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# Realist synthesis of factors affecting retention of staff in UK adult mental health services

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## ABSTRACT

**Objectives** The shortage of healthcare staff is a global problem. UK mental health services have, on average, a higher turnover of staff than the NHS. Factors affecting retention of this staff group need to be explored in more depth to understand what is working for whom, for what reasons and in what circumstances. This review aims to conduct a realist synthesis to explore evidence from published studies, together with stakeholder involvement to develop programme theories that hypothesise how and why retention occurs in the mental health workforce and identify additional evidence to explore and test these theories thereby highlighting any persistent gaps in understanding. This paper develops programme theories that hypothesise why retention occurs and in what context and tests these theories thereby highlighting any persistent gaps in understanding.

**Methods** Realist synthesis was used to develop programme theories for factors affecting retention of UK mental health staff. This involved: (1) stakeholder consultation and literature scoping to develop initial programme theories; (2) structured searches across six databases to identify 85 included relevant literature relating to the programme theories; and (3) analysis and synthesis to build and refine a final programme theory and logic model.

**Results** Phase I combined findings from 32 stakeholders and 24 publications to develop six initial programme theories. Phases II and III identified and synthesised evidence from 88 publications into three overarching programme theories stemming from organisational culture: interconnectedness of workload and quality of care, investment in staff support and development and involvement of staff and service users in policies and practice.

**Conclusions** Organisational culture was found to have a key underpinning effect on retention of mental health staff. This can be modified but staff need to be well supported and feel involved to derive satisfaction from their roles. Manageable workloads and being able to deliver good quality care were also key.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Realist synthesis focusses on interpretation rather than comprehensiveness.
⇒ The use of stakeholders early in the process was a strength.
⇒ The use of concepts rather than specific interventions in the synthesis improves the generalisability of the findings.

## INTRODUCTION

In 2022, the WHO called for all nations to invest in mental health workforce, with many facing shortages of trained mental health staff, with poor retention rates and low up take of new staff being trained.[1] Shortages are being seen across mental health professions, for example across much of the world's population there is just one psychiatrist to serve around 200 000 people, with the most severe shortages seen in rural areas where other mental healthcare providers who are trained to use psychosocial interventions are even scarcer.[2]

The problem of workforce retention in the UK National Health Service (NHS) is widely acknowledged and has worsened every year since 2011.[3] UK mental health services have, on average, a higher turnover of staff than the NHS as a whole (13.4% of all mental health staff left in 2018/2019 compared with 11.9% across all NHS employers) and more vacant positions.[4 5] Job satisfaction for mental health nurses is reportedly the lowest it has ever been, with many nurses emotionally and physically exhausted, leading them to consider leaving their profession.[6] In December 2021, there were 1 110 000 vacancies in the NHS, with 22% of all vacancies in mental health trusts despite only 14% of NHS spending being on mental health.[7] A recent report by the Royal Collage of Psychiatrist states that in England 9.3% vacancy rate in consultant posts and an increasing in use of locum consultant psychiatrist posts.[8] These staff shortages are known to impact patient quality of care with approximately 1.5 million people in England waiting for mental health treatment and that two-fifths of those on

mental health waiting lists, ended up receiving emergency or crisis services before receiving treatment.[9] More immediate emphasis should be placed on retaining the staff already in post as retaining experienced staff is seen to not only have the potential to improve patient care and waiting times but also has the potential to inspire a new mental health workforce to join aiding retention and boost recruitment.[6]

Previous reviews have focused on the determinants of the healthcare workforce turnover and intention to leave rather than retention, within the physical healthcare workforce[10–12] or only focused on specific mental health professions such as mental health nurses[13] and psychiatrists[14] rather than the entire workforce. Turnover and intention to leave has been associated with organisational factors such as resource allocation, leadership and pay as well as individual factors including stress and job dissatisfaction.[10 11] Stress experienced by healthcare staff appears linked to the ability to give time to patients in need, missed care and the perception of the quality of care delivered, all of which potentially impact job satisfaction an intent to leave.[15] Job dissatisfaction appears to be also strongly associated with poor retention of mental health nurses[13] and one of the key predictors of turnover of all healthcare staff. Leadership appears to have an indirect role, in that it affects the organisational culture (the set of beliefs, values and behaviours that determine an organisation's identity) which in turn affects job satisfaction.[16] For example a transformational leadership style is related to supportive work environments and staff intention to remain,[17] while a supportive and communicative leadership style leading to organisational commitment is a strong predictor of low turnover.[12]

Many of the stressors highlighted by previous reviews will be also relevant to the mental health workforce such as limited resources, job dissatisfaction, pay or poor leadership, but some stressors effecting mental health workforce retention maybe specific to this setting[13] such as the use of restraint and seclusion,[18] dealing with verbally aggressive and physical violent patient acts,[19] continuous monitoring of patients at risk of self-harm and suicide.[20] In 2018, the mental health workforce reported higher emotional exhaustion than emergency nurses and equal burnout to cancer professionals.[21] Factors affecting all mental health staff retention need to be explored in more depth to understand what is working for whom, for what reasons and in what circumstances.

This review aims to generate an in-depth understanding of not only why mental health services find it challenging to retain its clinical staff, but what retention strategies are working and in what circumstance. The review's objectives are to conduct a realist synthesis to explore evidence from published studies, together with stakeholder involvement to develop programme theories (PTs) that hypothesise how and why retention occurs in the mental health workforce and identify additional evidence to explore and test these theories thereby highlighting any persistent gaps in understanding.

## METHODS
We undertook a realist synthesis of the literature to create an overarching programme theory of the factors at an organisational, management and frontline level that influence retention and turnover of mental health staff in the UK.

### Realist methodology
A realist review is a theory-led method which seeks to understand a particular outcome through exploring the relationships between the context and the underlying causal processes (mechanisms) that lead to that outcome.[22] The realist review process is used to generate 'If–Then–Leading to' statements that provide possible explanations for the outcome of interest. For example, 'IF management ensure that staff have the time and support required to deliver needed care (Context) THEN patients engage with their care (Mechanism) and staff feel their role is meaningful and important (Mechanism) LEADING TO increased job satisfaction (Outcome) and enhanced patient outcomes (Outcome(s)). These statements, also known as Context–Mechanism–Outcome Configurations (CMOCs), are subsequently refined to produce PTs, which are then synthesised into a single overarching theory to be tested against existing studies (synthesis) or primary research (evaluation).

The realist approach was appropriate for this review as it recognises that the context within which mental health workforce retention occurs is 'complex, multifaceted and dynamic'.[23] Factors affecting this phenomenon/outcome are complex and changeable, involving various people, structures, policies and practice at different organisational levels. The effectiveness of any intervention to improve retention is contingent on diverse factors, and multiple explanations may be advanced for how these operate. This review seeks to identify the mechanisms that are activated across a variety of contexts operating at different levels (individual, team and organisational) within the healthcare system, which lead to outcomes relating to retention. Realist review methods enable exploration of this complexity and interconnectivity and enable development of a theoretical understanding of what factors influence retention within the UK mental health workforce.

The review was conducted in three phases[1]: exploratory scoping of key literature and stakeholder consultation to identify initial PTs[2]; structured searches, screening and data extraction of included studies related to each identified PT; and[3] analysis and synthesis leading to refinement of the PTs and development of a final overall PT and logic model.

No changes to the protocol were introduced during the review process. While the phases were sequential, each phase itself was iterative and went through rounds of refinement which ultimately resulted in new interpretations and the development of theory. The RAMESES (Realist and Meta-narrative Evidence Syntheses: Evolving

Standards) publication standards informed the reporting of this review.[22]

## Patient and public involvement
Phase I of the study (described below) involved extensive patient and staff involvement in the design of the research questions, particularly around priorities and experiences and in the design of the study, particularly around the structured searches.

## Phase I: exploratory scoping and stakeholder engagement
Exploratory scoping was conducted to locate and explore available evidence on what key factors might influence mental health workforce retention. Lines of inquiry included: exploring assumptions that underpin workforce retention interventions; the influence of job satisfaction on retention; and reported enablers or barriers to successful implementation of retention interventions at an organisation, management and frontline level. The purpose of this stage was to inform and shape subsequent search strategies and involved purposeful searching[24] of specific bodies of evidence based on the teams' clinical knowledge and review expertise.

Search terms related to 'healthcare personnel' were variously combined with such terms as 'retention, turnover, leavers, resignations and job satisfaction' in the Cochrane and PubMed databases and Google Scholar for grey literature. The wider review team identified and prioritised information sources that could contribute to theory-building about factors influencing workforce retention. Twenty-seven sources (see table 1) were included, including policy and guidance documents, key research literature and grey literature. All reviewers initially independently extracted data from five sample papers to ensure consistency in approach and develop extraction tables. Findings were compared and discussed until consensus was reached. Data extraction of the remaining key papers was then divided between the team. Data were extracted as 'If–Then–Leading to' statements, that is, CMOCs. Extraction only occurred when at least two components of the If–Then–Leading to' statements were present in a paper. Where complex 'If–Then–Leading to' statements were found with multiple components, these were extracted as individual statements on to an excel spreadsheet. When incomplete 'If–Then–Leading to' were extracted the team hypothesises on what the missing element might be during research meetings.

Key contexts, mechanisms and outcomes across the data were identified and agreed by the research team[25] and mapped to explore their dynamic and interconnected nature.[26] From this mapping process, initial PTs (IPT) were drawn out and refined. These were then discussed and prioritised by the reviewers, the research management group and a small panel of clinical academics (n=4), to identify a shortlist of eight initial PTs.

Two stakeholder consultation workshops were then held to obtain feedback on and further prioritisation and development of the initial PTs. Stakeholders were defined as people with experience of working in or using mental health settings and were approached via local NHS organisations research groups, professional bodies and service user groups. Thirty-one stakeholders were involved in this process: 23 mental health professionals (including doctors, nurses, occupational therapists and clinical psychologists) and 8 members of a local service user group. Both groups also suggested refinements to the wording of PTs. Following this process, six refined PTs were identified for further exploration in phase II.

## Phase II: structured searches, screening and data extraction
### Searches
Informed by phase I, search strategies to focus on each of the prioritised PTs were developed by an information specialist, who undertook the subsequent searches between March and July 2020. Search terms relating to the mental health workforce, the UK and qualitative research were combined with specific terms relating to each PT for each of the six searches. Full details of the search strategies are in online supplemental appendix tables 1 and 2. Medicine, nursing and health databases were supplemented by social science sources to cover human resource and workload aspects of the review question. The following databases were searched for literature published from 2004 onwards: MEDLINE (including Medline-in-Process and Epub ahead of print); EMBASE; CINAHL; Cochrane Library; PsycINFO; and ProQuest social science databases (including ASSIA). We included only qualitative studies of mental health staff to ensure we focused on participants' experiences and perceptions and explored rich contextual data. Duplicate references were removed. The search and screening for each PT was documented separately to enable tracking of individual records through the stages of the process.

### Sifting/screening
The review team worked with the wider project team to develop overall inclusion and exclusion criteria, as shown in table 2. These were supplemented by additional PT-specific criteria.

