Mental Health Nursing: sources of stress and strategies for coping

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LITERATURE REVIEW

Introduction

Health care workers at every level, qualified and unqualified, appear to have a higher than average sickness and absence rate than workers in other sectors, and it has been identified that stress may play a leading role in nurses leaving the profession. There are further strong indicators that sickness and absence is higher amongst mental health workers. Numerous small scale studies (Mazure 1995, Moore & Burrows 1996) were undertaken in the 1990s, mainly in England, to try and identify factors that lead to stress and burnout amongst staff in the community, and comparison studies have also been conducted, comparing community based staff with ward based staff. In this paper, the literature from 1994 onwards is reviewed, with a particular focus upon Community Mental Health Nurses (CMHNs) and, where comparisons are made, ward based staff.

Sources of Stress

An examination of the literature on stress within mental health nursing supports the argument that stress does exist within the profession (Dawkins et al 1985, Trygstad 1986, Dolan 1987, Firth et al 1987, Jones et al 1987, Newnes 1990, Sullivan 1993), though many of those studies have been criticised on the grounds that: the samples have been too small or unrepresentative; a lack of measures to assess stress; and, have too little information to prove reliability or validation.

Carson et al (1991) conducted one of the first studies to be carried out with CMHNs for stress and burnout. Conducting a survey with 61 nurses, he found that a number of factors led to stress – the top three factors were:
- a lack of facilities in the community for the CMHN to refer clients to;
- working with violent or potentially violent clients;
- interruptions while in the office.

In an 18-month follow up study involving 250 CMHN’s and 323 ward-based mental health nurses in the North East Thames Region, Carson et al (1994) discovered that there was a change in this hierarchy. Community referral remained the top factor, but
interruptions within the office had overtaken violent clients. They discovered that interruptions was the sixth most commonly cited stress factor, with violent clients being the ninth of ten top stressors for community nurses. Completed concurrently, a further study involving 144 qualified staff from two mental hospitals was conducted by DeVilliers, resulting in the creation of a specific stress questionnaire for ward-based staff.

The measures adopted for each study were identical: Demographic questionnaire (DQ) (Brown & Leary 1994); General Health Questionnaire (GHQ) (Goldberg & Williams 1998); Maslach Burnout Inventory (MBI) (Maslach & Jackson 1986); Rosenberg Self-Attitude Questionnaire (RS-AQ) (Rosenberg 1995); Minnesota Job Satisfaction Scale (MJSS) (Koelbel et al 1991); Coping Skills Questionnaire (CSQ) (Cooper et al 1998); Claybury CPN Stress Questionnaire (revised) (CPNSQ-R) (Brown et al 1995); DCL Stress Scale (DCLSS) (DeVilliers et al 1995).

These two studies indicated that stress exists within the CMHN service and is work related, raising some key points. Whilst previous studies had been conducted on small or highly selected samples, this study was large, used validated questionnaires and measures throughout, and was conducted over an extended period of time rather than being a snapshot of the here and now. However, the published report failed to demonstrate how often the measures and questionnaire were used, nor did it explain how the 717 nurses continued to support the study through an 18-month period. Neither dropout rates nor staff throughput were indicated, which would have been expected during such a study.

Ryan & Quayle (1999) suggested that it is organisational, rather than work-related, stress that CMHNs experience. Of 179 (42%) Irish CMHN respondents, representing a response rate of 42%, a mean score of 4.7 was obtained on the GHQ60, which compares with a mean score of 4.8 on the GHQ28 in Leary & Brown's (1995) UK study of CMHNs, showing a reduction in the levels of stress experienced. Ryan & Quayle (1999) indicated that the source of the stress experienced was due to:

- factors intrinsic to the job;
- managerial roles within the service;
- work-related relationships;
- career development and achievement;
- the organisational structure and climate of change;
- the difficulties of the home/work interface

Whilst they acknowledge that their study contradicts the findings of previous studies, in that it is reported that organisational issues cause most stress, this may be the consequence of using only a limited range of questionnaires. They achieved only a 42% response rate, some of whom were student nurses, unlike in other studies. Their study does, however, indicate high levels of stress in psychiatric nursing.

McLeod (1997) conducted a study of 60 CMHNs, randomly selected from Central England to test his hypothesis that CMHNs with caseloads of long-term mentally ill clients (schizophrenia or bipolar disorder) would suffer more stress than a CMHN with a mixed group consisting of enduring mental disorders or neurotic / psychological problems (affective and anxiety disorders), or a CMHN with primary / generic clients (anxiety, affective, transitional or adjustment disorders). Each group of 20 CMHNs completed the GHQ28: on the GHQ28 questionnaire, those working with the long-term mentally ill scored above the threshold of 5, at 8/20 (40% were above the threshold); those with a mixed caseload scored 4/20 (20% were above the threshold); and, those with the neurotic
caseload scored 3/20 (15% were above the threshold. The group working with the more severely mentally ill reported greater stress levels.

