

Inpatient Mental Health Staff Morale: a National Investigation

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Published January 2011

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This report should be referenced as follows:

Johnson S, Wood S, Paul M, Osborn DP, Wearn E, Lloyd-Evans B, *et al.* Inpatient Mental Health Staff Morale: a National Investigation. Final report. NIHR Service Delivery and Organisation programme; 2010.

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Executive Summary

Background

Despite the very large resource invested in in-patient mental health wards, their environment and safety and the lack of contact between staff and patients have been criticised in the UK. Wards are demanding places to work for staff, as they care for people whose needs cannot be met by community services. Staff recruitment and retention is problematic: the use of temporary staff in acute wards is common and costly. The government and many other national and local organisations have been working together to try and improve in-patient care. For these initiatives to succeed, wards need to attract and retain permanent staff who are committed to and satisfied with their work. There is a lack of information from large well-designed studies about NHS inpatient staff morale. Such studies could inform initiatives by service planners to optimise the morale of the inpatient workforce.

Aims

The overall aim of this multi-method study was to examine the morale of the NHS inpatient mental health workforce. Specific objectives were:

- a) To describe in-patient staff morale, measured by a cluster of indicators, in a large representative sample of wards.
- b) To investigate factors associated with morale. The Demand-Control-Support model, a widely used framework in investigations of job stress, was the starting point. The additional influences of built environment, organisational context, geographical context and clinical population, and adverse events, were investigated.
- c) To compare morale between ward and community mental health team (CMHT) and crisis resolution team (CRT) staff and investigate staff's reported reasons for leaving wards.
- d) To investigate prospectively whether good and poor morale persist over time and are associated with staff turnover and sickness rates.
- e) To use qualitative methods to elucidate the mechanisms underlying the development of good and poor staff morale.

Methods

The main elements of the study were as follows:

Module 1: The 100 ward survey. All staff and ward managers on 100 in-patient wards in 19 Mental Health Trusts in 4 regions were surveyed via questionnaires regarding their morale and potential influences on it.

Module 2: Comparison with community teams. Staff of 19 CMHTs and 19 CRTs completed the same measures of morale and, if applicable, were asked about reasons for leaving in-patient wards.

Module 3: Qualitative investigation of mechanisms underlying good and poor morale. Individual and group interviews were conducted with staff from a range of backgrounds and at varying levels of seniority on 7 wards, including high and low morale wards. These explored how good or poor morale develop and are maintained and the impact of the built environment and ward organisation.

Module 4: Investigation of leavers. As well as surveying CMHT and CRT staff in Module 2, we aimed to elicit reasons for leaving from all staff who left the 100 wards in the following year.

Module 5: Investigation of the persistence of high and morale. One year after the initial survey, repeat questionnaires were sent to a sub-sample of 20 wards with a range of initial morale scores.

Module 6: Prospective investigation of the relationship between morale and staff turnover and sickness. Wards were asked to supply data regarding sickness rates and staff turnover in the year following the Module 1 survey. Because of resource constraints, this took place in only three of the four regions. The relationship between initial morale and rates of sickness absence and staff turnover was explored.

Results

Our findings regarding the above main aims were as follows:

- (a) **Levels of morale in the inpatient mental health workforce.** Most NHS inpatient mental health staff report fairly good job satisfaction and a sense of achievement from their work. Levels of cynicism are low, and scores on two major measures of job-related well-being indicate that enthusiasm predominates over depression and contentment over anxiety, albeit narrowly. Staff reaching the threshold for burnout on the Maslach Burnout Inventory do so most frequently on the emotional exhaustion component of the measure. There were large variations between types of ward in both emotional exhaustion and GHQ score, a general measure of psychological distress. Generic acute ward staff showed most sign of stress: 49% met threshold for burnout on the emotional exhaustion scale and 29% met criteria for psychological distress on the GHQ. On rehabilitation wards, which had the most benign profile, 29% were burnt out on emotional exhaustion.
- (b) **Factors associated with morale:** Individual-level factors were found to have a more important influence on morale than ward-level factors, which typically accounted for only 5-8% of the variation on each morale indicator. Although causal pathways were often ambiguous, some strong associations emerged between morale indicators and other factors.