Four members of the team undertook title, abstract and then full text screening. Working in pairs they reviewed a common subset of approximately 20% of identified studies, comparing inclusion/exclusion and overall agreement. The high level of agreement from this process (95%) was considered justification for assigning the remaining screening to individual members of the team. Uncertainties regarding inclusion were brought to team meetings for discussion and resolution. The team met regularly throughout the screening process. Three key elements of richness, relevance and rigour were considered.[27] Screening was undertaken separately for each PT and items considered relevant to other PTs were added to the other PTs for full review. References of all full text papers were checked for additional eligible studies, which were then retrieved and screened.

**Table 1** Scoping papers included in phase I

| Area of retention (title screening) | Author and year | Study design | Workforce area | Focus |
|---|---|---|---|---|
| General retention strategies and policies | Brook et al 2019 *[35] | Systematic review | General healthcare workforce | Retention and turnover of early career nurses |
| | Loan-Clarke et al 2010[36] | Longitudinal study (UK) | General healthcare workforce | Retention and turnover allied health professionals |
| | Dieleman et al 2011*[37] | Realist review | General healthcare workforce | Rural health workers retention |
| | Drennan et al 2015[38] | Project report: mixed-methods (UK) | General healthcare workforce | Adult nurse turnover and retention |
| | Efendi et al 2019*[39] | Concept analysis review | General healthcare workforce | Nurse retention |
| | Halter et al 2017*[40] | Systematic review of systematic reviews | General healthcare workforce | Nursing turnover |
| Workforce well-being | Holland et al 2018[41] | Cross sectional survey (Australia) | General healthcare workforce | Nurses and midwives well-being |
| | Johnson et al 2018*[42] | Narrative review | Mental healthcare workforce | Mental healthcare staff well-being and burnout |
| | Morse et al 2012[43] | Literature review | Mental healthcare workforce | Mental healthcare staff burnout |
| | Tomietto et al 2019[44] | Cross-sectional validated questionnaire (European) | General healthcare workforce | Nurse well-being and engagement |
| Leadership | Hartviksen et al 2019[45] | Systematic review and meta-synthesis | General healthcare workforce | Healthcare middle managers' capability and capability |
| | Kleinman 2004[46] | Literature review | General healthcare workforce | Leadership in staff nurse retention strategy |
| Workplace environment | Jelfs et al 2014[47] | Literature review | General healthcare workforce | Retention strategies in healthcare organisations |
| | Redknap et al 2015[48] | Literature review | Mental healthcare workforce | Mental health nurse retention and practice environment |
| | Twigg and McCullough 2014[49] | Literature review | General healthcare workforce | Nurse retention and strategies to enhance positive practice environments |
| Workforce training and development | Edwards et al 2015[50] | Systematic review | General healthcare workforce | Transition and support for student and preceptorship nurses |
| | Morse et al 2012[43] | Literature review | Mental healthcare workforce | Burnout |
| | Williams et al 2016[51] | Realist review | General healthcare workforce | Workforce development interventions |
| | Zhang et al 2016[52] | Systematic review | General healthcare workforce | mentoring programme for newly graduated nurses |
| Workforce satisfaction and retention | Duffield et al 2009[53] | Cross-sectional survey (Australia) | General healthcare workforce | Staff satisfaction and retention and nursing unit manager role |
| | Duffield et al 2011[54] | Cross-sectional survey (Australia) | General healthcare workforce | Nursing unit manager, retention, and work environment. |
| | Rafferty et al 2018[55] | Literature review | General healthcare workforce | Nurse drift and dilution |
| | Salie and Schlechter 2012[56] | Evaluation (South Africa) | General workforce | Staff reward and recognition programme |
| Organisational factors | Okello and Gilson 2015[57] | Systematic review | General healthcare workforce | Relationships and motivation in the health sector |

Continued

**Table 1**  Continued

| Area of retention (title screening) | Author and year | Study design | Workforce area | Focus |
|---|---|---|---|---|
| Recruitment | Dolea et al 2010[58] | Literature review | General healthcare workforce | Strategies to attract and retain of health workers in remote and rural areas |
| | Kroezen et al 2015[59] | Review and case study (European) | General healthcare workforce | Recruitment and retention interventions |
| Safe staffing | Ball et al 2019[60] | Survey, national data, case studies and realist evaluation (UK) | General healthcare workforce | Safe staffing, impact and implications |

*Key papers.

## Data extraction

Study characteristics were extracted into bespoke data extraction forms (one for each PT) by three members of the team. Data extracted included: authors, year, nation (England, Wales etc), patient group, setting, type and number of staff involved in the research, data collection method, findings, limitations, and illustrative quotes.

Where papers were relevant to multiple PTs data, relevant data were added simultaneously to the different PT data extraction tables. The quantity and richness of relevant data varied considerably, with only very limited data being relevant in some cases for example, mixed-methods studies or surveys with open questions. Judgements on study quality were deferred until later stages of analysis.

Team members then used the data extraction table to identify key factors and issues from each PT. These key themes, informed by team member knowledge, were then used to inform the next stage of the review.

## Phase III: analysis and synthesis

Data synthesis was undertaken by three team members. Each team member independently summarised the key CMOCs from the data extraction and developed logic models to describe the PTs for which they had undertaken data extraction and were therefore most familiar with. This was done by starting with one CMOC and then looking for interconnections with others, until all had been incorporated into one large logic model. This was repeatedly refined to ensure overlapping elements were removed (eg, risk and safety are two sides of the same issue so were merged). Some of the CMOCs led on to each other meaning one outcome became the context for other CMOC. The logic model was refined to address this complexity. Findings were discussed within the wider team and logic model development was undertaken in consultation with the team methodologist.[28 29] These discussions assisted the refinement of the PTs, ensuring they were plausible, grounded in the evidence and comprehensible.

**Table 2**  Inclusion/exclusion criteria

| | Included | Excluded |
|---|---|---|
| Type of literature | Peer-reviewed studies English language | |
| | Primary qualitative research Qualitative components of mixed-methods studies | Systematic reviews Quantitative only studies |
| Setting/patients | Any adult mental health service including inpatient, outpatient and community Dementia services, if part of a mental health service Wider studies where mental health-specific data can be extracted | Children and Adolescent mental health services (CAMHS) Drug treatment and learning disability services, if not provided by mental health professionals Social care settings General healthcare settings providing treatment to mental health patients for example, Emergency department (ED), general pracitce (GP) |
| Staff groups | All grades and types of registered mental health professionals (including nurses, doctors, occupational therapists, psychiatrists) | Non-registered and non-clinical staff (eg, care assistants, porters, administrative staff) |
| Geographical area | UK, ie, England, Northern Ireland, Scotland, Wales or where UK-specific data can be extracted | All other countries |
| Date | 2004, with particular focus on 2010 onwards | |

The team also reviewed whether the findings from this process suggested the need to modify or further develop the existing PTs, including identifying connections and overlaps between the PTs. As a result, the six individual PTs were refined and assimilated within three integrated key PTs which the team considered more accurately provided a whole systems perspective on the issues relating to staff retention. While other PTs could be seen to be operating, these three appeared to be the key drivers, and a single overarching logic model was then developed to illustrate the interconnectedness and complexity of these refined PTs. One team member initially drafted this model, which was progressively refined and simplified through multiple iterations within the review team and wider advisory team to clarify and accentuate the key findings. This process in turn led to the reformulating of the six 'If–Then–Leading to' statements created in phase I to create three new more clearly articulated core PTs. Throughout this process, the team ensured that the evolving PTs remained underpinned by the literature and informed by the findings of the previous stages of the review.

## RESULTS

### Phase I findings: identification of initial PTs

Phase I led to prioritising of six PTs for further exploration in phase II searches: perceived quality of patient care delivered; workload and staffing levels; team relationships and cohesion; leadership; development opportunities; and supervision. These PTs were formally articulated in the CMOC format of IF–THEN–LEADING TO, see table 3.

### Phase II findings: characteristics of included studies from structured searches

In total 3277 titles and abstracts were screened leading to full text review of 383 articles and final identification of 88 relevant papers across all six PTs, with many included papers being relevant to more than one PT. The main exclusion reasons at this stage were lack of identifiable results relating to mental health staff, lack of qualitative findings and not relevant to the UK context. Only three full texts were excluded due to being unobtainable. Numbers of full text articles included for each PT were as follows: Workload: 26; Quality of Care: 37; Team Cohesion: 41; Leadership: 13; Development: 36; Supervision: 27 (categories are not mutually exclusive). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram in figure 1 shows numbers of papers identified for each search and for final inclusion.

The large majority (71, 81%) of papers had been published since 2010, with the remainder (17, 19%) between 2004 and 2009. Papers predominantly reported studies in England (65, 74%), with another 13 (15%) covering more than one nation or the UK as a whole. Very few related specifically to the other nations (Scotland 2, Wales 2, Northern Ireland 1). The predominant data collection methods were interviews (54, 61%), surveys or questionnaires (21, 24%) or focus groups (18, 20%), with

some studies employing more than one approach. Study size varied widely depending on the method used, with some surveys including several hundred people while some interview studies included less than 10 participants. Participants were often drawn from a variety of professions (38, 43%); where they focused on a single group, nurses were most common (26, 30%). Eight studies included patient views. Where the setting was specified, studies were approximately evenly split between inpatient and community. Details in relation to all the above characteristics were not always reported, but was only missing for a few studies except for study setting (33, 38%).

A full list of included papers mapped to their respective PTs is presented in online supplemental appendix table 3.

### Phase III findings: final PTs and logic model

The three core PTs finally identified were interconnectedness of workload and quality of care, investment in staff support and development and involvement of staff and service users in development of policies and practice. Figure 2 presents these PTs within the final overarching logic model developed to offer a holistic picture of what is required to encourage best practice for retention of the mental health workforce.

### Revised programme theory

From the initial PTs in phase I the hypothesis was that if interventions were focused on specific contexts (such as supervision, quality of care, team leadership) it would result in improving retention within the mental health workforce. However, while refining the PTs it became apparent that many of these, we had labelled contexts, were actually occurring further downstream as mechanisms and outcomes, proceeded by organisational contexts fundamental to change.

