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Morale and job perception of community mental health professionals in Berlin and London

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Abstract *Introduction* Morale and job perception of staff in community mental health care may influence feasibility and quality of care, and some research has suggested particularly high burnout of staff in the community. The aims of this study were to: a) assess morale, i. e. team identity, job satisfaction and burnout, in psychiatrists, community psychiatric nurses and social workers in community mental health care in Berlin and London; b) compare findings between the groups and test whether personal characteristics, place of working and professional group predict morale; and c) explore what tasks, obstacles, skills, enjoyable and stressful aspects interviewees perceived as important in their jobs. *Methods* In all, 189 mental health professionals (a minimum of 30 in each of the six groups) responded to a postal survey and reported activities per week using pre-formed categories. Perception of professional role was assessed on the Team Identity Scale, job satisfaction on the Minnesota Job Satisfaction Scale, and burnout on the Maslach Burnout Inventory. Seven simple open questions were used to elicit the main tasks, skills that staff did and did not feel competent in, aspects that they did and did not enjoy in their job, and obstacles and factors that caused pressure. Answers were subjected to content analysis using a posteriori formed categories. *Results* Weekly activities and morale varied between sites and professional groups. Some mean scores for groups in London

exceeded the threshold for a burnout syndrome, and are particularly less favourable for social workers. Working in London predicted higher burnout, lower job satisfaction and lower team identity. Being a psychiatrist predicted higher team identity, whilst being a social worker was associated with higher burnout and lower job satisfaction. Male gender predicted lower burnout and higher team identity. However, professional group and site interacted in predicting burnout and job satisfaction. Psychiatrists in London had much more favourable scores than the other two groups, whilst this did not hold true in Berlin. Answers to open questions revealed universal aspects, such as enjoying direct patient contact and disliking bureaucracy, but also various views that were specific to a site or professional group or both. *Conclusions* Burnout remains a problem for some, but not all, professional groups in community mental health care, and social workers in London appear to be a group with particularly low morale. Differences between professional groups depend on the location, and it remains unclear to what extent job-related and general factors impact on the morale of mental health professionals. Answers to open questions reveal general as well as specific aspects of the job perception of the professional groups, some of which may be relevant for service development, training and supervision. More conceptual and methodological work and more extensive studies are required to develop a better understanding of how community mental health professionals perceive their job and how morale may be improved.

Key words burnout – content analysis – community mental health care – job satisfaction – mental health professionals – staff morale

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Introduction

There is increasing evidence that occupational burnout is a significant problem to both employees and employers, with around 270,000 UK employees, for example,

taking time off work yearly because of work-related stress (McKee 1996). Mental health professionals, like other health care workers, are subject to stress and burnout, and since the 1990s, there have been calls for more systematic research on the morale and well-being of health care staff in general and mental health professionals working in the community in particular (e.g. Rees and Cooper 1992; Wall et al. 1997; Department of Health 1998). Studies investigating the morale of mental health professionals have shown that the burnout and poor mental well-being of these professionals were at higher levels compared with other occupational groups (Carson et al. 1995a; Onyett et al. 1995; Prosser et al. 1996; Wykes et al. 1997). These professionals face additional strain by the very nature of the mental health work and as a result may be more at risk than their colleagues in other areas of health care (Moore and Cooper 1996). Increased workloads, work intensity, understaffing, job insecurity and continuous, rapid organisational change within the profession have all been identified as major sources of stress among mental health workers (Edwards et al. 2000).

Studies have shown high levels of dissatisfaction, stress and burnout among psychiatrists (Benbow and Jolley 1998; Guthrie et al. 1999; Rathod et al. 2000), and community psychiatric nurses (Drake and Brumblecomb 1999; Snelgrove 1998). Particularly high levels of emotional exhaustion have been found among community mental health staff (Prosser et al. 1996; Carson et al. 1995b). Indeed, there is evidence suggesting that working in the community may be more stressful for mental health professionals than working in in-patient services (Prosser et al. 1999). The high level of stress and, in turn, burnout and demoralization can impact on the feasibility and quality of mental health services in the community, and concerns have been raised that burnout in community staff may make community-based services for mentally ill people difficult to sustain (Wykes et al. 1997). Burnout of community care staff has recently been investigated in London (Billings et al. 2004) and was found to be associated with poorer patient outcomes in assertive outreach services providing intensive community treatment (Priebe et al. 2004).

There are at least four different reasons why further research on the morale and job perception of community mental health staff may be important, and why regular assessments of staff morale may become part of routine quality management in community care in the future. First, a positive morale is essential to recruit and retain talented and qualified staff. Secondly, staff with higher morale are likely to deliver better care. Thirdly, community mental health care requires collaboration of different professional groups, and a precise understanding of the morale and job perception of the professionals involved should facilitate team working and optimal use of personal resources. And fourthly, staff's perception of their roles, tasks and problems may capture important features of the "philosophy" of a service and, in combination with outcome assessments, help to identify

specific strengths and weaknesses of different care approaches.

The latter two aspects require comparisons between professional groups and different health care systems. This study, therefore, assessed morale and job perception of psychiatrists, community psychiatric nurses (CPNs) and social workers (SWs), all working in community mental health care. The study was conducted in two capitals of larger European countries, i.e. in Berlin and London. The two capitals share various characteristics including the usual inner-city problems, but mental health care systems are differently organised in line with distinct traditions and funding arrangements. This applies in particular to community mental health care. In London, community mental health care teams are a central component of secondary care, which is organised in a co-ordinated fashion within a National Health Service. The teams provide the standard care for patients with severe mental illnesses and are supported by other in- and out-patient services. Berlin has a more fragmented health care system with several providers running services within the same area. Multi-disciplinary teams in the community are rare and linked to different types of provider organisations. They fulfil rather specific tertiary functions for people with severe and chronic mental illnesses, and their methods of working vary. Whilst working hours for staff in London and Berlin are similar, pay varies between the cities. The pay also varies within each professional group at each site depending on seniority and, for example, age and family status in Berlin. In London, the estimated average pre-tax salary in euro of psychiatrists is 105,000, CPNs 41,000, and SWs 48,000, while in Berlin that of psychiatrists is 57,000, CPNs 32,000 and SWs 38,000.