- (i) **The Demand-Support-Control model:** This model of job strain was largely upheld, particularly in its additive form, which suggests that high demands from a job are associated with psychological strain, but that this is mitigated by having a large amount of control over how the job is done, and by support from peers and managers. Work demands were very strongly associated with emotional exhaustion, but not with personal accomplishment. Job control remained strongly associated with all indicators of morale throughout all analyses. Both support from colleagues and from manager were associated with most dimensions of morale, but associations weakened or disappeared when organisational context variables such as role clarity and team communication were also added to models.
- (ii) **Organisational context:** In addition to the Demand-Support-Control variables, variables relating to role definition (role clarity and role conflict) and to fairness and communication within the team, rated by individual staff, were highly associated with morale. There was evidence that having a Personal Development Plan improved some aspects of morale. Team communication and role clarity tended to be rated as fairly good, but ratings were poorer for fairness and, in particular, voice in influencing senior managers. Only very limited evidence was found of associations between staffing levels or use of agency staff and morale, even though qualitative findings suggest great concern among staff about these.
- (iii) **Adverse incidents:** Nearly a quarter of the sample reported that they had been bullied in the past year and just over half that they had experienced discrimination. The most frequent form of discrimination was on grounds of ethnic background, and 54% of Black African or Caribbean staff reported discrimination, with patients the most frequent source. Staff also experienced high levels of violence: proportion of staff reporting at least one attack in the past year ranged from 45% on rehabilitation wards to 76% on older adult wards. Being bullied and experiencing violent and threatening behaviour were highly associated with poorer morale.
- (iv) **Built environment, geographical context and ward population:** No specific aspects of built environment were associated with morale, but staff perception of the quality of the ward environment was strongly associated with most morale indicators. There was some evidence for poorer morale in the most deprived catchment areas.

- (c) **Comparison with CMHTs and CRTs:** CRTs had a fairly benign profile, with good satisfaction and moderate levels of burnout. CMHT staff showed more evidence of psychological strain than any other group: 60% reached the burnt out threshold for emotional exhaustion, 39% the GHQ threshold for psychological distress. The combination of high demands, low managerial support and very high autonomy at work accounted to some extent for the apparent paradox of high psychological strain together with fairly good job satisfaction among these staff.
- (d) **Investigation of reasons for leaving:** Career development and greater job control were the most prominent reasons for leaving wards reported by staff from CRTs or CMHTs. Our survey of recent ward leavers achieved only a small response: both the wish for greater control and stresses in the ward environment were important reasons.
- (e) **Persistence of high and low morale:** At the level of individual staff, changes on most morale indicators over a year were modest, generally less than half a standard deviation. A tendency was found for initially high burnout wards to show substantial falls in mean burnout level at follow up.
- (f) **Correlations with sickness and staff turnover:** There were modest correlations between morale scores and subsequent sickness rates and turnover.

Conclusions

Even though our study is larger in scope and scale than most that precede it, significant reservations need to be noted regarding our methods and analysis. The study is cross-sectional and exploratory, and chance findings due to multiple testing are a significant risk. We have found a variety of potentially important links, but the causal status of these is often unclear, and reverse causality is often a real possibility. We report here on our initial set of full analyses, but some aspects of our data are yet to be fully explored and models yet to be fully developed.

These reservations aside, some important foci for further research and for policy and service development emerge. Further investigation of morale in CMHTs and the mechanisms that underlie it is a pressing concern. Bullying and violence are prevalent and strongly associated with poor morale, and better ways of addressing these need to be found. Initiatives to improve morale should be tested for effectiveness, as the evidence base is currently slight, and the high importance of control over way of working, role clarity and communication within teams are a potential basis for initiatives to consider whether jobs may be redesigned to improve these and thus optimise staff morale. Voice and fairness appear to be areas where mental health services do not currently perform well: senior managers should consider how this might be addressed.

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.