### Interconnectedness of workload and quality of care

In the early stages of the review, workload and the quality of care were identified as related, but ultimately different, concepts and assigned to separate initial PTs. As the review progressed and the wider literature was explored, we found that the two concepts were inseparable and were two aspects of the same critical driver of retention. When workload is high, due to acuity and staff shortages, staff feel they have to deliver lower quality care in order to be able to manage extended demands on their time. In relation to workload, the included studies considered not only the number of qualified staff on the ward or in community mental health services but also the experience level of those staff and if they were regular or temporary such as bank or agency staff. If the organisation did not prioritise strategies to manage these aspects of workload, then mechanisms such as perception of delivering high-quality care, ability to make a difference and therapeutic relationships were negatively affected. As most health professionals are motivated, at least in part, by a desire to help their patients, the realisation that working conditions are having a detrimental effect on their ability to

**Table 3** Initial programme theories developed during exploratory scoping and stakeholder engagement

| Initial programme theories (IF–THEN–LEADING TO statements) | Evidence from preliminary scoping and supporting references and stakeholder workshop |
|---|---|
| **PT1 Perceived quality of patient care**<br>IF staff have the time and support to deliver the care to their patients that meets their expectations. THEN patients are more likely to engage, and staff will feel the job is meaningful and important LEADING TO improved job satisfaction and better patient outcomes. | **Summary:**<br>Perceived quality of patient care increases job satisfaction.<br>**References:**<br>Brook et al, Dieleman, Johnson et al 2017; Williams et al 2016 (online supplemental appendix table 3)<br>**Stakeholders example quote:**<br>*When the demands outstrip the capacity of the person to meet them burnout and failures in care are inevitable. This is a systemic problem though, not a failure of individual resilience; no one could possibly have the resilience to continuously meet these demands and expectations. Qualtrics 2020 (anonymous IAPT staff)* |
| **PT2 Leadership**<br>IF team leaders are trained to be good communicators and effective problem solvers THEN frontline staff will have good role models who are accessible and that they trust and can aspire to, LEADING TO increased confidence and job satisfaction. | **Summary**:<br>Good Leadership leads to increased staff commitment, feeling valued and confidence in leadership.<br>**References:**<br>Ball et al 2019, Drennan et al 2015, Halter et al 2017, Hartviksen et al, Jelfs et al 2014, Johnson et al 2017, Kleinman 2004, Redknap et al 2015.<br>**Stakeholders example quote:**<br>*feeling valued and getting positive feedback for good work* - Padlet 2019 Anonymous research champion event.<br>*Recognition from management that we are doing a good job-* Qualtrics 2020 Anonymous MH nurse |
| **PT3 Supervision**<br>IF team leaders are able to offer regular, meaningful and supportive supervision THEN frontline staff will feel supported and less isolated LEADING to better job satisfaction and less stress | **Summary:**<br>Supervision needs to be **r**egular, meaningful and supportive to enable staff to feel supported and increase competence.<br>**References:**<br>Dolea et al 2010, Drennan et al 2015, Halter et al 2017, Jelfs et al 2014, Morse et al 2012<br>**Stakeholders example quote**:<br>*I have ranked supervision low but it probably should be higher. Mine is a waste of time, if it even happens. My supervisor (is) inconsistent and totally demotivating… I get my support from elsewhere* - Qualtrics 2020 ANONYMOUS theory development stakeholder event. |
| **PT4 Training and development**<br>IF an organisation offers a range of training and development opportunities for staff, WITH time/support allocated to complete, THEN staff will feel more competent and confident in their own abilities LEADING TO better perceived patient care and increase in job satisfaction. | **Summary**:<br>Development opportunities leads to loyal, skilled, confident staff who want to work for the organisation that invests in them<br>**References:**<br>Ball et al 2019, Brook et al 2019, Dieleman et al 2011, Drennan et al 2015, Efendi et al 2018, Jelfs et al 2014, Kleinman et al 2004, Morse et al 2012, Williams et al 2016<br>**Stakeholders example quote:**<br>*I think feeling you are on a career trajectory is important and might need to be pulled out more explicitly.* - Qualtrics 2020 Anonymous Allied health professional (AHP) |
| **PT5 Workload**<br>IF an organisation (has the policies in place) to ensure all its teams are meeting safe staffing levels THEN staff will have the capacity to deliver the quality of care they expect to LEADING TO less burnout/emotional stress/increased retention. | **Summary:**<br>Safe workload and staffing levels enable staff to deliver high quality care.<br>**References:**<br>Ball et al 2019, Duffield et al, Halter et al, Jelfs et al 2014, Johnson et al, Morse et al 2012<br>**Stakeholders example quote**:<br>*'When the demands outstrip the capacity of the person to meet them burnout and failures in care are inevitable'* Qualtrics 2020 Anonymous Nurse. |
| **PT6 Team cohesion**<br>IF frontline team cohesion is prioritised THEN staff feel less isolated, increase sense of peer support and sense of belonging LEADING TO Staff less likely to leave/turnover reduced. | **Summary:**<br>Team relationships and cohesion leads to staff less likely to leave/turnover reduced.<br>**References**:<br>Drennan et al 2015, Efendi et al 2018<br>**Stakeholders example quote**:<br>*'Feeling valued and respected as part of your team'* Qualtrics 2020 Anonymous AHP |
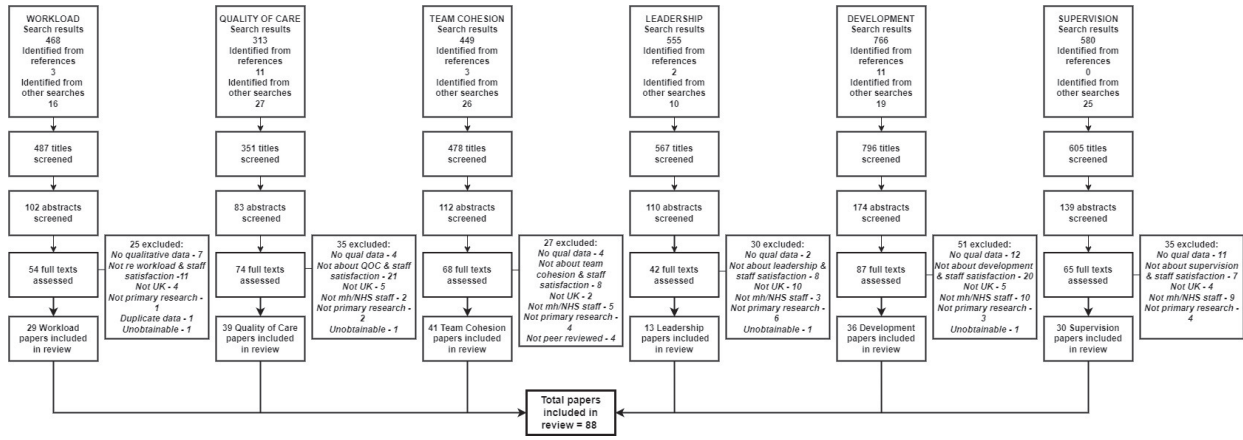
**Figure 1** Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram of included studies. NHS, National Health Service.
mh= mental health, QOC = quality of care

make a difference leads to reduced job satisfaction and in the longer term if it continues, reduced staff morale and intention to leave.

Table 4 contains the final statements and supporting evidence.

### Investment in staff support and development

Where organisations have developed effective structures for staff support such as supervision and offer training and development opportunities, staff felt more valued

and confident in their clinical skills and subsequent quality of care provided. In phase I, we considered that different elements of investment in staff, such as high-quality supervision and training and development opportunities, constituted separate PTs. Subsequent review of the wider literature led us to conclude that these are all elements of the same organisational contextual factor. An organisation that invests in its staff, to ensure that they are supported, enriched and feel valued, is likely to
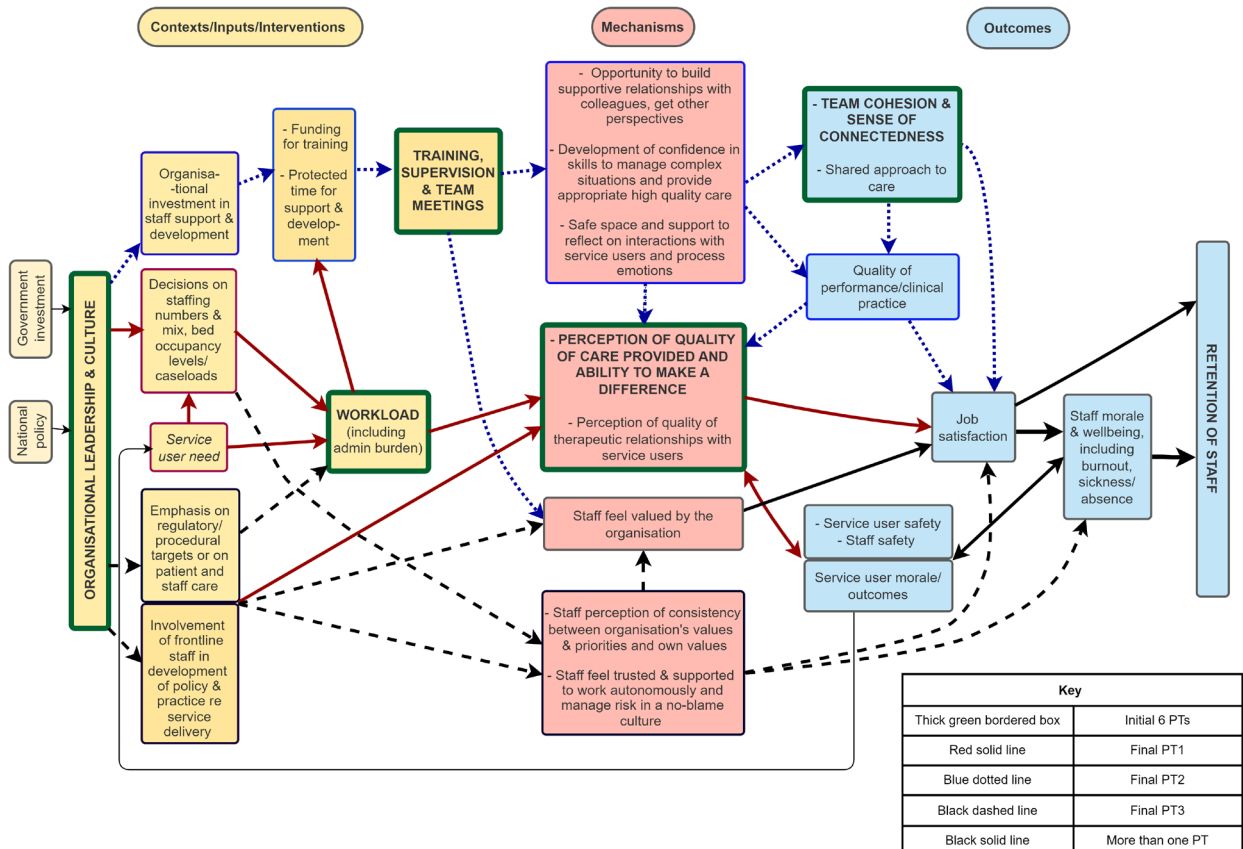


**Figure 2** The logic model of factors affecting the retention of mental health staff.

**Table 4** Phase IIII: refined 'IF… THEN…LEADING TO…' statements with evidence

| Brief title | Full If Then Leading |
|---|---|
| **Interconnectedness of workload and quality of care** | IF the organisation's leadership prioritises safe staffing levels to meet service user acuity and numbers (including a suitable balance of permanent and temporary staff on wards, capped caseloads in the community, and an appropriate mix of staff professions and experience) (context). THEN clinical staff perceive they have a manageable workload to enable them to deliver high-quality care, build therapeutic relationships and make a difference to service users (mechanisms). This LEADS TO increased job satisfaction, improved safety and morale (for staff and service users); reduced stress and burnout and increased staff retention (outcomes). |
| **Investment in staff support and development** | IF the organisation's leadership invests in the support and development of clinical staff (including protected time for quality supervision and regular supportive team meetings; and time and funding to undertake professional development) (context). THEN staff feel confident that they have the appropriate skills to provide high-quality care; have appropriate support to reflect on practice and process emotions; and believe they are valued members of the team and organisation (mechanisms). This LEADS TO improved clinical practice, better team relationships and a collaborative approach to service users' care; increased job satisfaction, improved morale; reduced stress and burnout and increased staff retention (outcomes). |
| **Involvement of staff and service users in policies and practice** | IF the organisation's leadership develops policies and practices which are informed by and involve clinical staff and service users in decisions about the delivery of services and prioritise targets relating to service user care and staff well-being (context). THEN staff feel listened to and valued, and perceive that the organisation's values align with their own (ie, focusing on clinical need rather than targets and financial considerations) (mechanisms). This LEADS TO increased job satisfaction, improved morale; reduced stress and burnout and increased staff retention (outcomes). |

also invest in clinical supervision and training and development opportunities. The level of investment and the priority given to it therefore provides a key context, which then triggers mechanisms relating to staff feeling valued and supported and more able to deliver high-quality care. Outcomes may be as diverse as impacts on patient care (better trained staff deliver better care) and staff morale, both of which lead to greater job satisfaction and improved retention.