The current exploratory cross-sectional study had three aims: (1) to assess morale, i.e. team identity, job satisfaction and burnout, in psychiatrists, CPNs and SWs working in community mental health care in Berlin and London; (2) to compare findings between the groups and test whether and, if so, in what way personal characteristics of the interviewees, the place of working and the professional identity predict morale; and (3) to explore what tasks, obstacles, skills, enjoyable and stressful aspects interviewees perceived as important in their job.

The study, therefore, employed quantitative and qualitative methods, using established questionnaires and simple open questions, the answers to which were subjected to content analysis.

Subjects and methods

■ Sample

The sample consisted of psychiatrists, CPNs and SWs, providing care in community settings for people with mental health problems in Berlin, Germany, and London, United Kingdom. We aimed at a minimum sample size of 30 participants from each mental health professional group at each site. This was based on the Central Limit Theo-

rem, which suggests that with samples of 30 or more the average and distribution of scores in the sample will be close to those in the population that the sample is taken from (Dancey and Reidy 2002). In this exploratory study, we were interested in substantial effect sizes so that samples of 30 were considered appropriate although they provided low statistical power to detect small and medium-sized effects.

In London, the sample of psychiatrists ($n=30$) was randomly drawn from a list of all consultant psychiatrists in adult mental health care with catchment area responsibilities working for The East London and The City Mental Health Trust (East London), South-West London and St. George's Trust (South-West London) and South London and The Maudsley Trust (South London). The samples of CPNs ($n=30$) and SWs ($n=30$) were randomly drawn from a database compiled by the Sainsbury Centre for Mental Health of London-based social workers and community psychiatric nurses. To achieve a sample size of 30 per mental health professional group, postal questionnaires, followed by two reminders, were sent to 40 psychiatrists, 47 SWs and 75 CPNs, resulting in 75%, 69%, and 40% response rates, respectively.

In Berlin, letters explaining the study and asking staff to participate were sent to the directors of all 27 hospital-attached out-patient services for difficult-to-treat patients ('Institutsambulanzen'), all 23 social-psychiatric district services ('SpDs'), which are attached to local authorities, six providers of complementary services, six providers of social and nursing care ('Pflegeleistungen' and 'Sozialstationen') for patients with chronic mental illnesses, and five psychiatrists in private office-based practice with an emphasis on 'social-psychiatric' care ('sozialpsychiatrische Schwerpunktpraxis'). In one district, representatives of all providers were personally approached by one of the researchers (K. H.). A total of 220 questionnaires were sent out – with one reminder in case of non-response – of which 109 were returned (49.6%). One questionnaire was incomplete; three had been filled in by staff of other professional groups, three by staff on wards, and three by staff in services with no direct responsibility for patients. Thus, the results of 30 psychiatrists, 31 CPNs, and 38 SWs were included in the analysis.

Because the study used postal questionnaires to collect information, no data were gathered on the characteristics of staff who did not return the questionnaire.

■ Instruments

The study used established scales and open questions. A structured questionnaire covered the sociodemographic characteristics (age, gender) and job details (e.g. caseloads, length of experience, professional responsibilities, and activities per week) of professionals.

Established instruments were used to assess job perception and professional role (The Team Identity Scale) (Rizzo et al. 1970), job satisfaction (The Minnesota Job Satisfaction Scale) (Weiss et al. 1967), and burnout (The Maslach Burnout Inventory) (Maslach and Jackson 1981; Maslach et al. 1996).

The Team Identity Scale contains 16 items, which are rated on a five-point Likert-type scale with answers ranging from (1) strongly disagree to (5) strongly agree. The sum score has a minimum of 16 and a maximum of 80.

The Minnesota Job Satisfaction Scale used in this study was the 20-item short version. For each item, ratings ranged from (1) very dissatisfied to (5) very satisfied, with sum scores ranging from 20 to 100. The manual for the instrument (Weiss et al. 1967) suggests that the items of the general scale can be grouped into (1) intrinsic satisfaction and (2) extrinsic satisfaction. Intrinsic satisfaction reflects the extent to which professionals feel their job fits their skills and needs. It consists of 12 items with sum scores ranging from 12 to 60. The remaining eight items capture extrinsic satisfaction that assesses satisfaction with working conditions and rewards (sum scores ranging from 8 to 40). A total job satisfaction score was obtained by adding up the scores for intrinsic and extrinsic satisfaction for each respondent.

The Maslach Burnout Inventory has 22 items. Respondents were asked to provide a rating for each item, ranging from (0) never to (6) everyday (with possible sum scores of burnout ranging from 0 to 132). The scale itself is divided into three domains: (1) emotional exhaustion, (2) depersonalisation, and (3) personal accomplishment. The emotional exhaustion domain (reduction in emotional re-

sources) consists of nine items (sum scores ranging from 0 to 54). The depersonalisation domain (negative attitude to patients) has five items (sum scores between 0 and 30). Finally, the personal accomplishment domain (negative evaluation of oneself) includes eight items (scores ranging from 0 to 48). A total burnout score was obtained by adding up the scores for emotional exhaustion, depersonalisation, and personal accomplishment (scoring of items in this subscale was reversed to be in the same direction as those in the emotional exhaustion and depersonalisation sub-scales).

