

Situational levels of burnout among staff in six European inpatient and community mental health teams

Robert G Hill, South London and Maudsley NHS Trust, London, UK

Peter Ryan, Middlesex University, London, UK

Polly Hardy, Murdoch Children's Research Institute, Melbourne, Australia

Marta Anczewska, Institute of Psychiatry and Neurology, Poland

Anna Kurek, Department of Animal Breeding and Production, Warsaw Agricultural University, Warsaw

Ian Dawson, Nordland Psychiatric Hospital Bodo, Norway

Heli Laijarvi, University of Tampere, Finland

Katia Nielson, Social and Psychiatry Department of Storstrøm County, Storstrøm, Denmark

Klaus Nybourn, Psychiatry Department County of Aarhus, Aarhus, Denmark

Iliana Rokku, University of Cambridge, UK

and Colette Turner, Middlesex University, London, UK

Abstract

Working in mental health services has always been recognised as a stressful occupation and many studies have attested to the high levels of stress and burnout. This study examined comparative levels of stress among inpatient and community mental health staff across five European countries.

Using a quasi experimental pre-test post-test design, data was collected from staff at baseline, six months and 12 months. This paper examines data from the baseline period. Staff working in acute inpatient wards and community mental health teams in Denmark (Aarhus, Storstrøm), Finland (Tampere), Norway (Bodo), Poland (Warsaw) and the UK (Cambridge), were asked to complete the Maslach Burnout Inventory (MBI) (Maslach, & Jackson, 1986), the Mental Health Professional Stress Scale (Cushway, Tyler & Nolan, 1996) and a demographic questionnaire designed for this study. Results on the MBI are reported in this article. Both community and inpatient teams reported high levels of burnout. There was evidence to suggest that burnout differed by site but not by team type. The English teams scored highest in emotional exhaustion and depersonalisation. Relatively high levels of work-related personal accomplishment were reported across all of the sites.

Key words

occupational stress; burnout; European

Introduction

There is now persuasive evidence to suggest that hospital and community-based mental health staff experience considerable stress in the course of carrying out their work, and that stress and burnout not only affect their level of performance and the success of their interventions, but also their job satisfaction and ultimately their own health (Van der Klink *et al*, 2001; Carson *et al*, 1996). Structural costs in terms of absenteeism, loss of productivity and use of health service resources is high and increasing. These findings have been confirmed from a number of recent studies which suggest that most of the main 'caring' professions are experiencing extremely high levels of stress and burnout. So far as community psychiatric nurses are concerned, Edwards *et al* (2001) found high stress levels in a Welsh survey. The aim of this study was to examine the variety, frequency and severity of stressors experienced by community mental health nurses (CMHNs) in Wales. Overall, it was concluded that CMHNs in Wales were experiencing high levels of stress. The GHQ-12 measure indicated that 35% of CMHNs crossed the GHQ-30 threshold of 'caseness'. Measured against a normative sample of mental health workers 51% of CMHNs were experiencing high levels of long-term emotional exhaustion: 24% were suffering from high levels of depersonalisation, while 14% were experiencing severe long-term feelings of lack of personal accomplishment.

As far as mental health social workers are concerned, a study by Evans *et al* (2006) found that excessive job demands and limited scope for decision making were leading to poor job satisfaction and high levels of emotional exhaustion. The survey also found that the social workers worked an average of 43 hours per week, roughly six hours more than they were contracted for. Moreover, the mental health social workers who had approved social worker status had greater job dissatisfaction. Just over one fifth of the survey's respondents had made specific plans to leave their job and 28% had a strong desire to leave. A review of studies examining occupational stress among mental health social workers also confirmed high stress levels in this occupational group (Coyle *et al*, 2005). These findings are confirmed by earlier studies. Martin and Schinke (1998) compared mental health workers and family workers in New York using the Minnesota Satisfaction Questionnaire, the Maslach Burnout Inventory and the Staff Burnout Scale for Health Professionals, and found that 57% of psychiatric and 71% of family social workers identified themselves as being moderately or severely burnt out. They concluded that absence of promotional opportunities and remuneration are associated with burnout. Prosser *et al* (1996) found that when comparing UK mental health community and ward-based social workers using the GHQ-12, community staff scored higher.

