issues, getting people housed, that is something that we sometimes get involved in and I've had no training in that. (OT)

Four out of six ward staff felt that dealing with violent situations was an area in which training was inadequate. A number of staff wanted 'control and restraint' training, feeling that this would increase their confidence in managing violent confrontations and reduce the incidence of staff injuries on the ward.

Discussion

A number of potential strategies for improving the support staff receive at work may be derived from our findings and could form the basis for further, hypothesis-testing research in larger samples across a wider range of areas about how to reduce 'burnout' and increase satisfaction among mental health professionals. Work colleagues are clearly a vital and highly valued source of support for most staff through informal interactions, not formal support groups. Several studies have suggested an association between support from colleagues and increased levels of job satisfaction (e.g. Pines and Maslach 1977) and reduced levels of 'burnout' (Corrigan et al. 1995). Thus our findings and those of these earlier studies suggest that a useful focus in thinking about reducing 'burnout' and stress management may be to consider how such support from colleagues could be recognised and maximised. For example, it may be that frequent 'away days' and 'team building days' at which team members spend time with one another and participate in a variety of structured activities together may be helpful. Similarly, team meals and other social events may be helpful ways of increasing the availability of highly valued informal support from colleagues, and a case could be made for such events to receive funding from employers.

Several staff identified techniques for managing their workload, such as time management, as particularly helpful. It may be that further formal training in such techniques would improve the ability of mental health professionals to manage the competing demands on their time. Consideration also obviously needs to be given to whether these demands are in fact reasonable and whether staff well-being might be best served by organisational changes such as reduction in caseloads or greater specialisation, so that staff would not be expected to juggle as many roles and functions as a generic mental health team usually requires. This is discussed in the companion paper (Reid et al. 1999).

Most staff interviewed had access to frequent supervision, found it on the whole a source of support and were satisfied with its structure and frequency. It was notable, however, that when questioned directly about it staff tended to report that supervision was useful, yet only around one-third mentioned it spontaneously when asked more open questions about important sources of support and coping strategies. Moreover, its reported importance lagged considerably behind that of informal support from colleagues. Currently, supervision seems to consist mainly of provision of general support and reassurance, with some education on clinical management and advice and discussion regarding particular patients. General discussion of career and professional development is less prominent, and there is little evidence of supervision being used as a vehicle for detailed exploration of the emotional effects on staff of interactions with patients, or for discussion of effective time management and stress reduction techniques. It appears that training provided in clinical supervision is limited, and there is little research evidence indicating what the 'active ingredients' of effective supervision are: potentially such evidence could maximise the effectiveness of clinical supervision in supporting staff.

Staff support groups in mental health services have traditionally been the principal organised way of supporting staff and allowing them to ventilate and resolve difficulties in the teams in which they work. However, our findings suggest that staff in fact have very mixed responses to such groups, often with different people within the same group viewing the group very differently. These relatively unstructured groups seem to produce considerable uncertainty and bewilderment in many staff, so that they do not feel able to discuss their problems and frustrations and are unable to obtain support. The views expressed suggest that facilitated, but more structured, groups with an agenda, attended consistently by all staff within the team, might be a

more acceptable and useful way of providing support and discussing difficulties arising within the team. In future research it would be useful to test the hypothesis that such a group might have a beneficial effect on staff morale. Given that most staff members value highly the informal support of their colleagues, it seems worth persisting with attempts to harness this in a formal way, but the traditional unstructured group based on a broadly psychodynamic model does not seem to do this very successfully. Large supervision groups, led by an outside facilitator, in which staff could discuss particularly difficult patients in a group context were described positively by the minority of teams with experience of them. This may be a future avenue for exploration, particularly for community staff, who expressed the view that working autonomously with high levels of responsibility for patients can be particularly stressful.

Almost all staff interviewed reported that their jobs could be made more rewarding by further training. A large proportion of community staff, particularly CPNs and occupational therapists, felt that there were too few opportunities available for them to develop their clinical skills. On the wards, the need to develop strategies for dealing with violent and aggressive patients appeared especially pressing. The emphasis in recent service development has often been more on the organisation of services than on the content of interventions. Much attention has been focused on organisational developments such as establishing multidisciplinary teams, developing effective structures for case management or 'keyworking', sectorisation, and the setting up of community mental health centres. There has been less focus on what staff actually do in their interactions with the often demanding patients with whom they work, and our study suggests that staff themselves often doubt that they are fully trained in the skills that might enable them to manage these interactions confidently and effectively. Assessment of risk and management of aggression and violence are areas in which all staff should be as skilled as possible, although these are aspects of work that are likely to continue sometimes to provoke anxiety regardless of the training staff have had. Treatments of known efficacy, such as family interventions or cognitive behavioural therapy for psychosis, are not yet used routinely throughout UK community services. Skills in delivery of specific clinical interventions such as these is an area in which further training might allow staff to feel greater confidence and satisfaction in their work, as well as to deliver a more effective service. It does need to be acknowledged that providing treatment and care for people with severe mental illnesses is challenging work, likely to provoke uncertainties and strong emotions at times even in the most skilled and well-trained of professionals. However, if effective, initiatives to provide more extensive training in clinical skills for mental health staff might improve the well-being both of patients who have severe and enduring mental health problems and of the staff who work with them.

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