Seven open-ended questions were used to assess the respondents' job perception. The questions asked respondents to list: (1) three main tasks of their job; (2) three main obstacles they encountered in their job; (3) three main skills they felt competent in; (4) three main skills they did not feel competent in; (5) three main aspects they enjoyed in their job; (6) three main aspects they did not enjoy in their job; and (7) three main factors that caused pressure in their job.

■ Data analysis

The Statistical Package for Social Sciences (SPSS) Windows Version 11 was used to analyse the data. For quantitative data, descriptive statistics are presented with frequency and percentage distributions for categorical data and means and standard deviations (SD) for continuous data. In the analysis of the activities per week, the number of hours reported per week on each activity by each respondent was transformed into a percentage out of the total number of hours reported by that respondent. A mean percentage for each activity was then calculated for each group of professionals.

One-way analysis of variance (ANOVA) (Scheffe test) was used to test the statistical significance of differences between psychiatrists, community psychiatric nurses and social workers in Berlin and London. The Pearson's Chi-square test was used to assess statistical significance for group differences between categorical variables. In the tables, for a simpler presentation of the results, only the level of the statistical significance was reported for all comparisons. Throughout the analysis, a significance criterion equal to or smaller than 0.05 was used to determine statistical significance.

To test whether differences in burnout, job satisfaction, and team identity were due to site of practice (Berlin, London), type of professional group (psychiatrists, CPNs, SWs), or personal characteristics of the interviewees (age, gender, length of experience), the General Linear Model (GLM) Univariate test was used. This test provides regression analysis and analysis of variance for one dependent variable by one or more factors and/or variables, and provides effect of interactions between variables. In our case, three models were computed, with burnout, job satisfaction, and team identity as dependent variables. Study site and type of professional group were entered as fixed factors. The other variables that were also entered in the GLM were age, gender, and years of practice in mental health. In the table presenting the results, only variables that significantly contributed to the model were presented, with their partial Eta squared (the proportion of variance in the dependent variable that is explained by differences among groups). This model was used because it can identify interaction effects between predictor variables, e.g. between professional group and site. In order to assess the extent of the predictive value of each predictor, the same dependent and independent variables were subjected to stepwise multiple regression analyses, with data on the standardised regression coefficient, and variance explained by each variable, presented.

For the answers to the seven open questions, thematic content analysis was conducted, using a posteriori formed categories. Two researchers per site (Berlin/London) separately derived categories for the answers to each question out of the provided material. These categories were then compared and agreed upon by the two researchers. Researchers at the two sites developed their own categories to reflect local practice, concepts and terminology. After the analysis was completed, the categories identified in Berlin were translated into English. Several of the categories for answers of professionals in Berlin and London were, therefore, different. The percentage of respondents whose answers fell into each category was then calculated. It is to be noted that the categories were mutually exclusive and, hence, the percentages do not add up to 100.

Results

Age, gender and some job characteristics of the six groups of mental health professionals are summarised in Table 1. There are some significant differences between professional groups and sites, with psychiatrists in London being more often male, having a higher caseload, taking less often a key working role and having more frequently on-call duties than the other five groups.

Table 2 shows what activities mental health professionals reported spending their time on during a normal working week. Between 19.5% and 34.7% of the working time is spent on administration and travel. In London, each group additionally spends more than 20% of their time in meetings, whilst this is slightly lower in Berlin. Other activities also vary between groups and for each group between sites, in particular how much time is spent on seeing patients in the hospital, in patients' homes and elsewhere.

Table 3 shows data on burnout, job satisfaction and

Table 1 Differences between mental health professionals in Berlin and London

	Psychiatrists	Community psychiatric nurses	Social workers
	Mean \pm SD (or %)	Mean \pm SD (or %)	Mean \pm SD (or %)
Gender (female)			
Berlin	50% ¹	81% ²	63%
London	20%	61% ²	54% ³
Age			
Berlin	46.0 \pm 10.1	41.3 \pm 8.4	40.6 \pm 8.6
London	41.8 \pm 7.2	41.9 \pm 9.8	40.3 \pm 7.8
Years employed in mental health			
Berlin	17.2 \pm 10.0	9.7 \pm 9.5 ²	8.6 \pm 7.1 ³
London	14.6 \pm 6.7	9.6 \pm 5.8	13.5 \pm 7.5
Number of patients in caseload			
Berlin	139.8 \pm 150.0 ¹	17.8 \pm 18.0 ²	28.9 \pm 68.9 ³
London	295.2 \pm 308.2	13.0 \pm 9.8	17.7 \pm 8.2
Keyword role			
Berlin	90% ¹	97%	97%
London	63%	82%	89% ³
Shift-work			
Berlin	0 ¹	48% ^{1,2}	19% ^{3,4}
London	13%	11%	18%
On-call duty			
Berlin	53% ¹	29%	32%
London	97%	36% ²	39% ³

¹ The Scheffe test (or Chi-square in case of %) comparing same professional group by site of practice (London or Berlin) is statistically significant

² The Scheffe test (or Chi-square in case of %) comparing psychiatrists and community psychiatric nurses in the same site of practice is statistically significant

³ The Scheffe test (or Chi-square in case of %) comparing psychiatrists and social workers in the same site of practice is statistically significant

⁴ The Scheffe test (or Chi-square in case of %) comparing community psychiatric nurses and social workers in the same site of practice is statistically significant