### Involvement of staff and service users in development of policies and practice

The processes of organisational policy development were not initially identified as a PT in phase I, however closer exploration of the literature revealed that these are key and underpin many other activities. If policies and practices of an organisation are developed using input from frontline staff and patients then they will be perceived to be directly relevant to what is important to those groups, they will feel included, valued and supported. In contrast, in situations such as where there is a perceived clash of values, for example when management are perceived as being very focused on financially driven targets rather than patient or staff well-being, these triggers mechanisms relating to not feeling valued, and a lack of consistency between their own values and those of the organisation. This leads to poorer job satisfaction and morale, both of which directly impact on retention.

### DISCUSSION

The aim of our realist review was to identify, from the published literature and stakeholder priorities, which factors are affecting the retention of mental health staff in UK adult services, in what contexts these factors operate and for what reasons. This can potentially increase understanding to help organisations design and implement more effective, evidence-based retention strategies and interventions. The review findings enabled the development of a programme theory incorporating three key processes which influence the retention of mental health staff. First, if organisations enable safe workload/staffing levels, staff perceive that they can provide high-quality patient care. Second, if organisations invest in training, development and protected supervision, staff feel valued and more able to provide good patient care. Finally, if the organisation's policies and practices are informed by and congruent with staff values and prioritise patient and staff well-being, staff feel valued and supported. These processes re all vital to job satisfaction and successful staff retention.

The programme theory also allows the development of hypotheses of why things might not work and in what circumstance. Much of the included literature in this review focused on interventions targeted at individuals rather than at a team or an organisational level. The lack of workforce retention interventions focusing on the interconnectedness of individual, team and organisation has previously been highlighted in reviews targeting single professions such as nursing[10] and doctors.[30]

In line with the Kings Fund 2022 statement that workforce strategies cannot be looked at in isolation, the programme theory developed in this review suggests that retention interventions which are focused on frontline individual staff stress and resilience levels are likely to have minimal success and only short-term gain.[31] This is supported by Foster et al[32] who found that while individual

retention interventions were positively received by frontline staff they led only to short-term gains and highlighted the need for organisational issues to be addressed.[32] Therefore, while interventions focusing on individuals or teams may have some effect on job satisfaction, to be effective in the longer-term healthcare workforce retention strategies must be mapped back through the IF, THEN, LEADING to statements and refocused further 'upstream'.

This review suggests organisational culture is the foundation for successful healthcare workforce retention and the key context for any mechanisms to be activated or not.

If this is the case, then significant change in retention levels requires organisational culture to be the primary focus of positive change. Previous literature has identified that interventions that address organisational and professional issues simultaneously are more likely to be successful[30]; our review would go one step further to suggest that organisational change is a necessary precondition for positive and effective change downstream. This potentially has significant implications for healthcare organisation decisions on where to prioritise their workforce retention interventions.

Job satisfaction has been well documented as a strong predictor of turnover intent.[33 34] This paper employed job satisfaction as a proxy to retention, its position in the final programme theory as a director precursor outcome to staff burnout, sickness and finally to staff retention. All three 'If–Then–Leading to' statements tracked through job satisfaction, suggesting it may be a useful measure for measuring effectiveness of any retention interventions.

## Strengths and limitations

Using a realist approach is considered a strength as realist synthesis privileges relevant, rich and rigorous literature with the focus on depth and breadth of understanding. An added strength was the inclusion of job satisfaction in the search terms as a proxy for retention, which widened the search strategies to enable a more comprehensive search of relevant literature. However, the team acknowledged that the priority for synthesis was interpretation rather than ensuring the most comprehensive identification of information and is possible that other relevant evidence may have been missed or overlooked.

Another strength of the study is the embedding of stakeholders within phase I to aid development, prioritisation, refining and testing of the initial emerging PTs. The inclusion of diverse healthcare personnel, service users and academics ensured that the widest range of differing perspectives as possible was taken into account within the review process.

Although the mental health workforce is highly diverse in profession and setting, much of the included research was conducted in inpatient settings, and the resulting theory is therefore mostly based on this context. Despite the review only including mental health settings, and most of that being inpatient, the findings are potentially generalisable to other settings. For example, staffing is a retention issue in many healthcare settings. However, staffing issues in mental health contexts bring specific challenges that may not exist elsewhere, such as increased risk of violence, aggression, and self-harm.

The focus on UK NHS staff experience helped to reduce the volume of potentially relevant literature and provided a specific context for the findings but may also have limited international generalisability. However, the exploration of underlying mechanisms, rather than specific interventions, helps to increase the potential transferability of the findings. Healthcare staff retention is a complex phenomenon and other causal relationships may be present in the data and more influential in other contexts (including different countries and different healthcare settings).

## Future research and recommendations

Research is needed to test the programme theory, looking at how upstream organisational changes may have a knock-on effect allowing a multiple of mechanisms to be fired in to action and looking at ways to measure the downstream effect such as job satisfaction as a proxy for staff retention. The reviewed highlighted significantly less published literature on leaderships impact on job satisfaction and retention than the other five IPTs despite the high weighting stakeholders gave this IPT.

Additionally, all the included studies were conducted in the UK, it is not known if this programme theory is applicable to both low and high resource settings. The PTs require further testing against data from low-income and middle-income countries.

Research papers looked at the opinions and satisfaction of staff who were still employed within their respective trust. No studies included in the review focussed on those staff who had already left and why.

## CONCLUSIONS

This realist review facilitated the construction of robust, evidence-based and stakeholder informed PTs about the mechanisms underlying mental health workforce retention. These explanations hold the potential to support the future development and delivery of effective retention strategies and interventions. The logic model illustrates the interconnectivity of the three overarching theories. Findings highlight the importance of organisation context as preceding and activating mechanisms to produce particular retention outcomes. The findings further suggest that workforce retention interventions may need to first focus on organisational policy changes which can influence context to achieve an effect downstream.

Retention interventions which focus on 'outcomes' such as team cohesion may have some influence on outcomes. However, much of the evidence explored workload and staff development, so often the product of organisational decision-making. Frontline reconfigurations and individual-level interventions cannot help

in the long term if organisations do not demonstrate to their staff that they are valued and supported to make a difference to patients. 'Demonstrate' is key here, if staff do not feel valued and supported, then changes will be resisted.

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Appendix

ROMHS search

Searches for each PT were run in sequence over a period of several months (from March to July 2020) but were imported into a shared EndNote library making it easier to identify which results had been seen previously (given that some overlap was anticipated in the results for each PT). Where the review team identified a record of potential interest to a different PT, tags were added to indicate this.

Searches covered MEDLINE (including Medline-in-Process and Epub ahead of print); EMBASE; CINAHL; The Cochrane Library; PsycINFO; and ProQuest social science databases (including ASSIA).

The aim was to sample the literature across a wide range of disciplines using a structured literature search prioritising specificity over sensitivity.

Every search was built around the following common facets (with indicative search terms):

Appendix Table 1:

| Mental Health workforce | AND | UK | AND | Qualitative |
|---|---|---|---|---|
| Psychiatrist OR counsel?or OR Psychologist<br><br>OR<br><br>((health personnel OR health worker OR nurs* OR doctor* OR team OR staff OR counsel?or OR psychologist*) AND (mental health or psychiatr*)) | | United Kingdom OR UK OR Brit* OR England OR Scotland OR Wales OR (Northern) Ireland OR NHS | | Qualitative OR interview OR in-depth OR findings OR focus group* OR experience* OR perspective* OR view* OR opinion* |

For each programme theory, a fourth facet was added to the search, as follows:

Appendix table 2:

| Workload and staffing levels* | workload or work load or case load or caseload or bed occupancy or understaff* or under-staff* or<br><br>((staff* or team or workforce or workplace) adj3 (level* or ratio* or capacity or management or resourc* or model* or program* or policy or policies or number* or mix* or rota* or rosta* or roster* or schedul* or overtime or supervision or supervisory or administration or administrative or organization or organisation or turnover or "co-ordination")) or |
|---|---|

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| | ((staff* or team* or workforce or workplace) adj3 (experienced or inexperienced or competen* or sufficient* or sufficiency or adequate* or knowledge or adequac* or target* or insufficient* or insufficienc* or inadequate* or inadequac* or short or shortage or efficient* or efficienc* or inefficien*)) |
|---|---|
| Perceived quality of patient care* | ((quality or opinion* or evaluat* or satisf*) adj3 care) OR exp "Quality of Health Care"/<br>AND<br>exp Health Personnel Attitudes/ or (perception* or perspective* or perceived or opinion* or attitude* or view* or assessment* or evaluation* or belie* or consider* or guilt* or worry* or worrie* or concerned or doubt* or anxi* or satisf*) adj3 (staff or nurs* or worker* or doctor* or psychologist* or counsel?or*) |
| Team relationships and cohesion | (team* adj2 (cohe* or cultur* or support*)) or (support* adj3 (peer* or colleague* or coworker* or co-worker* or supervisor*)) or ((colleague* or coworker* or co-worker* or team*) adj2 relat*) |
| Leadership | leader* or management style or senior manage* or governance or strateg* or board or executive or chief operating officer* or CEO or "head* of department*" or organizational culture/ or ((culture adj2 organi#ation*) or supportive culture or "no blame" or crisis manag* or risk avers* or whistle blow* or whistleblow* or ((policy or policies) adj2 (local* or organi#ation* or trust*))) |
| Development opportunities* | Career progression or<br>Develop* adj3 (opportunit* or career* or profession* or staff or training) |
| Supervision | |

*for these topics, due to the high volume of results, an additional facet was introduced to the search focusing on "burnout" / resilience / retention / job satisfaction / motivation / morale since these were the primary outcomes in which we were interested.