Hannigan *et al* (2004) conducted a systematic review of stress experienced by clinical psychologists. The major conclusion of this review was that up to 40% of clinical psychologists surveyed were experiencing 'caseness' levels of stress and burnout. Reported sources of stress included: working with difficult clients; excessive workloads; professional self-doubt; and experiencing poor line management. These findings confirm the conclusions of an earlier study (Cushway & Tyler, 1996) which also found that three quarters of the psychologists surveyed reported being 'moderately' or 'highly' stressed, approaching 'caseness' levels as measured by the GHQ-28. In another study focusing on clinical psychologists, Crowley and Avdi (1999) found that psychologists reported being emotionally exhausted or overwhelmed with respect to their work with their clients.

Psychiatrists have also been found to experience extremely high stress levels. Onyett's survey of 54 nationally distributed community mental health teams

(CMHTs) found that psychiatrists scored highest in the burnout categories of emotional exhaustion (63.4%) and depersonalisation (47.5%) out of all the professional groups within a CMHT (Onyett *et al*, 1995; 1997).

In an Australian study focusing on occupational therapists and social workers, Lloyd *et al* (2005) examined the sources of stress experienced by these two occupational groups, as measured by the Mental Health Professionals Stress Scale (Cushway *et al*, 1996). Using a cross-sectional survey design, Lloyd found that stress experienced by occupational therapists and social workers was greater than that experienced by clinical psychologists and nurses, but not significantly so.

Edwards *et al* (2000) also examined eight studies on burnout and stress among members of the mental health multidisciplinary team. The evidence reviewed suggested that members of community mental health teams were experiencing increasing levels of stress and burnout. The major stress factors identified were:

- job-based stressors: increases in workload and administration; time management problems; inappropriate referrals and violent and suicidal clients
- role-based stressors: role conflict; responsibility and role change; lack of time for personal study
- stressors relating to organisational structure and climate such as NHS and legislative reforms
- stressors relating to relationships with others around inadequate supervision and dysfunctional community mental health teams.

Burnout: a definition

Burnout is related to stress and it is most frequently linked to three factors: (a) emotional exhaustion, (b) depersonalisation related to the work environment, and (c) a sense of diminishing personal accomplishment. Outcomes of burnout in the workplace are generally linked to costly increases in turnover, absenteeism and reduced productivity for the individual and the organisation. These outcomes can also negatively affect the user of mental health services. Burnout has been defined as 'a syndrome of emotional exhaustion, depersonalization and a reduced sense of personal accomplishment, which can occur among individuals who work with people in some capacity' (Maslach & Jackson, 1986). Burnout is a state of physical, emotional fatigue and can be described as a sense of helplessness and

hopelessness, low energy levels, chronic tiredness, fatigue and a feeling of being trapped. One of the consequences of these symptomatic effects can be a severe disruption or dislocation of the therapeutic relationship between the service provider and client (Leiter & Maslach, 2000).

Methodology: the aim and objectives of the study

This article reports results from a European multicentre project OSCAR. The OSCAR project (Occupational Stress with Mental Health Clients in Acute Response) (2001–2004) was granted €1.4 million under framework five quality of life European funding.

The OSCAR study aimed to:

- compare the levels of occupational stress and burnout of mental health workers in acute psychiatric hospital and community settings across six European mental health services
- consider the aetiological factors which precipitate the occurrence of patients' violent behaviour
- examine the efficacy of risk management strategies
- develop and evaluate effective stress reduction training packages.

The outcomes of the training intervention are reported in Ryan *et al* (2005). In this article we report on the situational variations in levels of burnout amongst staff in six different European settings. We wanted to explore whether there were any particular differences in staff burnout levels on the different sites and, if so, to tease out why this might be the case. We also wanted to see whether there were any differences between community and inpatient teams both within and between the different sites.

The project was undertaken in seven European centres across six European countries.