Table 2 Activity per week for each professional group (percentage of time spent on each activity per week)

	Psychiatrists	Community psychiatric nurses	Social workers
	Mean \pm SD	Mean \pm SD	Mean \pm SD
Meetings on individual service user care			
Berlin	11.2 \pm 10.8	8.4 \pm 7.0	12.1 \pm 8.2
London	19.6 \pm 12.5	12.3 \pm 12.6	12.6 \pm 11.0
Meetings on non-direct service user care issues			
Berlin	5.3 \pm 4.1	5.7 \pm 4.6	6.9 \pm 5.2
London	6.9 \pm 6.5	7.5 \pm 9.3	9.9 \pm 10.7
Administration			
Berlin	15.5 \pm 16.3	13.5 \pm 10.4	15.8 \pm 11.6
London	12.0 \pm 7.6	16.9 \pm 8.5	22.5 \pm 11.7 ³
Travel			
Berlin	19.8 \pm 16.8 ¹	10.1 \pm 11.3 ²	10.8 \pm 8.0 ³
London	9.2 \pm 6.7	13.4 \pm 8.0	7.9 \pm 5.8
Personal training			
Berlin	4.4 \pm 4.6	7.9 \pm 8.9	4.1 \pm 7.8
London	4.5 \pm 4.6	4.9 \pm 9.3	2.7 \pm 4.0
Service user contacts in hospital			
Berlin	3.4 \pm 7.1	7.2 \pm 10.8	3.4 \pm 7.2
London	8.9 \pm 6.7	6.3 \pm 5.6	8.6 \pm 14.2
Service user contacts in day hospital			
Berlin	1.3 \pm 1.5	0.1 \pm 0.6	1.7 \pm 6.5
London	3.8 \pm 14.7	0.8 \pm 1.9	1.1 \pm 2.0
Service user contacts in community-based services			
Berlin	1.1 \pm 3.1 ¹	2.7 \pm 4.7	2.1 \pm 5.2
London	13.6 \pm 13.6	5.7 \pm 7.8 ²	5.7 \pm 7.1 ³
Contacts in patients' homes			
Berlin	20.5 \pm 22.3 ¹	5.3 \pm 6.3 ²	14.2 \pm 17.5
London	2.9 \pm 2.8	11.2 \pm 9.6	7.2 \pm 8.1
Contacts with patients elsewhere			
Berlin	5.6 \pm 11.35	21.5 \pm 20.7 ^{1,2}	11.6 \pm 12.8 ⁴
London	3.3 \pm 5.2	2.8 \pm 3.4	4.2 \pm 6.1
Contacts with employers			
Berlin	4.2 \pm 3.9	4.9 \pm 4.7	5.3 \pm 5.9
London	2.0 \pm 2.0	4.4 \pm 4.2	3.7 \pm 4.6
Contacts with other agencies			
Berlin	2.3 \pm 2.3	2.5 \pm 2.2	7.7 \pm 8.3 ^{3,4}
London	2.5 \pm 2.5	4.9 \pm 5.7	6.4 \pm 5.9
Research			
Berlin	0.0 \pm 0.0	1.6 \pm 6.3	0.0 \pm 0.0
London	4.9 \pm 7.5	1.1 \pm 2.5 ²	0.4 \pm 1.1 ³
Training other staff			
Berlin	0.4 \pm 1.1	2.1 \pm 4.5	1.2 \pm 2.7
London	3.0 \pm 2.9	3.5 \pm 5.1	2.5 \pm 8.3
Supervision			
Berlin	2.1 \pm 3.4	3.8 \pm 12.1	2.5 \pm 0.4
London	5.4 \pm 10.7	4.2 \pm 4.0	5.0 \pm 7.1

¹ The Scheffe test comparing same professional group by site of practice (London or Berlin) is statistically significant

² The Scheffe test comparing psychiatrists and community psychiatric nurses in the same site of practice is statistically significant

³ The Scheffe test comparing psychiatrists and social workers in the same site of practice is statistically significant

⁴ The Scheffe test comparing community psychiatric nurses and social workers in the same site of practice is statistically significant

team identity for the six groups of mental health professionals. Psychiatrists report more depersonalisation and lower team identity in London. CPNs show the same differences plus higher emotional exhaustion and burnout in London. SWs in London have less favourable scores

on all scales other than personal accomplishment, and they have consistently the least favourable scores of all six groups.

Table 4 shows the results of the General Linear Model Univariate predictive analysis with total scores of

Table 3 Satisfaction, burnout and team identity mean scores of professionals in Berlin and London

	Psychiatrists Mean ± SD	Community psychiatric nurses Mean ± SD	Social workers Mean ± SD	F (ANOVA)	P
Intrinsic satisfaction					
Berlin	44.9±7.5	45.3±5.5	43.6±5.7	3.39 (5.178)	0.006
London	46.5±4.8	43.6±7.9	40.0±7.7 ³		
Extrinsic satisfaction					
Berlin	26.7±5.7	26.3±4.3	25.3±4.4	5.00 (5.178)	< 0.0001
London	24.4±3.9	22.5±6.2	21.5±5.7		
Total satisfaction score					
Berlin	71.3±11.1	71.4±8.7	69.0±8.8	4.1 (5.178)	0.001
London	70.9±7.0	66.8±12.6	61.7±12.4 ³		
Emotional Exhaustion					
Berlin	18.7±8.6	15.1±7.4	17.4±7.3 ¹	5.96 (5.180)	< 0.0001
London	17.9±9.5	21.8±8.5	26.5±12.5 ³		
Depersonalisation					
Berlin	5.7±4.3 ¹	3.7±3.5 ¹	5.7±4.4	33.24 (5.179)	< 0.0001
London	11.1±5.9	15.0±5.2	18.2±9.0 ³		
Personal accomplishment					
Berlin	37.1±4.9	36.3±7.2	33.5±6.6	3.90 (5.177)	0.001
London	39.2±4.2	36.9±4.3	34.4±6.8		
Total burnout score					
Berlin	35.3±13.1	30.5±13.7 ¹	37.7±13.3 ¹	9.58 (5.174)	< 0.0001
London	37.8±17.7	48.0±16.5	58.4±27.7 ³		
Team identity					
Berlin	63.4±7.6	62.0±7.1 ¹	59.0±8.3 ¹	14.08 (5.183)	< 0.0001
London	58.9±8.3	50.0±7.7 ²	49.7±12.1 ³		