An example search strategy (the MEDLINE search for the PT on development) is presented below:

Database: Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions(R) <1946 to July 02, 2020>

Search Strategy:

--------------------------------------------------------------------------------

1    exp Interview/ or (interview* or findings or qualitative).mp. (2495859)

2    qualitative research/ or (qualitative or in-depth or interview* or "focus group*" or ((staff or worker* or nurs* or team*) adj3 (experience* or perspective* or view* or opinion*))).mp. (624643)

3    1 or 2 (2561987)

4    exp Great Britain/ (364282)

5    (national health service* or nhs*).ti,ab,in. (195576)

6    (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab. (94886)

7    (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in. (2060497)

8    4 or 5 or 6 or 7 (2319489)

9    (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or expoceania/) not (exp great britain/ or europe/) (2703362)

10    8 not 9 (2212138)

11    exp mental health personnel/ or (psychiatrist* or counsel?or* or psychologist*).mp. (47270)

12    exp Health Personnel/ or exp Health Personnel Attitudes/ or exp Medical Personnel/ or (nurs* or doctor* or occupational therapist* or care worker* or frontline or front-line or team* or staff).ti,hw. (1054880)

13    exp Psychiatric Hospitals/ or exp Psychiatry/ or exp Mental Health Services/ or exp Community Mental Health Services/ (208892)

14    (nursing home* or care home* or dementia care or ((mental health or psychiatr*) adj2 (ward* or service* or clinic))).mp. (123939)

15    12 and (13 or 14) (80386)

16    11 or 15 (123212)

17    (UK or united kingdom or brit* or england or scotland or wales or ireland or london or edinburgh or belfast or NHS or national health service or manchester or leeds or newcastle or sheffield or birmingham or bristol).mp,cp. (7156248)

18    (burnout or burn* out or occupational stress or overwork* or over work* or impact on staff or absen* or strain or presentee* or morale or motivation or (staff adj2 (wellbeing or well-being or outcome*))).mp. (1313085)

19    exp Health Personnel Attitudes/ (157883)

20    (burn* out or burnout or motivat* or morale or demoral* or demotivat*).mp. (193994)

21    (demotivat* or demorali* or job satisfaction or job strain).mp. (30268)

22    20 or 21 (216792)

23    3 or 19 (2677388)

24    10 or 17 (7871000)

25    23 and 24 (819537)

26    18 or 20 or 21 (1390639)

27    16 and 25 (14014)

28    (develop* adj2 (opportunit* or career* or profession* or staff or training)).mp. (35119)

29    (career adj2 progress*).ti,ab,hw,kw. (684)

30    CPD.mp. (6094)

31    ((staff or nurs* or team*) adj2 (train* or course* or workshop*)).mp. (23813)

32    28 or 29 or 30 (41043)

33    28 or 29 or 30 or 31 (63842)

34    27 and 33 (710)

35    limit 34 to (english language and yr="2004 -Current") (588)

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Appendix Table 3: Phase 2 included papers and their key findings

| Author, date & country | Patient group & setting | Staff group, number & data collection method | PTs | Key findings |
|---|---|---|---|---|
| 1 Abendstem et al 2014*[1] England | Older people Community | Mostly team managers (376) Survey | Team cohesion Workload | Too few staff creates stress within teams – working to capacity, no time for reflection, not able to provide the service needed, person-centred approach. Inefficient admin systems impacted on morale, took time away from clinical work. Importance of supportive relationships within teams, shared approaches to decision-making – reduces vulnerability. Clarifying roles of different professionals important, including team leader. Importance of regular, structured supervision. |
| 2 Abendstem et al 2016*[1] England | Older people Community | Various (42) Interviews | Team cohesion | Social workers valued within teams as bringing specific skills, knowledge and values – balanced out medical model. Importance of them being integrated within the teams, having shared understanding. Enables provision of better service – more knowledge of external resources and processes for referral → quicker access, more joined-up provision. |
| 3 Abendstem et al 2017*[1] England | Older people Community | OTs (5) Interviews | Workload Quality of care Supervision | Work more restricted due to bigger caseloads, shorter timescales, limits to role, faster discharge → unable to do work properly. Supervision potentially helpful but not always available due to lack of appropriate people in team. Have to find supervision for themselves. |
| 4 Allen et al 2020 England | Not specified In-patient | Various Evaluation form (number unclear) & focus group (9) | Team cohesion | Schwartz rounds valued for offering opportunity to express emotion (particularly negative emotions re patients), share experiences and feel validated and supported by colleagues, develop emotional literacy. Importance of providing ongoing forum for this, as part of being a compassionate organisation to work in. Work patterns made it difficult for people to access/attend for whole time. |
| 5 Baker et al 2019 | Various In-patient & community | Various (21) Interviews | Workload Quality of care Supervision | Vicious cycle: understaffing → chronic understaffing (sickness, poor recruitment & retention, use of agency staff) → unsafe staffing. Not just numbers – skill level and experience important. Agency staff lack knowledge of patients, limited in what they |

| | | | | |
|---|---|---|---|---|
| UK | | | | can do, variable quality, so permanent staff feel unable to rely on them – can make the situation worse.  No agency cover when community staff off.  Increased admin burden takes time which doesn't contribute to patient care.  Long waits for treatment in community → people more ill before they get help, more safety concerns (patients and staff).  Continuity of care disrupted by staff changes → unable to build therapeutic relationships that are key to recovery and care (in-patient & community).  Unable to work proactively to prevent problems.  Inability to provide good enough care undermines confidence & motivation.  No time/emotional capacity/motivation to reflect, attend training, supervision. |
| 6 Barnicot et al 2017 England | Not specified In-patient: acute | Various staff (31),  patients (28) Interviews | Team cohesion | Conflict between privacy and safety when introducing continuous observation – potentially damaging intervention, undermining trust and recovery, stressful for staff, reduces capacity to meet other patients' needs.  Short-term solution, especially used when don't know patients well – busy ward makes it hard to build relationships, or find more collaborative solutions.  Concern re blame → caution.  Importance of staff supporting each other in positive risk-taking, consistent approach, reducing stress through training and support, |
| 7 Baskind et al 2010 England & Wales | Adult In-patient | 'Lead contact', probably nurses (8) Interviews | Quality of care Team cohesion | Re accreditation programme.  Clear standards beneficial – clear guidance on practice e.g. 15 minute one-to-one contact time with patients – often done previously but not routine or recorded properly.  Improved communication, helped staff negotiate for more resources.  Good to be rewarded, gave a boost to think work was being recognised.  Better team working helped bring staff together, prevented people feeling marginalised. |
| 8 Bee et al 2005 England | Psychosis & bipolar In-patient: acute | Nurses and nursing assistants (54) Focus groups & questionnaire | Development Quality of care Workload | Re specialist training.  Value of meeting others, sharing experiences, reassured that others have similar problems, explore different solutions – reduced isolation. Challenges of mixed skill group – level not always appropriate, unqualified staff felt intimidated.  Gaining knowledge and skills boosted confidence, immediate benefit with patients.  Some motivated to apply for further training.  Increased self-awareness, more positive attitudes to service-users. Workload and staff shortages impacted on ability to implement changes.  Bank staff didn't attend, so not all aware of changes.  Pessimism re implementation. |
| 9 Belling et al 2011 England | Adult In-patient & community | Various (113) Interviews | Workload Team cohesion Leadership | Therapeutic continuity affected by vacancies, absences, turnover, temporary staff. Financial pressures → cutbacks, higher caseloads.  Bigger caseloads and more admin/paperwork impact on staff attrition.  Team support important to positive |

| | | | Development | working environment, with shared discussion, equitable workloads. Some leadership more empowering, democratic in decision-making, leaders drawn from a range of professionals; other more authoritarian, medical model (psychiatrist led), lack of power-sharing re decisions, hard to maintain service. However, some reluctant to move away from medically-dominated hierarchy. Concerns about taking on roles without training, preparation. Lack of training in skills relevant to role development. Difficulties accessing training. |
|---|---|---|---|---|
| 10 Berry, C et al 2011 UK | Not specified | Peer support workers & managers (4) Interviews | Team cohesion | Peer support workers seen as 'other' by other workers, expected to challenge practice and culture, work in more creative, collaborative ways with patients. Ambivalent attitudes from other workers in some instances, importance of shared expectations. |
| 11 Berry, K et al 2017 UK | Complex needs In-patient: rehab | Various (57), patients (20) interviews | Team cohesion | Intervention → improved staff understanding of patients and their behaviour → more creative ways of working. Also better team collaboration, shared understanding of patients, better communication, more mutual support. Increased staff awareness of their own feelings. Initial anxiety from both staff and patients. Time and resource constraints impacted on engagement, delivery. Managers' support important. |
| 12 Beryl et al 2018 England | Women In-patient, high secure forensic | Nurses (7) Interviews | Quality of care Team cohesion Supervision | Challenging work – horror of self-harm → ripple effect on ward, constant fire-fighting, anxiety/apprehension. Dealing with violence, aggression. Constant balance between security and care – therapeutic risk, especially if in charge. Emotional hard labour → drained, taking work home, loss of confidence. Frustration of not being able to help, but seeing people progress and move on gave meaning to the work. Self-care important - formal support/supervision systems provide space to reflect, to avoid being drawn into issues. Team support, informal supervision, 'looking out for each other' also essential – conflicts in team very challenging. Satisfaction of passing on skills. |
| 13 Bowden et al 2015 England | Not specified Community | Link-workers (9) Interviews & focus groups | Workload Quality of care Team cohesion Supervision | Stress from demands of the work, especially when unable to provide support if people in crisis. Feeling solely responsible - particularly difficult when positive risk-taking. Increasing referrals, admin tasks, with same or less resources. Having to set limits, say no, less creativity in the role – change in ethos of the service. Less ownership & pride in work, increased potential for burnout. Offloading with team colleagues important coping strategy – need a safe base, support from others, but workload pressures have reduced team contact time without increasing efficiency. |

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| 14 Bowen 2013 England | PD In-patient specialist | Various (9) Interviews | Team cohesion | Importance of shared decision-making, open communication, creating culture of enquiry amongst staff and patients, challenges of working in this way. Encouraging patients to take on tasks, social roles in the community, building peer support, compassionate environment for patients, staff not taking over. |
| 15 Burbach et al 2019 England | Psychosis Community: early intervention | Various (59) Case study - peer visits & interviews | Supervision | Good staff morale related to good supervision & feeling valued by managers and colleagues. Supervision provides a place to talk about personal & clinical issues. |
| 16 Chambers et al 2006 Northern Ireland | Not specified | Not specified (24) Questionnaire & focus groups | Quality of care Development | Re practice development project. Gaining new knowledge and perspectives, learning from others, building confidence. More able to think critically, challenge current practice, to make change in organisational culture, improved leadership skills beneficial for all. Improved patient care – more person-centred approach, innovation, partnership → positive feedback from patients and carers. Improved networking & collaboration, communication, mutual support. Less sick leave, staff more engaged. Some resistance, hostility from other staff when taking time out to attend, especially if lack of back up resources to cover absence. |
| 17 Chambers et al 2013 England | Adult In-patient: acute & PICU | Various (8) Focus groups | Quality of care Team cohesion Development | Re practice development project. Training relevant, motivating, valuable to practice. Increased confidence & competence in interactions with patients. New skills, improved communication, clearer sense of purpose in work → more positive about work, doing a better job, more self-aware & confident. Felt valued, cared for. Team relationships improved – seen as very important. Supervision of agency staff took time away from interactions with patients, created resentment. |
| 18 Chambers et al 2015 England | Adult In-patient: acute | Nurses (12) Focus groups | Quality of care Development Supervision | Emotional and cognitive dissonance when having to use coercive measures - often seen as negative and created discomfort, fear, anxiety & vulnerability. Reluctance to get involved. Concern to avoid damaging relationships with patients, wanting to build relationships, develop clear advance agreements with patients, promote alternative methods of care and management but lack of time to do this. Feeling forced into decisions → embarrassment, shame at finding it difficult. Support from peers and managers important, including after incidents. Supervision and training a part of this – helps develop emotional skills, safe space to work through emotions |