Participating centres in the OSCAR project

- Chancellor, Masters and Scholars of the Department of Psychiatry, University of Cambridge, Cambridge, UK
- Institute of Psychiatry and Neurology, Warsaw, Poland
- Middlesex University, London, UK
- Nordland Psychiatric Hospital Bodo, Norway
- Psychiatry Department County of Aarhus, Aarhus, Denmark
- Social and Psychiatry Department of Storstrøm County, Storstrøm, Denmark
- University of Tampere, Tampere, Finland

Study design and sampling

The research design was a simple time series. The staff groups were assessed at baseline ie, prior to receiving training specifically designed and developed to reduce levels of occupational stress, and to increase efficacy of risk assessment. Staff were followed up at six and 12 months post intervention. This design was considered more appropriate as it would allow for variability in a number of potentially unknown factors between sites. It would also overcome contamination issues that would otherwise be problematic in a randomised design.

The number of participants for each site was calculated by taking into account the longitudinal design of the study, a re-test correlation of a minimum of 60% for the measures, and a drop out rate of approximately 35%. Assuming a type I error rate of 5% and power of 80% and treating each of the six sites, as well as inpatient and community staff, as separate groups, (ie, 12 groups in total) a sample size of 35 was required per group in order to detect a small to medium effect size of 0.5. Teams were randomly selected from each site, stratified by inpatient vs community teams, until the approximate required sample size was reached. In some cases this resulted in all available teams entering the study (see **Table 1**).

Table 1 OSCAR sample

Setting	Community/ inpatient	Total number of staff in sample*	Type of sample
UK - Cambridge	Community	37	Census of both teams
	Inpatient	29	Random sample of one team
Denmark - Aarhus	Community	30	Census of one team
	Inpatient	25.5	Census of one team
Denmark - Storstrøm	Community	18.5	Census of both teams
	Inpatient	47	Census of both teams
Finland	Community	35	Random sample of seven teams
	Inpatient	39	Random sample of two teams
Norway	Community	33	Census of three teams
	Inpatient	31	Census of one team
Poland	Community	37	Census of one team
	Inpatient	30	Random sample of one team

*This number includes staff that have dual roles, but does not include administration staff

Measures

The following measures were administered at baseline and at six months and 12 months after the training intervention: (i) The Maslach Burnout Inventory (Maslach & Jackson, 1986); (ii) The Mental Health Professional Stress Scale (Cushway *et al*, 1996); (iii) The Ward Atmosphere Scale or Community Orientated Programme Scale (Moos, 1986a; 1986b); (iv) The Questionnaire for Psychosocial Work Environment - Survey and Changes (Agervold, 2000) and (v) a Demographics Questionnaire. This paper focuses on the Maslach Burnout Inventory data only.

The Maslach Burnout Inventory (MBI) is a 22-item measure designed to assess three aspects of the burnout syndrome at work: emotional exhaustion (nine items); depersonalisation (five items) and personal accomplishment (eight items). Each item is scored on a seven-point scale measuring frequency (ranging from none to every day). Reliability and validity are satisfactory, although the factor structure is a matter of

some dispute (Kalliath *et al*, 1998). Research studies using the MBI with mental health professionals are numerous (McElfrick *et al*, 2000; Fagin *et al*, 1996; Prosser *et al*, 1996; Onyett *et al*, 1995).

Data analysis strategies

Means and standard deviations are presented for the MBI subscales by site and team type. In addition, MBI subscales are categorised into three groups: low, medium and high, based upon the cut-offs for staff working in mental health provided by Maslach. The effect of both site and team type (inpatient versus community) was assessed in adjusted linear regression analyses of baseline MBI subscales. The interaction between site and team type was also investigated for all analyses; however none were found to be statistically significant at the 5% level. Assumptions of regression analyses were checked and found to be violated. Appropriate transformations of the outcomes were applied. All analyses were carried out using SPSS version 12.01.

Results

Tables 2 and 3 show the scores for emotional exhaustion on the Maslach Burnout Inventory in both the inpatient and community teams.

As one can see from Table 2 there is a statistically significant difference on scores for emotional exhaustion (EE) between sites after controlling for team type. Storstrøm's inpatient team had the lowest mean score for EE, while Warsaw's community team had the highest. Although there was no statistical difference between inpatient and community teams on EE after adjusting for site, there does appear to be a trend for five of the six community teams to record higher levels of emotional

exhaustion than their inpatient colleagues.

Table 3 breaks down the emotional exhaustion scores into low, medium and high levels. These results indicate a relatively even balance between those individuals recording low levels of burnout and those rating theirs as medium or high in all inpatient sites, with the exception of Cambridge where there were fewer staff recording low levels.