¹ The Scheffe test comparing same professional group by site of practice (London or Berlin) is statistically significant

² The Scheffe test comparing psychiatrists and community psychiatric nurses in the same site of practice is statistically significant

³ The Scheffe test comparing psychiatrists and social workers in the same site of practice is statistically significant

⁴ The Scheffe test comparing community psychiatric nurses and social workers in the same site of practice is statistically significant

Table 4 Regression and analysis of variance using General Linear Model Univariate test for burnout, job satisfaction and team identity as dependent variables^{a, b} for mental health professionals in Berlin and London

	Type III sum of squares	Mean square	df	F	P value	Partial Eta squared
Burnout						
Type of professional	12,538.82	6,269.41	2	20.72	< 0.0001	0.21
Interaction factor: site by type of professional	2,677.67	1,338.84	2	4.43	0.014	0.05
Job satisfaction						
Age	429.34	429.34	1	3.99	0.048	0.02
Type of professional	1,849.62	924.81	2	8.59	< 0.0001	0.10
Interaction factor: site by type of professional	982.65	491.32	2	4.56	0.012	0.05
Team identity						
Type of professional	4,117.92	2,058.96	2	27.99	< 0.0001	0.26

^a Variables entered as fixed factors: site of the study (Berlin/London), type of professional (psychiatrist, community psychiatric nurse, social worker), gender (male/female). Variables entered in the model as covariates: age, years employed in mental health

^b Variables presented in the table are those that had a significance level for the F-test smaller or equal to 0.05

burnout, job satisfaction and team identity as dependent variables. When the influence of personal characteristics, study site and professional identity are considered in a predictive equation, the professional group is identified as a significant predictor of each of the three aspects of morale. However, for burnout and job satisfaction, there is a significant interaction effect between site and professional identity, indicating that the differences between professional groups depend on the location. Psychiatrists in London have much more favourable scores than the other two groups, whilst this difference does not hold true – or at least not in a statistically significant way – in Berlin.

Forward stepwise multiple regression analyses showed that, independent of the study site, being a SW is a significant predictor of higher burnout ($\beta = +0.22$, $t = +3.19$, $p = 0.002$, $r^2 = 5.7$) and lower job satisfaction ($\beta = -0.19$, $t = -2.68$, $p = 0.008$, $r^2 = 2.9$), whilst being a psychiatrist is a significant predictor of higher team identity ($\beta = +0.26$, $t = +4.06$, $p < 0.0001$, $r^2 = 7.1$). Working in London is a significant predictor of higher burnout ($\beta = +0.33$, $t = +4.72$, $p < 0.0001$, $r^2 = 10.0$), lower job satisfaction ($\beta = -0.19$, $t = -2.66$, $p = 0.009$, $r^2 = 3.2$), and lower team identity ($\beta = -0.40$, $t = -6.21$, $p < 0.0001$, $r^2 = 15.4$). Being a male mental health professional is a predictor of lower burnout ($\beta = -0.17$, $t = -2.50$, $p = 0.013$, $r^2 = 2.5$), and higher team identity ($\beta = +0.18$, $t = +2.73$, $p = 0.007$, $r^2 = 2.7$).

Tables 5 and 6 show the categories of the answers to the seven open questions. Some aspects were consistently reported across all groups. Most professionals in each group regarded clinical care as a main task and enjoyed contact with patients. Also, a substantial number of respondents in each group mentioned as a main task administrative responsibilities and a managerial role (less so in CPNs and SWs in London), complained about lack of resources (less so in Berlin) and lack of time, felt competent in their clinical work (less so in London), and did not enjoy administrative responsibilities and bureaucracy. Although bureaucracy was mentioned as not as enjoyable in Berlin as in London, professionals in Berlin less often reported it as an obstacle to perform their job and did not mention it as causing pressure. Also, lack of resources was not mentioned as causing pressure in Berlin, whilst communication problems with other staff featured in all groups.

There were further differences between the sites. For example, patience in dealing with patients was reported as an important skill only in Berlin, pre-occupation with risk assessment was mentioned as causing pressure only in London, and managerial work overload featured more prominently in London. There are also specific aspects for professional groups. For instance, psychiatrists in London frequently report supervision and training as a main task of their job, enjoy the diversity and challenge of the work as well as training and teaching – and research – and mention their low pay as something they do not enjoy in their job. Also, they are the only group not mentioning teamwork as an enjoyable aspect of their job.