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| 19 Clinkscales et al 2018 England | Women with PD In-patient | Various (45) Questionnaire | Development | Re training course. Valued opportunity to review & improve practice, team functioning, understanding. More insight into self & patients. Able to do job better – improved interactions with patients, dealing with challenging situations, better care. Improved team communication & consistency of approach, shared language. More able to reflect on own responses, support each other. |
| 20 Crawford, M et al 2010 England/UK | PD Community | Various (89) Interviews | Team cohesion Supervision | Key factors that helped staff work in PD services include teamwork, strong leadership, whole team supervision. Space to reflect important when working with this patient group – helps people contain & manage emotions. Teamwork builds sense of joint responsibility, mutual support, improved communication, less burnout. External supervision valuable, important for avoiding burnout. Quantity and frequency of supervision an issue, and availability for admin staff. |
| 21 Crawford, P et al 2008 England | Not specified Community | Nurses (34) Interviews | Quality of care Development | Stigma – lack of recognition of mental health conditions → lack of recognition for mh nursing. The invisibility of nursing, striving for recognition – do this by doing your best for the patient. Client focus - empowerment of the patient eclipses nurse, identify focuses on this. Willing to accept change if focused on patients. Importance of appreciation, from patients or managers – lack of this from managers. CPD seen as a way to appear more professional, to progress – can only develop by leaving the profession. |
| 22 Currid 2008*[2] England 23 Currid 2009*[2] England | Not specified In-patient, acute | Nurses (8) Interviews | Workload Quality of care Leadership | Heavy workload, lack of staff, competing demands, excessive responsibility → impact on health & wellbeing. Pressure from managers, especially re bed shortages → having to make decisions that don't feel right (e.g. discharging too soon) → disempowerment. Impossible to meet demands, deliver a quality service → questioning role, benefit to patients, self-worth, impact on coping. Unable to use skills, admin/management/finance valued more than clinical. Having to prove their worth, fight for own & patients' rights. Blame culture, lack of support if things go wrong, lack of praise/acknowledgment of good practice. Patient aggression linked to lack of staff, not taken seriously by management → staff withdrawal, lack of engagement if emotionally drained. |
| 24 Dallimore et al 2016 England | Not specified In-patient: acute | Various (12) Interviews | Supervision | Multidisciplinary clinical meetings valuable - greater understanding of cases, new perspectives, validation of feelings, mutual support, more coherent team approach which can improve outcomes for patients. Work patterns, attitudes and awareness can impact attendance, no mechanism for disseminating to those not present. Less qual staff could feel less confident to speak. Varied opinions on frequency. |

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| 25 Donald et al 2019 England | Later life In-patient | Various (12) Interviews | Workload Quality of care Team cohesion Development | Re training. Relentless workplace pressure – anxiety about coming to work. Focus on tasks, managing risk/safety to cope, but this detracts from compassionate care and building team cohesion. Course enabled emotional sharing, building team relationships, helped people connect with own empathy, be less self-critical. Also enabled more patient-focused perspective, which changed interactions. Recognition of need for self-care to be able to care for others. Need to address staff pressures to improve patient care. |
| 26 Ebrahim et al 2016 England | PD In-patient & community | Nurses & OTs (5) Interviews | Development | Re training course re PD. Increased confidence with patients, willingness to challenge negative attitudes of staff. Improved interactions with patients, positive impact on practice. More understanding of patients without being overwhelmed. Able to reflect on own reactions. Barriers to implementation - organisational culture, lack of training & team resistance. Supervision important in enabling. |
| 27 Edward et al 2012 England | Not specified | Nurses (12) Questionnaire | Development | Re training course. Satisfaction with course, impact on clinical practice – increased knowledge, ability and confidence to explore issues around oral health – had been a taboo area – and links to other areas of health. Helps facilitate recovery. Confirmed/validated work some were already doing. |
| 28 Edwards, K et al 2008 England | Adult In-patient: acute | Nurses (16) & patients (17) Questionnaire | Workload Supervision | Protected time with patients welcomed as opportunity for more engagement, but concerns about lack of staff to do it safely – need more regular staff to enable increase in protected time. Supervision inconsistent, not always focused on enhancing skills, not frequent enough and absent for some. |
| 29 Edwards, K 2011 England | Adult In-patient: acute | Senior nurses & ward managers (15) Interviews | Workload Quality of care Supervision | Decisions re bed occupancy and staffing levels made by others with lack of understanding of demands on the wards, need for interaction → lack of control, disempowerment. Lack of appreciation of staff's psychological needs – some burnout, and unable to engage therapeutically. Building therapeutic relationships undermined by requirements to undertake containment work. Culture of admin taking priority over engagement. Conflict in role of acute wards, balancing therapy & containment. Staff difficulties in engaging with 'revolving door' patients, those with PD. Not all staff understand or committed to building therapeutic relationships, especially bank staff, some long-term staff. Lack of development and support to build confidence and skills - mandatory training takes priority over other training which could enhance these skills. Support from service managers variable – clear leadership, good teamwork appreciated. Need to improve quality and frequency of supervision, especially group supervision. |

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| 30 Elliott et al 2020 England | Various Not specified | Nurses (17) Interviews | Quality of care Team cohesion | Exploration of providing for spiritual care of patients. Permeating anxiety a key theme. Taking it seriously as part of care, feeling responsible, but anxious re 'getting it wrong': causing offence, imposing own beliefs. Also concerns re embarrassment, ridicule from colleagues. Ability to express own views depends on feeling part of team, in a supportive community. Some teams had shared approach, but this could be challenging for individuals who did not share this view. Different interpretations of patients' experiences e.g. psychosis or spiritual phenomenon? |
| 31 Freeman et al 2011 Wales | Not specified Community: crisis resolution & home treatment | Various (5) Interviews | Workload Quality of care Team cohesion Development Supervision | Demands on team outweighing resources, especially volume and appropriateness of referrals → conflict with referrers, other professionals. Lack of control, high demand and high level of responsibility → stress. Staff motivated by seeing positive impact of work on clients, building relationships, empowering clients to make own decisions and stay at home - satisfaction & achievement. Stress and disappointment when people are re-referred. Allocation of work within team causing tension, but team important for coping: sharing information, emotional support, safety, trusting relationships. Lack of supervision, no time set aside for it – impacts on stress levels. Lack of training in crisis intervention creates stress – need this to feel confident and competent, cope with the job. |
| 32 Gilding 2017 England | Not specified | Support workers (38) Feedback form | Development | Re skills development. Care certificate key to developing knowledge and skills, but not always taken seriously by others. Lack of protected time in workplace a barrier to implementation, busy environment made it difficult to focus on learning. Shift work a barrier to supervision meetings, some supervisors lacked skills and confidence. Lack of understanding from other staff → less support. |
| 33 Green & Searle 2017 England | Not specified Community assessment & treatment | Nurses (11) Data collection method unclear | Workload Supervision | Working part time and other commitments impacted attendance at Balint group. Group and psychodynamic facilitation style valued – provided safe space to debrief, explore impact of patients, increase understanding of relationships, gain others' perspectives, consider new approaches. An active process rather than just being told what to do. |
| 34 Hanley et al 2017 England | Adult Community | Various (8) Interviews | Workload Quality of care Team cohesion Leadership Supervision | Staff leaving, especially long-term staff, due to workload and pressure causing burnout/stress. Greater use of agency staff disrupts continuity of care, therapeutic relationships – destabilises clients. Safety concern – clients at risk due to large caseloads. Overwhelmed by admin tasks – concern re impact on clinical work. Cultural change in organisation, decline of ethos. Perceived divide: 'caring clinicians, uncaring managers'. Managers focused on finances, targets, whilst clinicians focused |

| | | | | on patient care. Increased regulation, performance management, bullying & punitive management culture → fear & anxiety, undermines wellbeing and productivity. Working relationships important but teams too fragmented/large/busy to provide support. Supervision not valued by senior staff, so staff not supported to engage → impacts on ability to do a good job. |
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| 35 Hargate et al 2017 England | Male suicidal/self-harm In-patient: medium secure | Not specified (5) & patients (6) Interviews | Team cohesion | Impact of suicide and self-harm → desensitisation, sense of loss and trauma. Other people have important role in protecting against negative impacts – shared experiences and peer support most significant. Importance of understanding and experience – helps to create more positive attitudes, need for training and education. |
| 36 Huxley et al 2005 England & Wales | Various In-patient & community | Social workers (237) Survey & focus groups | Workload Quality of care Team cohesion Supervision | Pressure of work, workload too high. Constant organisation change → hard to do job, confusion. Lack of joined up services. More effective when able to determine own work priorities. Feeling they were making a difference despite pressures. Enjoying the client group key reason for feeling happy in the job; also supportive colleagues, good team relationships one of main reasons for staying. Fear of blame if something goes wrong. Pressure from self and managers. Feeling valued by service managers and others important to motivation, how people feel about their work. Good supervision a positive aspect for many. |
| 37 Janner & Delaney 2012 UK | Adult In-patient – various | Unclear, likely nurses (188) Questionnaire | Quality of care | Introduction of STAR wards - focus on patients' daily experience, promoted staff autonomy, support, validation. Improved staff-patient interactions – more rewarding, interesting, innovative, fun. Increased contact improved atmosphere, less boredom. Improved staff morale, patient satisfaction, quality of care. |
| 38 Johnson et al 2011*³ England 39 Totman et al 2011*³ England (paper published | Various In-patient - various | Various (71) Focus groups & interviews | Workload Quality of care Team cohesion Leadership Development Supervision | Feeling overworked – physical and emotional toll. Lack of staff key issue – would reduce pressure, relieve rotas, improve morale and enjoyment, reduce risk of violence. Staffing levels insufficient for staff to feel safe. Sickness absence → more use of agency staff – concern re skill level, patients reluctant to engage → increased burden on permanent staff. Meaningful time with patients most rewarding part of work, unhappy having to limit this, compromise patient care. Seeing patients get better boosted morale. Senior managers seen as having poor understanding of frontline work, rarely visited wards, prioritising financial concerns over staff welfare. Staff often felt unheard within organisation in relation to ward policies. Good morale where culture of openness and acceptance, staff encouraged to give their views. |

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| from Johnson report) | | | | Role clarity and autonomy important – important for confidence, to avoid uncertainty which created anxiety. Impact of structural and organisational change. Staff sustained by cohesive teams, mutual loyalty and trust – peer relationships and teamwork important for morale. Ongoing development opps appreciated - boosted morale, clarified role, built confidence. Limited access to non-mandatory training, lack of resources → using own time to do it. Managers saw formal support and supervision as important, but some staff valued informal support more e.g. managers' presence on the ward, responsiveness to problems. Supervision available to varying extents. Lack of time to access supervision, training. |
| 40 Jones & Annesley 2019 England | Women with complex presentation Forensic in-patient | Various (92) Evaluation form | Development | Re training. Potential to improve team relationships, learn from each other. Gained new skills, tools, approach – more confidence, especially in complex situations. More aware of own feelings and how to use this to understand situation, able to reflect, work through experiences, be less drawn in. |
| 41 Keers et al 2018 England | Various In-patient – various | Nurses (20) Interviews | Workload | Medication errors due to workload, short staffing → rushing, pressure to complete tasks, multi-tasking, poor skill mix, lack of experience, including agency staff. Lone working often a factor, especially for junior staff – feeling responsible, not confident to manage patient demands. Low staffing → patient distress, demands, chaotic environment, which also contributes to errors. Lack of protected time for medication dispensing. Supervision and support can help prevent errors. |
| 42 Kellett et al 2014 England | Schizophrenia Community: assertive outreach | Various (7) Interviews | Team cohesion Supervision | New approach → improvements in team climate and practice – more cohesion, teamwork, more understanding of each other's work, consistency of approach. Enhanced clinical practice – increased awareness and understanding of patients and relationships with them, not stuck in unhelpful patterns. Supervision enabled sharing of difficulties, time to reflect on practice, increased communication and mutual care. |
| 43 Kowalski et al 2018 England | Various Not specified | Various (105) Survey & focus groups | Development | Re training. Increased confidence, skills in managing complex dynamics of working with families, staying focused. Recognising importance of reflection. Greater appreciation of joint working with other staff, patients, families. Sense of connection with group, seeing others have similar problems. Seeing potential for better care → motivated to build relationships, improve communication. |
| 44 Kurtz & Turner 2007*[4] | Forensic, medium-secure, PD | Various (13) Interviews | Quality of care Team cohesion | Strongly invested in bringing positive change to patients. Complexity of the task – difficult but exciting work, satisfying and frustrating. Tension between therapeutic work and public protection. Desire to build meaningful relationships with patients. |