In the community teams the majority of staff recorded their emotional exhaustion as medium to high, with the exception of Storstrøm where there was an approximate balance between the two groups.

Table 2 MBI - Emotional exhaustion by site and team type

MBI - Emotional Exhaustion

	Inpatient/Community						Table Total		
	Inpatient			Community			Valid N	Mean	Standard Deviation
	Valid N	Mean	Standard Deviation	Valid N	Mean	Standard Deviation			
Site Code Aarhus	N=33	15.21	8.67	N=20	18.75	8.19	N=53	16.55	8.59
Bodo	N=27	14.43	7.71	N=34	16.07	7.79	N=61	15.34	7.73
Cambridge	N=37	17.46	9.40	N=50	19.92	10.77	N=87	18.87	10.22
Storstrøm	N=34	13.03	8.92	N=13	14.38	11.38	N=47	13.41	9.55
Tampere	N=42	18.80	12.41	N=62	17.56	11.15	N=104	18.06	11.63
Warsaw	N=32	14.78	8.89	N=30	21.10	11.76	N=62	17.84	10.78
Table Total	N=205	15.82	9.74	N=209	18.31	10.49	N=414	17.08	10.19

Significance of site in the model - p=0.036 (F=2.40, 5 df)

Significance of team type in the model - p=0.081 (F=3.07, 1 df)

Table 3 MBI - Emotional exhaustion low, medium, high categorisation by site and team type

	Inpatient/Community						Table Total
	Inpatient			Community			
	Emotional Exhaustion - grouped			Emotional Exhaustion - grouped			
	Low Count	Medium Count	High Count	Low Count	Medium Count	High Count	Count
Site Code Aarhus	17	6	10	7	4	9	53
Bodo	13	8	6	15	11	8	61
Cambridge	13	11	13	16	12	22	87
Storstrøm	18	8	8	7	2	4	47
Tampere	21	5	16	26	17	19	104
Warsaw	17	4	11	8	7	15	62
Table Total	99	42	64	79	53	77	414

Situational levels of burnout among staff in six European mental health teams

Tables 4 and 5 show the scores for depersonalisation on the Maslach Burnout Inventory in both the inpatient and community teams.

There is strong evidence to suggest that scores on depersonalisation differed between sites after adjusting for team type. This is illustrated by the large difference between the scores of staff working in inpatient facilities in Cambridge (mean 6.41) and staff working in the community in Storstrøm (mean 1.62).

Examining Table 5, one can see that more staff rated their level of depersonalisation as low in comparison to medium/high. Tampere's and Cambridge's inpatient teams were the exception to this, as was Cambridge's community mental health team, where there was an approximately equal divide between the low and medium/high groups.

Table 4 MBI - Depersonalisation by site and team type

	Inpatient/Community						Table Total		
	Inpatient			Community			Valid N	Mean	Standard Deviation
	Valid N	Mean	Standard Deviation	Valid N	Mean	Standard Deviation			
Site Code Aarhus	N=33	3.45	3.72	N=20	3.50	2.91	N=53	3.47	3.41
Bodo	N=26	5.67	4.42	N=34	3.10	3.63	N=60	4.22	4.16
Cambridge	N=37	6.41	5.67	N=50	5.76	4.62	N=87	6.03	5.07
Storstrøm	N=33	3.70	4.63	N=13	1.62	2.02	N=46	3.11	4.15
Tampere	N=42	5.61	5.25	N=62	4.68	5.10	N=104	5.05	5.16
Warsaw	N=32	4.16	3.58	N=30	5.47	4.34	N=62	4.79	3.99
Table Total	N=203	4.87	4.75	N=209	4.49	4.45	N=412	4.68	4.60

Significance of site in the model - $p < 0.001$ ($F=4.73$, 5 df)

Significance of team type in the model - $p=0.097$ ($F=2.76$, 1 df)

Table 5 MBI - Depersonalisation low, medium, high categorisation by site and team type

	Inpatient/Community						Table Total
	Inpatient			Community			
	Depersonalisation - grouped			Depersonalisation - grouped			
	Low Count	Medium Count	High Count	Low Count	Medium Count	High Count	Count
Site Code Aarhus	24	4	5	11	8	1	53
Bodo	14	5	7	27	5	2	60
Cambridge	18	6	13	25	12	13	87
Storstrøm	23	7	3	12	1		46
Tampere	21	9	11	36	13	13	104
Warsaw	18	10	4	14	7	9	62
Table Total	118	41	43	125	46	38	412

Situational levels of burnout among staff in six European mental health teams

Tables 6 and 7 show the scores for personal accomplishment on the Maslach Burnout Inventory in both the inpatient and community teams.