Discussion

Previous research has described the extent of burnout in psychiatrists (Naisbergfenning et al. 1991; Deary et al. 1996; Amstutz et al. 2001), nurses (e.g. Fagin et al. 1996) and social workers (Siefert et al. 1991; Marriott et al. 1994) in different areas of mental health care. Professionals working in community settings appear to be more vulnerable to develop burnout than staff working in hospital settings (Thornton 1992; Fagin et al. 1995; Carson et al. 1995; Prosser et al. 1996). Yet, professionals in community care have also reported higher levels of job satisfaction (Waite et al. 1995; Carson et al. 1995). The findings of this study indicate that morale with its three components – job satisfaction, burnout and team identity – varies between professional groups and contexts of health care systems. According to the criteria published by Maslach et al. (1996), the mean scores for emotional exhaustion exceeded the threshold for a burnout syndrome in CPNs and SWs in London, and the depersonalisation scores for all groups in London. Scores of emotional exhaustion and depersonalisation for the other groups and personal accomplishment scores for all groups were below the burnout threshold. Job satisfaction scores were particularly low for SWs in London and team identity scores varied with lower scores for SWs and nurses in London. Levels of personal accomplishment and emotional exhaustion in both Berlin and London, and levels of depersonalisation in Berlin, were comparable to the levels identified in other community care staff's burnout studies (Wykes et al. 1997), making our data comparable to the other studies, despite the fact that the response rates in the current study varied between 40% and 75%.

The differences between professional groups are not consistent across sites. Whilst in London psychiatrists show a much higher morale score than the other two professional groups – and SWs a particularly low one – such differences do not exist in Berlin. The situation of SWs in the UK is worth commenting on. It has been noted that local authorities have a serious problem recruiting and retaining these professionals. In an article in the national newspaper 'The Guardian' in 2000, it was pointed out that nearly two-thirds of local government authorities are short of SWs – with London and the South-East facing vacancy levels as high as 20% – because of poor pay, high stress levels, falling job satisfaction, a blame culture and a hostile working environment (<http://society.guardian.co.uk/socialcare/>). Difficulties recruiting and retaining health and social care staff, particularly SWs, remain today.

In an interpretation of the findings, various methodological shortcomings of this exploratory study have to be taken into account. The sample size for each group at each site was equal or slightly larger than 30, increasing the probability of type II error that occurs when a real difference between two groups is obscured by the small sample size (Lawrie et al. 2002). The small sample size –

Table 5 Tasks and problems reported by psychiatrists, community psychiatric nurses and social workers in London

	Psychiatrists %	Community psychiatric nurses %	Social workers %
Main tasks of the job			
Academic responsibilities	7	7	–
Administrative responsibilities	37	28	21
Clinical/care work	100	93	82
Involvement in service development	27	10	–
Management role	70	10	21
Supervision/training roles	53	–	–
Obstacles encountered to perform the job			
Bureaucracy	13	24	29
Communication problems with other staff	17	–	–
High caseload	–	48	21
Lack of resources	47	17	50
Lack of time	47	41	43
Management/administrative work overload	37	38	39
Staffing problems	3	–	–
Skills competent in to perform the job			
Academic	50	3	–
Clinical/care work	63	41	25
Communication	38	38	61
Management	47	10	21
Training	20	–	–
Skills not competent in to perform the tasks			
Assertiveness skills (with patients/staff)	13	17	25
Management/administrative skills	47	17	21
Specialised skills/knowledge	40	50	50
Stress management	13	7	–
Things respondents enjoy in their job			
Autonomy	–	45	14
Clinical work	33	–	–
Diversity/challenge of work	63	31	21
Patient contact	60	67	79
Research	20	–	–
Team work	–	41	36
Training/teaching aspect	43	3	4
Things respondents do not enjoy in their job			
Administrative responsibilities	23	–	54
Being threatened by violent patients	–	14	11
Bureaucracy	47	35	–
Lack of resources/funds	30	62	32
Low pay	47	3	–
Overwork/lack of time	33	38	32
Problems with other professionals in co-ordinating care	28	28	29
Things respondents feel cause pressure in their job			
Bureaucracy	27	35	32
Communication problems with other staff	23	27	39
Lack of resources/funds	50	62	50
Overwork/lack of time	53	38	38
Pre-occupation with risk assessment	13	7	–
Unnecessary urgent referrals	7	–	–
Violence towards staff	7	7	–

and the problem of multiple testing – was accepted because we were interested in identifying rather substantial effects and aimed to combine the questionnaire survey with simple qualitative methods. Further limitations are the cross-sectional approach, the inevitably different selection process, and the varying response rate. Community mental health teams are mainstream services in

London, and taking a job in such teams is an obvious choice for many psychiatrists, nurses and SWs. In Berlin, however, these services are an exception, so that staff represent a selection based on interests, attitudes and qualification. What impact this selection has on morale remains unclear. Also, working in an unusual setting might help to establish team identity, reduce burnout

Table 6 Tasks and problems reported by psychiatrists, community psychiatric nurses and social workers in Berlin