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| England | specialist, male | | | Risk of isolation – feeling cut off from outside world, other mh services – lack of sympathy for patient group, envy of resources.  Importance of connection with colleagues: belonging, open communication, having a voice in team.  Problems when difficulties within team – instability, vulnerability, risk of raising concerns in case lose support → leaving. |
| 45 Kurtz & Jeffcote 2011*⁴ England | Forensic, medium-secure & PD specialist | Various (25) Interviews | Quality of care Team cohesion | Difficulty in achieving task integration; motivation to build relationships, work through difficulty and bring about change; minimal sense of risk and anxiety at the centre.  Difficult relationship with wider organisation - fragmentation.  Staff seeing themselves as people-focused, whilst management commercially driven.  Preoccupation with staff relationships, feeling unsafe. |
| 46 Lamb & Cogan 2016 Scotland | Not specified | Psychologists, counsellors (9) Focus groups | Workload Quality of care Leadership | Balancing multiple demands, lack of control over volume of work, managing risk, complexity of patients' situations. Hard to find time for breaks. Excess workload, admin demands → unable to provide quality of care, develop skills. Values re providing quality care compromised, and trying to sustain them adds to stress.  Patient relationships most enjoyable part of work. Lack of acknowledgement and understanding from management, focus on targets and waiting lists, lack of recognition of need for self-care. |
| 47 Lambley 2019 Not specified | Not specified | Various Survey & interviews (number not specified) | Supervision | Supervision seen as important to maintain standards of work – provides emotional containment, debriefing, helps people stay engaged, build confidence working with challenging clients, set boundaries → benefits service users as well.  Problems arise when supervisor off sick, as nobody replaced, even if long-term absence.  Workload can lead to supervision being less prioritised, even though people know they need it. Staff don't always get the right training to deliver supervision – can be expensive. |
| 48 Lavelle et al 2017 England | Adult In-patient, triage wards | Various (53) Survey, & focus group (8) | Team cohesion Development | Re training.  Greater confidence to manage medical deterioration, cope with pressured situations.  More sense of responsibility for patients' physical health, desire to be skilled in this and not rely on others.  Improved understanding of good teamwork, more aware of others' skills and roles, increased confidence in own & others' abilities.  More able to communicate with colleagues, challenge when needed. Valuing team reflection to debrief from challenging situations, improve performance and patient care. |
| 49 Lewis et al 2016 | Schizophre-nia, bipolar | Various (8) Interviews | Quality of care | New service model enabled staff to spend more time with patients, build rapport, more equal relationship, more freedom to respond to their needs.  Emphasis on |

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| England | In-patient & community, including crisis team | | | client-centred service delivery, shared decision-making. Giving patients more knowledge and skills to become independent → staff more fulfilled, happy. Positive impact on job satisfaction, sickness, wellbeing. Able to do the job they were trained for, make a difference. Positive feedback loop between patients and staff. Learn new skills and knowledge, share ideas through multidisciplinary team working. |
| 50 Lloyd 2007 Wales | Adult In-patient, acute admissions | Nurses (10) Interviews | Workload Quality of care | Having enough staff most important resource. Main purpose of role seen as 'being with' service users, building connection to enable smooth progression through hospital. Frustration when this was disrupted – by staffing levels, lack of privacy, attitudes of other staff. Team working most effective way of providing care – communication important to decision-making. |
| 51 MacLaren et al 2016 Not specified | Not specified Community | Nurses (8) Interviews | Supervision | Quality of supervision more important than frequency etc. Has to be regular, sustained, quality of relationship which enables safe space for expression and exploration of emotion, critical reflection. Counselling supervision culture very different from organisational culture of emotional control, stoicism – nursing supervision can reflect the latter rather than providing emotionally reflective space. |
| 52 McAllister & McCrae 2017 England | In-patient: PICU | Nurses & psychotherapists (4) Interviews | Quality of care | Personal interactions with patients seen as ultimate aim. Spreading self too thinly exhausting, demanding. Concern from staff that organisational pressures will affect their inherent caring qualities, forget reason for being in the job. |
| 53 McGuinness 2004 England | Not specified Community | Team managers 2 focus groups (number not specified) | Team cohesion | Team manager role demanding, high responsibility. Managers had strong commitment to team staff, positive working relationships. Multidisciplinary teamwork important source of reward, also being involved in improving quality of care. Lack of resources, especially staff, a key pressure, together with volume of work, unrealistic demands from managers, deadlines, constant change. |
| 54 McPherson et al 2016 England | Older adults, dementia In-patient | Nurses & HCAs (10) Interviews | Workload Team cohesion Leadership | Pressure from factors including shift work, nature of clients, lack of resources, bureaucracy, lack of autonomy and high demands. Management style, feeling undervalued, colleagues' behaviour also contribute. Internal pressure to keep going, maintain standards. Admin tasks taking more time than caring, especially after incidents. No time to take any breaks due to staffing levels and ward structures. Increased anxiety from responsibility if only qualified staff on duty. Feel unsupported at organisational level, that compassion and self-compassion not valued or rewarded. |

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| 55 Mistry et al 2015 England | Varied In-patient – various | Patients (21) Interviews | Workload Quality of care Team cohesion | Workload, admin took staff away from patient contact → patient frustration, aggression – impact on morale. Bank staff not engaged with patients, not aware of ward routines → patients uncomfortable, not developing rapport with them. Job satisfaction from contributing to patients' lives, building close relationships, having a positive impact. Staff and patient morale interdependent – patients concerned about staff and their impact on them. Supportive teamwork key to quality care – creates containment, security, preserve morale. Leadership and management important in promoting teamwork, establishing good routines. |
| 56 Moorhead et al 2016 England | Not specified In-patient – urgent care | Nurses & OTs (8) Interviews | Quality of care Development | Re training. Learning that self-awareness helped self-regulation, which benefited patient care and staff wellbeing (challenged previous assumption that noticing own state suggested over-involvement and have negative impact on patient care) . Able to relate in calmer, less reactive way in a demanding environment, often requiring quick decisions. Motivated to expand skills and provide good quality care. |
| 57 Oates, J 2018 UK | Various In-patient & community | Nurses (27) Interviews | Supervision | Clinical supervision an important part of maintaining wellbeing – opportunity to reflect on practice, explore difficult cases, connect to colleagues, seek guidance, contain the work/maintain boundaries – especially important when working with trauma. Part of process of self-nurture. Organisations failing to offer regular supervision in some instance → some arranged their own if not provided. |
| 58 Oates, J et al 2017 Not specified | Not specified | Nurses with history of a mental health diagnosis (27) Interviews | Quality of care | Staff use of self-disclosure only if it had intended benefit to the service user. Staff having a mental health condition could increase empathy and understanding, but could also impact on emotional availability, make it hard to build close relationships. |
| 59 Piette et al 2018 England | Adult Community | Various (57) Survey & Interviews (8) | Team cohesion Development | Re training. Greater understanding of other colleagues' skills, knowledge & roles, how to collaborate → impact on clinical practice. Greater emphasis on service users' perspectives, and importance of consistent quality care. Reflective nature of the course away from workload pressures → increased support for and from colleagues, improved team morale, ongoing commitment to debriefing, reflective time. Being observed and getting feedback enabled skills development, built confidence. Impact on staff wellbeing. Felt valued by the experience. |

| 60 Posner et al 2017 England | Various, including LD, psychosis Rehab units | Various (10) Nominal group technique | Team cohesion Leadership Development Supervision | Organisational culture important – need to feel valued by organisation, opinions and ideas listened to, involved in decision-making, needs understood, that organisation is aware of issues.  Higher management seen as needing training in staff wellbeing. Importance of creating a positive culture, time to reflect on what's been done well. Want input into development of training - this would improve engagement with it. Need training in wellbeing techniques to manage stress, professional education to improve confidence, develop new ways of working, do job more effectively. Need time away from work to bond with team.  Lack of supervision/support or no time to access because of work, or not available due to supervisors' absence. |
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| 61 Poulopoulos & Wolff 2010 England | Drug users Assessment unit & community | Various (6) Focus groups | Workload Leadership | Burnout due to high pressure with lack of support from management.  Lack of clear role, lack of involvement in decision-making, lack of appreciation and recognition for work, lack of leadership and support in implementing change. Poor communication. Long hours, lack of staff, work overload increases risk of burnout, work less effectively.  Fear to admit burnout due to concern that individual will be blamed rather than organisational level problem.  Guilt at taking time off, aware of work when at home.  Lack of supervision & support. |
| 62 Priebe et al 2005 England | Not specified Community | Various (90) Survey | Workload Team cohesion | Complaints about lack of resources/funds, lack of time, high caseloads, overwork. Admin & bureaucracy seen as causing pressure, an obstacle to doing the job. Overload of managerial work.  Teamwork an enjoyable aspect of the job. Communication with other staff causes pressure. |
| 63 Procter et al 2016 England | Not specified Community | Support workers & managers (31) Interviews & documents | Workload | Excessive workload placed on teams.  Consultant psychiatrists feel burdened by responsibility → off sick with stress, retirement; other staff feel power should be more shared.  New roles and models developed to try and share responsibility, decentralise, but staff in these roles felt isolated, not taking on envisaged role. |
| 64 Ramon et al 2017 England | Community rehab & recovery | Care-co-ordinators, psychiatrists & patients (61) Interviews & feedback form | Quality of care Development | Training → increased confidence in shared decision-making, how to initiate dialogue with service-users, and importance of helping them have a choice, less fear to work collaboratively.  Valued opportunities to exchange ideas and experiences, get suggestions for information and tools.  Valued time to reflect, opportunity to develop practice. Lack of confidence that it would be implemented in practice.  Some concern that specialist knowledge of doctors was undervalued. Psychiatrists had particular concerns about managing risk and responsibility. |