Personal accomplishment was rated as high in all centres, except for the Warsaw inpatient team and this would account for the statistically significant site difference. There was no evidence of a difference between

inpatient and community staff after adjusting for site.

In terms of the 'personal accomplishment' sub-scale, all the sites scored in the 'high' category, apart from Warsaw (Poland) which was ranked 'medium' and was rated as significant. Storstrøm was significantly higher in terms of personal accomplishment than all of the other sites.

Table 6 MBI - Personal accomplishment by site and team type

	Inpatient/Community						Table Total		
	Inpatient			Community			Valid N	Mean	Standard Deviation
	Valid N	Mean	Standard Deviation	Valid N	Mean	Standard Deviation			
Site Code Aarhus	N=33	38.97	6.57	N=20	34.59	9.60	N=53	37.32	8.06
Bodo	N=26	36.67	6.27	N=34	37.69	6.20	N=60	37.25	6.20
Cambridge	N=37	36.28	7.54	N=50	37.04	6.05	N=87	36.72	6.69
Storstrøm	N=33	38.03	8.96	N=13	42.45	5.14	N=46	39.28	8.25
Tampere	N=41	35.16	7.99	N=62	36.57	9.19	N=103	36.01	8.72
Warsaw	N=32	32.50	9.70	N=30	32.40	6.49	N=62	32.45	8.24
Table Total	N=202	36.23	8.13	N=209	36.44	7.78	N=411	36.34	7.95

Significance of site in the model - $p < 0.001$ ($F = 6.19$, 5 df)

Significance of team type in the model - $p = 0.497$ ($F = 0.46$, 1 df)

Table 7 MBI - Personal accomplishment low, medium, high categorisation by site and team type

	Inpatient/Community						Table Total
	Inpatient			Community			
	Personal Accomplishment - grouped			Personal Accomplishment - grouped			
	Low Count	Medium Count	High Count	Low Count	Medium Count	High Count	
Site Code Aarhus	3	2	28	3	2	15	53
Bodo	3	5	17	4	4	26	62
Cambridge	7	3	27	5	6	39	87
Storstrøm	3	2	28		1	12	47
Tampere	5	7	28	7	9	46	105
Warsaw	10	6	16	8	9	13	62
Table Total	31	25	144	27	31	151	416

Limitations of the study

Clearly the study is of its time and place. Health services are developing systems that are never truly static and results need to be continually questioned if not for their relevance, then certainly for their validity. In this respect there are a number of methodological limitations of this study that also need to be addressed. A major limitation lies in the fact that the centres chosen for study were purposive. Thus it is difficult to generalise as to what degree any of the centres were representative of typical working conditions operative in their own countries on a wider basis. Another limitation was the matter of questionnaire translations and their revalidation in new languages. While it was always hoped that this would occur during the course of the project, unfortunately the complexity and cost of the task could not be borne by the project's funding. However, all of the key researchers were English speakers as a second or third language and in one site, Bodo (Norway), the researcher was a native English speaker which we hope minimised issues of understanding and question nuance. Moreover, a weekly internet web meeting was used throughout the project to discuss such issues.

Another issue that emerged during the course of the project was the cultural acceptability of expressing dissatisfaction with services. Given that staff responses to the questionnaires were to be used as part of the training intervention, albeit anonymously, this may have impacted on the extent to which staff were able to be open and honest, particularly in the presence of their ward managers.

Consideration must also be given to the sample sizes achieved for each site and team type. It is particularly noticeable that Storstrøm has the most imbalance between community and inpatient numbers ($n=47$ for inpatient and 18.5 for community), which could account for the noticeable differences in all outcomes compared to other sites.