	Psychiatrists %	Community psychiatric nurses %	Social workers %
Main tasks of the job			
Academic responsibilities	4	–	–
Administrative responsibilities	20	30	29
Clinical/care work	100	58	76
Involvement in service development	–	10	–
Management role	60	39	74
Supervision	7	13	5
Support in and training of daily living skills	–	39	24
Obstacles encountered to perform the job			
Bureaucracy	7	3	11
Communication problems with other staff	10	7	13
Lack of co-operation by patients	–	32	37
Lack of resources	27	19	13
Lack of time	63	36	32
Management/administrative work overload			
Personal problems	10	23	16
Skills competent in to perform the job			
Clinical/care work	77	71	76
Communication	20	42	26
Experience	13	13	3
Management	33	19	34
Patience when dealing with patients	7	7	–
Practical skills	–	7	5
Assertiveness/setting boundaries for relationship with patients	–	3	5
Training	3	6	5
Skills not competent in to perform the tasks			
Assertiveness/setting boundaries for relationship with patients	13	–	8
Management/administrative skills	23	16	24
Specialised skills/knowledge	13	32	40
Stress management	–	–	3
Patience when dealing with patients	17	10	8
Things respondents enjoy in their job			
Autonomy	17	42	29
Clinical/care work	37	39	37
Diversity/challenge of work	20	7	32
Patient contact	77	77	58
Co-operation and work in committees	3	3	18
Team work	50	45	58
Training/teaching aspect	3	3	3
Positive feedback on and acknowledgement of their work	33	26	13
Social activities with patients	–	7	32
Things respondents do not enjoy in their job			
Administrative responsibilities	40	26	42
Bureaucracy	50	16	24
Helping patients in activities of daily living	–	13	10
Lack of resources/funds	17	7	8
Low pay	3	–	–
Overwork/lack of time	40	29	8
Problems with other professionals in co-ordinating care	20	23	16
Stress	7	–	5
Working unsociable hours	3	16	5
Things respondents feel cause pressure in their job			
Communication problems with other staff	20	45	40
Compulsory measures used with patients	13	–	3
General working conditions	13	13	29
Problems emanating from patient behaviour and/or characteristics	3	19	37
Problems with hierarchy	7	3	11
Violence towards staff	3	13	5

and raise job satisfaction. Moreover, the impact of these factors might differ in the three professional groups. In any case, the findings suggest that statements on morale of staff in community mental health care cannot be generalised and should be specified depending on professional identity and context. Further studies are required to identify what aspects of the context are relevant for staff morale. The significant difference between Berlin and London may be associated with features of the health care system, specific job descriptions or qualifications (e.g. better resources, higher clinical competence, and less pressure through bureaucracy reported by staff in Berlin in open questions), but might also be influenced by more general factors such as different traditions of work ethos, self-esteem of helping professions, and the reputation of community mental health care in the media and public. Such general factors may vary between and within countries.

The findings of this study allow only speculations as to what the reasons for differences in morale – not just between sites, but also between professional groups and between male and female staff – are. Reports on weekly activities are likely to have been inaccurate and biased, but still suggest that there are substantial differences between the activities of the assessed professional groups which might influence morale along with various other factors such as status, autonomy, rewards, support and stress.

The answers to the open questions reveal how professional groups in the two capitals view their job. Some views appear universal, and – not surprisingly – all groups report enjoying direct clinical work and disliking bureaucracy. Whether, in practice, it is possible to reduce bureaucracy in favour of more clinical work and contact with patients, and whether such change will indeed improve morale remains to be tested. Training in time management and team communication skills might benefit all professional groups. Various other aspects, however, are more specific to one site or one professional group and may need to be considered in training, supervision and job planning. These aspects cannot all be discussed here. The positive perception of academic work of London psychiatrists raises the question as to whether the other professional groups and their morale might also benefit from a stronger academic role with tasks in teaching and research. More in-depth studies are probably needed to explain some of the findings. For instance, without further exploration, it may be difficult to understand why London psychiatrists are the only group with frequent complaints about low pay, when in fact they have – by far – the highest salary of all six groups investigated in this study.

Staff morale and job perceptions should be routinely assessed in community mental health care and used for quality management and service development. Also, they should be investigated within mental health services research as non-specific contextual factors influencing the feasibility and outcome of interventions. For both purposes, a transparent, brief and sound method-

ology is required. Such methods should be consistently applied across different places and health care systems so that findings can be compared and interpreted. This study presents an attempt to do that, and is linked to surveys in Italy (Galeazzi et al. 2004) and Austria (Swoboda et al. a, b, in print) using a similar approach.

The findings of this study suggest that a combination of established scales and simple open questions may be a reasonable way forward to develop valid methods that can be used in routine practice and research. Once appropriate methods have been established, longitudinal measurements are required to assess changes over time and identify factors that – positively and negatively – impact on staff morale. One may conclude that more conceptual and methodological work is needed to develop a better understanding of how staff in community mental health care perceive their jobs and how morale may be improved.

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References

1. Amstutz MC, Neuenschwander M, Modestin J (2001) Burnout bei psychiatrisch tätigen Ärztinnen und Ärzten. Resultate einer empirischen Untersuchung. *Psychiatr Praxis* 8:163–167
2. Benbow S, Jolley D (1998) Psychiatrists under stress. *Psychiatr Bull* 22:1–2
3. Billings J, Johnson S, Bebbington P, Greaves A, Priebe S, Muijen M, Ryrie I, Watts J, White I, Wright C (2003) Assertive outreach teams in London: staff experiences and perceptions. *Pan-London Assertive Outreach Study Part 2*. *Br J Psychiatry* 183:139–147
4. British Medical Association (1992) *Stress and the medical profession*. BMA, London
5. Carson J, Fagin L, Ritter S (1995a) *Stress and Coping in Mental Health Nursing*. Chapman and Hall, London
6. Carson J, Barlett H, O'Malley P, de Wilde A, Brown D (1995b) Stress and coping in mental health nurses. *Psychiatric care* 3(6):235–239
7. Dancy CP, Reidy J (2002) *Statistics without Maths for Psychology*. Pearson Education Limited, England
8. Department of Health (1998) *Working together: securing a quality workforce for the NHS*. The Stationary Office, London
9. Drake M, Brumblcombe N (1999) Stress in community mental health nursing: comparing teams. *Ment Health Nurs* 19:14–19
10. Deary IJ, Agius RM, Sadler A (1996) Personality and stress in consultant psychiatrists. *Int J Soc Psychiatry* 42(4):112–123
11. Edwards D, Burnard P, Coyle D, Fothergill A, Hannigan B (2000) Stress and burnout in community mental health nursing: a review of the literature. *J Psychiatr Ment Health Nurs* 7:7–14
12. Fagin F, Carson J, Leary J, De Villiers N, Bartlett H, O'Malley P, West M, Mcelfrick S, Brown P (1996) Stress, coping and burnout in mental health nurses: findings from three research studies. *Int J Soc Psychiatry* 42(2):102–111
13. Fagin L, Brown D, Bartlett H, Leary J, Carson J (1995) The Claybury CPN under stress study. Is it more stressful to work in hospital or in the community? *J Adv Nursing* 22:1–12
14. Galeazzi GM, Delmonte S, Fakhoury WK, Priebe S (2004) Morale of mental health professionals in Community Mental Health Services of a Northern Italian Province. *Epidemiologia e Psichiatria Sociale* 13(3):191–197