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| 65 Robertson, J & Collinson 2011 England | Various including learning disabilty Community, outreach teams | Outreach workers (14) Interviews | Team cohesion Leadership | Organisational incoherence. Organisational attitude to risk management varied – some staff felt trusted, others that organisation indifferent to the risks they worked with, or overcautious and more concerned with liability and public perception than with enabling service user autonomy. Lack of practical guidance on positive risk-taking → feeling unsupported, inconsistent practice. Need for organisation to take responsibility, lead service improvement, provide support. Lack of broader understanding of processes of risk management. Multidisciplinary team important for supporting risk-taking, developing guidance. Relationships with other staff helped reduce isolation, share best practice. |
| 66 Robertson, K et al 2013 England & Wales | Women, including learning disability, In-patient, high secure | Nurses & HCAs (59) Questionnaire | Development | Training → improved confidence in working with trauma and self-injury, able to identify examples of good practice. Enhanced skills. Training valued as informative, relevant, desire for more. |
| 67 Rose et al 2015 England | General In-patient – acute | Nurses & HCAs (50), patients (37) Focus groups | Workload Quality of care | Staff unable to spend enough time with patients due to admin, paperwork, task-focused work. Bank staff unfamiliar with patients. Lack of interaction → staff frustration, concern at becoming deskilled, not doing good job, but withdrawal also a way of coping when burnt out/anxious. Talking therapies valued but little experience of them. Lack of support – senior management seen as uncaring, having to cope alone in volatile situation. De-escalation impossible due to lack of staff → more use of coercion. Patients experiencing wards as untherapeutic due to lack of available, helpful staff → frustration, perceived by staff as aggression. Mutual powerlessness. |
| 68 Ryan et al 2019 UK | Not specified Community | Counsellors & therapists (1918) Survey | Quality of care Leadership Development | Feeling undervalued as a profession and as individuals by service managers. Some experience of bullying. Expectation to work more unpaid hours, increased burden of work, less client-centred. Lack of respect, understanding and support. Service organised in a way that restricted practice, didn't value clinical judgement, inappropriate referrals. Feeling compromised – producing statistics at the expense of counselling, focus on quantity not quality → lowering of standards, not meeting clients' needs, safety concerns. Loss of time for reflection and supervision, no opportunities for career progression, no resources for training. |
| 69 Sequeira & | Secure in-patient | Nurses (17) Interviews | Quality of care | Discomfort and dislike of administering restraint and seclusion → anxiety, ager, guilt, distress. Sense of conflict with role of nurse. Feelings of boredom, frustration and |

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| Halstead 2004 Not specified | | | | low morale.  Need for support, but the climate not one where expressing feelings was acceptable, so support was ineffective. |
| 70 Sheridan et al 2011 England | Drug & alcohol users In-patient & community | Various (32) Interviews | Workload Quality of care Team cohesion Leadership Development Supervision | Under-resourced, overwhelmed – high workload → burnout, turnover, sickness. Paperwork adding to the burden, impacting on treatment time.  A feeling that targets are seen as more important than quality of care, pressure to move people on. Satisfaction from helping others but unable to spend as much time with clients due to workload.  Lack of consistency impacts on quality of care.  Building relationships with colleagues important - improved communication and better patient care through fuller picture of needs.  Lack of understanding of different roles could → problems.  Lack of support from management could undermine the benefits of supervision and peer support, and could be a greater stress than the challenges of working with clients. Management seen as focusing on targets rather than clinical need → pressure to move people through the system.  Supervision seen as an indication that staff are valued, an opportunity to get feedback, validation.  Lack of qualified staff to provide supervision, or these people too overburdened.  Lack of support → isolation, anxiety about being able to do the job.  Having to deliver interventions without sufficient training. |
| 71 Smythe et al 2015 England | Dementia In-patient & community | Various staff (70), family carers (16) Focus groups | Workload Quality of care Team cohesion Development | Unable to provide person-centred care due to lack of time, inadequate staffing. Need good mutual support, connections with patients to enable person-centred care. Mutual support important to job satisfaction and stress management.  Job satisfaction also from rewards of caring.  Loss of motivation from not feeling valued by senior staff, patient distress, limits on time → stressful environment. Resistance to formal training amongst nursing assistants – not relevant to work, trainers not having enough knowledge of the actual work. |
| 72 Spence et al 2014 Not specified | Not specified | Psychologists (10) Interviews | Supervision | Value of self-reflection, but concerns that disclosure can be viewed as failure, weakness in clinical psychology culture.  Quality of supervision relationship key to counteracting this culture – need competence, skills, compatible outlook. Managerial relationship can impact.  Right environment – frequency, location, privacy, etc also important. |

| 73 Stevens et al 2019 England | Not specified | AMHPs (52) Interviews & survey | Development Supervision | AHMP role enables best outcome in difficult circumstances, having skills and experience to use. Satisfaction from good decision. Concern at potential damage to existing therapeutic relationships. Benefit to career, increasing knowledge and skills, enhancing credibility especially for nurses. Lack of remuneration reduced status. Lack of support from organisation to take on role – funding, releasing time. Variable experiences of supervision. |
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| 74 Stockmann et al 2019 England | Not specified | Various (26) Focus groups | Quality of care Team cohesion Development | Re open dialogue training – challenging but valuable: improved relationships with colleagues and patients, greater empathy for patients, compassion for self and listening to own needs. Going back to original values, re-humanising practice – greater job satisfaction and wellbeing. Challenging to implement within existing structures – shift in power, patient focused – whole system needs change. Strong connections built with others during the training – sense of community, mutual support. |
| 75 Stone 2019 England | Not specified | Nurse AMHPs (10) Interviews | Development | Structural challenges in accessing training and approval – lack of support from local authority. Training challenging but enjoyable, broadening perspective, enabling people to make more contribution to team, having skills others value. Some integrated into AHMP team with social workers, others felt isolated. Less recognition, including financially, than social worker AHMPs. |
| 76 Taylor et al 2009 Scotland | Not specified Community | Various Not specified, unclear | Supervision | Lack of clarity about whether supervision managerial or clinical. Workers felt scrutiny was unsupportive, negative. New framework for multidisciplinary group supervision introduced and valued by staff – clarifying priorities, roles; built confidence to discuss sensitive issues; focused on problem-solving, constructive discussion, drawing on others' expertise; validating concerns etc. |
| 77 Thompson A et al 2008 (a) England | Not specified – self-harm Community | Nurses (8) Interviews | Team cohesion | Emotional impact of working with those who self-harm, challenge of managing boundaries of responsibility, managing risk, fear of blame, feeling isolated. Time pressures impacted ability to meet needs. Therapeutic relationship crucial. Trying to understand behaviour to develop empathy. Lack of training to manage. Supervision important in coping, also informal support from within team – emotional and practice. Importance of good communication, risk of splits over differing attitudes to self-harm. |
| 78 Thompson | Challenging cases Community | Social workers & CPNs (12)- Interviews | Team cohesion Development Supervision | Evaluation of training in cognitive analytic therapy. Enthusiasm to attend due to perceived lack of psychological tools to work with patients; also supported by senior managers. Satisfaction high – helped create shared philosophy and approach, |

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|---|---|---|---|---|
| A et al 2008 (b) England | | | Quality of care | increased cohesion, confidence and morale. Team more supportive of each other → improved culture. Group supervision important in developing cohesion. Gave staff a structure to work with, more skills to offer to those with complex needs, reduced anxiety, increased optimism. Some concerns about increased workload. |
| 79 Tobias 2016 England | Various, including LD In-patient & community | Nurses & healthcare workers – focus groups (21) & survey (max 176) | Supervision | Negative views of supervision from many – seen as adding to workload, tick box exercise, used punitively by some managers. Others felt not enough, no time allocated to do it. Need for protected, confidential time especially for those in in-patient settings. Manager-led supervision could be problematic, but if not, then problems may not get resolved. Need a proactive approach rather than in response to incidents. Clear contracts important. Differing views on whether supervisor should be from same discipline. Supervisors need more support and training. |
| 80 Townend 2005 UK | Various Not specified | Cognitive behavioural psychotherapists, mostly nurses (170) – Survey | Supervision | Varied experiences of inter-professional supervision – can lead to misunderstandings from different theory base/practice but can also enable more creative thinking, new perspectives, introduce new skills. Shared understanding can be helpful, but may feel willing to disclose more to those outside own group. |
| 81 Walker et al 2017 UK | Women In-patient medium secure services | Various (18) Interviews | Workload Quality of care Team cohesion Development Supervision | Relational security key to creating therapeutic environment – need appropriate staffing levels; good communication and supportive staff relationships; commitment to patient group; team working to ensure consistent approach; established relationships with patients so aware of triggers – lost if using agency staff. Importance of valuing staff if want them to value patients. Formal supervision system had better uptake and satisfaction than informal – helped formulate plans. Growing emphasis on supervision but not always taken up due to time pressure, shift patterns or perception of ineffectiveness, especially amongst nurses. Informal supervision/support important but less available to new/unqualified staff. Staff training important but lack of time a barrier, courses not always relevant to practice, lack of availability for unqualified staff. Training important for service progression. |
| 82 Waller et al 2015 England | Psychosis, long term problems Community – early | Various staff (7), patients (17) Interviews | Development Supervision | Training in low-intensity CBT enabled staff to achieve positive outcomes with service users → motivated them to continue, despite challenges of workload. Positive experience of learning skills, delivering therapy, protected time to focus on goals with service users. Gave team a more consistent approach, more efficient. Group supervision introduced as part of this – valuable, space to discuss difficulties, |

| | intervention & recovery | | | celebrate success. Time commitments made attendance difficult, not all understood its purpose. |
|---|---|---|---|---|
| 83 Watson 2016 England | Not specified | AMHPs (12) Interviews | Development | Role of AMHP seen to offer job security, career progression opportunities. Training enhanced skills, knowledge, expertise – able to help people in crisis, protect their rights, challenge medical model. Exciting but challenging work – harder since austerity due to less resources, more risk. Good to work in time-limited way, see process through to completion. |
| 84 White et al 2014 England | Not specified In-patient & community | Nurses & healthcare workers (53) Questionnaire | Development | Specific training session re a tool to assess physical health needs of mh service users. Session found to be relevant, interesting, helped ensure high quality of care, gave tools to plan care – motivating. Importance of involving managers to support implementation of change. Pressure of other work a barrier to implementation, or not seeing it as part of own job to do this. |
| 85 Wilberforce et al 2013 England | Older adults Community | Various (378) Questionnaire | Team cohesion | Successful multidisciplinary working a benefit of team structure – importance of open, honest, respectful communication – value of discussing complex cases, peer supervision. Some teams preferred to be single discipline, in other cases staff continued to work in professional silos even when teams formally integrated. |
| 86 Wilberforce et al 2017 England | Older adults Community | Various, focused on support workers (42) Interviews | Team cohesion Development | Regular referral/review meetings helped support workers not feel pulled in different directions by different lines of accountability. Sometimes felt unsupported, that people forgot they were less qualified, but also valued trust & autonomy. Inconsistent opportunities for training. Not all keen to progress, particularly if this required formal education. Others keen and unhappy at not being encouraged or expected to attend courses, not given opportunities, or found it hard to find appropriate training: either too basic or aimed at qualified staff. Low pay and time pressures also an obstacle. |
| 87 Wilcox 2013 England | Learning disability Community | Various (max 13) Questionnaire | Team cohesion Development | Multidisciplinary reflective meetings a safe space where team members offered support to each other. Staff mostly worked alone, so valued being able to share, discuss cases, develop a shared way forward. Helped build understanding and confidence working with clients, ability to manage risks. |
| 88 Woolnough 2006 UK | Not specified | Senior staff mentoring female nurses (24) Interviews | Development | Senior staff became more aware of career barriers for female nurses, had more insight into on the ground, organisational issues re staffing & patient care. Mentoring role improved own reputation with mentees, raised profile, opportunities to network, satisfaction of seeing someone develop. |

| | | | | Desire to implement organisation change to improve career progression but having to protect confidentiality of mentees. |
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**Notes/Key**

PD – Personality Disorder; PICU – Psychiatric Intensive Care Unit

*[1-4] – indicates where multiple papers published from the same study

Where data was collected by survey or questionnaire, only data from qualitative free-text responses have been included in the review. If a number is reported as a maximum, this indicates the number of participants who submitted survey responses, but the number providing qualitative data is not specified.

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