Discussion of results

A number of findings have emerged from this data and are worth discussing. First, by undertaking a regression analysis where comparisons are made between each site's inpatient and community data and a reference site (Tampere, Finland as this had the largest number of observations) a number of statistically significant findings emerged in relation to the

MBI. As one can see from the mean scores above, Storstrøm's (Denmark) community teams had the lowest levels of emotional exhaustion and depersonalisation along with the highest levels of personal accomplishment. Their inpatient counterparts also had a similar profile. Interestingly, inpatient staff in another part of the country, Aarhus, had similarly low levels of depersonalisation and high levels of personal accomplishment, although their scores of emotional exhaustion were higher. These findings were confirmed in the regression analyses, in that there were significant differences on emotional exhaustion for Storstrøm's staff as compared to Finland. No other site was found to be statistically significant on the emotional exhaustion sub-scale.

In terms of depersonalisation, both Aarhus and Storstrøm were significantly different to Tampere, while Cambridge (UK) was significantly higher. On the categorisation of the MBI, the difference was between low and medium scores.

In terms of the 'personal accomplishment' sub-scale, all the sites scored in the 'high' category, apart from Warsaw (Poland), which was ranked 'medium' and was rated as significant. Storstrøm was significantly higher in terms of personal accomplishment than all of the other sites. Perhaps the most striking finding here is the relatively high levels of personal accomplishment in all settings apart from the Polish teams.

What this data highlights is the important role that site plays in measures of burnout. While a country's health system may have a degree of influence, local policies and practices also play a part. Thus, the difference between Poland and Denmark in relation to feelings of personal accomplishment in work, may be related to the finances and status of their respective health systems, but even in well-resourced Denmark, there can be a difference in levels of emotional exhaustion depending in which locality one works.

A second finding is the trend for community team members to experience more exhaustion than their inpatient counterparts. Role clarity has been associated with high levels of burnout (Mirvis *et al*, 1999) and it may be that professionals working alone for much of the day receive less structural support, less support from their colleagues and less opportunity for role conformation through contact with others undertaking the same job, giving rise to stressful self-doubt.

A third finding concerned the levels of client depersonalisation reported by staff members, where there were differences by site. Depersonalisation is regarded by many as a necessary feature of working with distressed clients and can be viewed as potentially self-protective against emotional exhaustion. However, it is the degree of depersonalisation that is the main issue. In our study depersonalisation was marginally higher in the inpatient wards compared to the community teams. This may make sense in terms of the large numbers of clients, many of whom will not be key working in the inpatient wards as compared to the community teams. In addition patients admitted for ward-based care will almost certainly be in an acute phase of their illness, making inter-personal relationships more difficult. Therefore, it is of some surprise that any of the community teams would report higher levels than their inpatient colleagues, and only Warsaw fell into this category. The highest level of depersonalisation was to be found in the inpatient team of Cambridge. One explanation of this may be the extremely high levels of bed occupancy in the UK, along with the very high threshold needed to be admitted into a UK-based acute ward.

Conclusions and implications for English mental health services

It is of course not possible to say to what degree the English mental health service included in this study is 'representative' of English or UK mental health services as a whole – the same limitation can be levelled at all the other services in the other European centres for that matter. Having said that, it remains the case that the English inpatient and community services scored higher than the European services in the study with respect to emotional exhaustion and depersonalisation. Staff referred to issues such as constant restructuring, high workloads and poor resources as being contributory factors. It is perhaps sufficient cause to question the overall 'state of health' of English mental health services, and to wonder whether a constant diet of change, 'improvement' and the consequent need to constantly change service configurations is necessarily 'a good thing' so far as achieving a manageable level of occupational stress in English mental health services.