15. Guthrie E, Black D (1997) Psychiatric disorder, stress and burnout. *Adv Psychiatr Treatment* 3:275–281
16. Lawrie S, McIntosh A, Rao S (2002) *Critical Appraisal for Psychiatry*. Elsevier Science Limited, Philadelphia
17. Marriott A, Sexton L, Staley D (1994) Components of job satisfaction in psychiatric social workers. *Health and Social Work* 19(3):199–205
18. Maslach C, Jackson S (1981) *Maslach Burnout Inventory Manual (Human Services Survey)*. Consulting Psychologists Press, California
19. Maslach C, Jackson S, Leiter MP (1996) *Maslach Burnout Inventory Manual, 3rd edition*. Consulting Psychologists Press, California
20. McKee V (1996) Working to a Frenzy. *The Guardian*, London, Tuesday, 1 October, p 14
21. Moore KA, Cooper CL (1996) Stress in mental health professionals: a theoretical overview. *Int J Soc Psychiatry* 42:82–89
22. Naisberg-Fennig S, Keinin G, Elizur A (1991) Personality characteristics and proneness to burnout. A study among psychiatrists. *Stress Medicine* 7:201–205
23. Onyett S, Heppleston T, Bushnell D (1994) A national survey of community mental health teams. *J Ment Health* 3:175–194
24. Priebe S, Fakhoury W, White I, Watts J, Bebbington P, Billings J, Burns T, Johnson S, Muijen M, Ryrie I, Wright C for the Pan-London Assertive Outreach Study Group (2004) Characteristics of teams, staff and patients: associations with outcomes of patients in assertive outreach. *Br J Psychiatry* 185:306–311
25. 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. *Br J Psychiatry* 170:334–338
26. Prosser D, Johnson S, Kuipers E, Szmukler G, Bebbington P, Thornicroft G (1997) Perceived sources of work stress and satisfaction among hospital and community mental health staff, and their relation to mental health, burnout and job satisfaction. *J Psychosom Res* 43(1):51–59
27. Prosser D, Johnson S, Kuipers E, Dunn G, Szmukler G, Reid Y, Bebbington P, Thornicroft G (1999) Mental health, burnout and job satisfaction in a longitudinal study of mental health staff. *Soc Psychiatry Psychiatr Epidemiol* 34:295–300
28. Rathod S, Roy L, Ramsay M, et al. (2000) A survey of stress in psychiatrists working in the Wessex region. *Psychiatr Bull* 24: 133–136
29. Rees D, Cooper C (1992) Occupational stress in health service workers in the UK. *Stress and Medicine* 8:79–90
30. Reid Y, Johnson S, Morant N, Kuipers E, Szmukler G, Thornicroft G, Bebbington P, Prosser D (1999) Explanations for stress and satisfaction in mental health professionals: a qualitative study. *Soc Psychiatry Psychiatr Epidemiol* 34(6):301–308
31. Rizzo J, House R, Lirtzman S (1970). Role conflict and ambiguity in complex organisations. *Administrative Science Quarterly* 15: 150–163
32. Seifert K, Jayaratne S, Chess WA (1991) Job satisfaction, burnout, and turnover in health care social workers. *Health and Social Work* 16(1):193–202
33. Snelgrove SR (1998) Occupational stress and job satisfaction: a comparative study of health visitors, district nurses and community psychiatric nurses. *J Nurs Management* 6:97–104
34. Swoboda H, Sibitz I, Fruhwald S, Klug G, Bauer B, Priebe S (in print) Job satisfaction and burnout among community-based mental health staff. *Psychiatrische Praxis*
35. Swoboda H, Sibitz I, Fruhwald S, Klug G, Bauer B, Priebe S (in print) How do community-based mental health staff in Austria perceive their job? A qualitative study. *Psychiatrische Praxis*
36. Thornton PI (1992) The relation of coping, appraisal, and burnout in mental health workers. *J Psychol* 126(3):261–271
37. Waite A, Oliver N, Carson J, Fagin L (1995) Job satisfaction in mental health nursing: is community or ward based work more satisfying. *Psychiatr Care* 2(5):167–170
38. Wall T, Bolden R, Borrill C, Carter A, Golya D, Hardy G, Haynes C, Rick J, Shapiro D, West M (1997) Minor psychiatric disorder in NHS trust staff: occupational and gender differences. *Br J Psychiatry* 171:519–523
39. Weiss DJ, Davis RV, England GW, Loftquist LH (1967) *Manual for the Minnesota Satisfaction Questionnaire*. University of Minnesota, Minneapolis
40. Wykes T, Stevens W, Everitt B (1997) Stress in community care teams: will it affect the sustainability of community care? *Soc Psychiatry Psychiatr Epidemiol* 32:398–407