Address for correspondence

Dr Robert Hill
Wickham Park House
Bethlem Royal Hospital
Monks Orchard Road
Beckenham
Kent BR3 3BX

Tel: 020 8776 4113

Email: robert.hill@slam.nhs.uk

References

- Agervold M (2000) *Questionnaire for Psychosocial Work Environment – Survey and Changes*. Denmark: Institute of Psychology, University of Aarhus.
- Carson J, Fagin L & Ritters S (1996) *Stress and Coping in Mental Health Nursing*. London: Chapman and Hall.
- Coyle D, Edwards D, Hannigan B, Fothergill A & Burnard F (2005) A systematic review of stress amongst mental health social workers. *International Social Work* 48 (2) 201–211.
- Crowley A & Avdi E (1999) The impact of complex cases in an adult mental health speciality. *Clinical Psychology Forum* 130 (13) 13–17.
- Cushway D & Tyler PA (1996) Stress in clinical psychologists. *International Journal of Social Psychiatry* 43 (4) 141–149.
- Cushway D, Tyler PA & Nolan P (1996) Development of a stress scale for mental health professionals. *British Journal of Clinical Psychology* 35 279–295.
- Edwards D, Burnard P, Coyle D, Fothergill A & Hannigan B (2000) Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing* 7 7–14.
- Edwards D, Burnard P, Coyle D, Fothergill A & Hannigan B (2001) A stepwise multivariate analysis of factors that contribute to stress for mental health nurses working in the community. *Journal of Advanced Nursing* 36 (6) 805–813.
- Evans S, Gately C & Webber M (2006) Mental health, burnout and job satisfaction amongst mental health social workers in England and Wales. *British Journal of Psychiatry* 188 75–80.
- Fagin L, Carson J, Leary J, de Villiers N, Bartlett H, O'Malley P, West M, Mcelfatrick S & Brown D (1996) Stress, coping and burnout in mental health nurses: Findings from three research studies. *International Journal of Social Psychiatry* 42 (2) 102–111.
- Hannigan B, Edwards D & Burnard B (2004) Stress and Stress Management in Clinical Psychology: findings from a systematic review. *Journal of Mental Health* 13 (3) 235–245.
- Kalliath TJ, O'Driscoll MP & Gillespie DF (1998) The relationship between burnout and organizational commitment in two samples of health professionals. *Work & Stress* 12 (2) 179–185.

Leiter MP & Maslach C (2000) *Preventing Burnout and Building Engagement: A complete program for organizational renewal*. San Francisco, CA: Jossey-Bass.

Lloyd C, McKenna K & King R (2005) Sources of stress experienced by occupational therapists and social workers in mental health settings. *Occupational Therapy International* **12** (2) 81-94.

Martin U & Schinke SP (1998) Organizational and individual factors influencing job satisfaction and burnout of mental health workers. *Social Work in Health Care* **28** (2) 51-62.

Maslach C & Jackson SE (1986) *Maslach Burnout Inventory* (2nd edition). Palo Alto, CA: Consulting Psychologists Press.

McElpatrick S, Carson J, Annet A, Cooper C, Holloway F & Kuipers J (2000) Assessing coping skills in mental health nurses: Is an occupation specific measure better than a generic coping skills scale? *Personality and Individual Differences* **28** (5) 965-976.

Mirvis DM, Graney MJ & Kilpatrick AO (1999) Burnout among veterans of the Department of Veterans Affairs medical centers: contributing factors as determined by a longitudinal study. *Journal of Health and Human Services Administration* **21** 390-412.

Moos R (1986a) *The Social Climate Scales: A user's guide*. Palo Alto, CA: Consulting Psychologists Press.

Moos R (1986b) *The Ward Atmosphere Scale*. Palo Alto, CA: Consulting Psychologists Press.

Onyett S, Pillinger T & Muijen M (1995) *Making Community Mental Health Teams Work*. London: The Sainsbury Centre for Mental Health.

Onyett S, Pillinger T & Muijen M (1997) Job satisfaction and burnout amongst members of community mental health teams. *The Journal of Mental Health* **6** 55-66.

Prosser D, Johnson S, Kuipers E, Szmukler G, Bebbington P & Thornicroft G (1996) Mental health 'burnout' and job satisfaction among hospital and community-based mental health staff. *British Journal of Psychiatry* **169** 334-337.

Ryan P, Hill R, Anczewska M, Hardy P, Kurek A, Nilesen K, Turner C & The OSCAR Group (2005) Team-based occupational stress reduction. A European overview from the perspective of the OSCAR project. *International Review of Psychiatry* **17** (5) 1-8.

Van der Klink JJ, Blouk RW, Schene AH & van Dijk FJ (2001) The benefits of intervention for work-related stress. *American Journal of Public Health* **91** 720-275.