McLeod (1997) acknowledged that the small sample was not indicative of the CMHN population as a whole, but it did seem to go some way to prove that the more severe the illness of the client group, the more stress the mental health worker can be under. He also found that the CMHNs who were working with the more severely ill were younger and less experienced than those working with primary care patients, and that lower graded staff were responsible for the more severe mentally ill. Qualifications such as the CMHN ENB811 and ENB812-diploma post-basic courses were held mainly by the higher graded staff resulting in an imbalance of skill-mix throughout the service area.

Majomip, Brown & Crawford (2003) conducted a semi-structured interview about stress and its impact on home life with twenty nurses. In a grounded theory analysis, they found conflicts between the work and home roles of the participants. The aim of the study was to explore those conflicts. Difficulties were being experienced due to the demands of home life and organisational changes at work. This led to more stress, periods of illness and to a re-assessment of their work role. As this was a hitherto neglected area of research, the inter-relationship was explored using a qualitative and grounded theory approach, which involved conducting open structured interviews.

They concluded that all the roles undertaken by CMHNs should be considered when looking at stress. The balance between home and work kept crossing boundaries, especially when child-care became an issue, leading to role conflict. Stress and sickness became the norm rather than the exception, leading to burnout (Ray & Miller 1994). The stress experienced by participants was highlighted thus, ‘looking around me here, I know of four nurses who are off because of stress-related problems’, and there is growing evidence to support this finding (Rabin et al 1999).

Majomip et al (2003) also felt that there was a lack of formal and informal support for CMHNs, as they worked outside of the institutions that historically provided it. They also felt that as the nursing role has become extended, out of hours working to enable contact with other agencies has become common practice, making it more difficult to separate work from family time. Specific difficulties relating to the care of people with long term and enduring mental health problems were highlighted.

Comparing CMHN & In-patient Mental Health Nurse Experiences

The Claybury CPN Stress Study (Fagin et al 1994) involved the collection of data from 250 CMHNs and 323 ward based psychiatric nurses (WBPNs). Conducted at the time of the closure of a large psychiatric hospital, with many patients being transferred back into the community, the results clearly showed that CMHNs were under a great deal of work-related stress: 41% of CMHNs scored highly on the GHQ28; 48% scored highly on the MBI. This is well beyond the accepted norm, being almost double the rates report by Carson et al (1991) in their earlier research. However, CMHNs reported higher levels of job satisfaction and lower rates of burnout compared to their ward-based colleagues. Some 71% of WBPNs felt that their job security was threatened, mainly because of the closures taking place. WBPNs had greater feelings of depersonalisation / detachment than the CMHNs and were less likely to report a sense of personal achievement within their working
A certain amount of dissatisfaction was experienced by both groups, especially around salary, status and the low levels of respect from the general public.

It is worth noting that staff cover has always been an issue, with most wards being perceived as understaffed. Changes in the service and hospital closure, especially if redundancies are involved, would be stressful in any industry and thus this study cannot truly reflect the normal stresses experienced. As indicated, there is a great difference between this study and the smaller scale study of Carson et al (1991) – perhaps a consequence of the projected hospital closure becoming a reality. A follow-up study of the respondents may have given a different picture. It is also worth noting that the nursing shortage of the last few years has greatly reduced the need for redundancies within the NHS and, while no job is secure, the stress of feared redundancy has reduced.

Comparing CMHN, Health Visitor & District Nurse Experiences

In her comparative study of health visitors, district nurses and CMHNs, Snelgrove (1998) examined self-reported stress and job satisfaction in one health authority in the UK. She used the GHQ12 and an undisclosed 47-item likert scale questionnaire, compiled by herself – the latter was validated by asking nurses and health visitors to examine the terms and items for clarity and relevance. The numbers were small: 68/122 health visitors (HV), 56/122 district nurses (DN) and 19/33 CMHNs responded. The sources and levels of stress were examined in relation to each speciality. All of the respondents worked at Grade ‘F’ or ‘G’ level and as part of a team with two or more colleagues of the same discipline.

Health Visitors showed higher levels of stress on the GHQ12 (14.3) than the two other groups (DNs = 12.6 & CMHNs = 9.7). The most significant sources of stress for the Health Visitors were: worries over decision-making; quantifying work; the home / work interface; not liking a colleague; and, feelings of emotional pressure. For the District Nurses, they were: lack of time on visits; and, physical exhaustion. For the CMHNs, they were: the stress of failed visits; and, feeling pressured. Using Snelgrove’s own questionnaire, 25% or more showed ‘considerable to extreme stress’ due to organisational issues, a lack of resources and administrative duties. For the HVs and DNs, 60% found that the ‘lack of resources’ caused considerable to extreme stress. HVs reported less job satisfaction than the other groups.

Snelgrove showed similarities between her study and that of Hipwell et al (1989), indicating few differences in the levels of stress between specialities. Her study also supports previous research that suggests that stress in nursing may vary as a function of the speciality (Marshall 1980, Slater 1993). Whilst there were similarities between all three groups, the severity of the source of stress seems to be a function of the demands peculiar to each occupational group.

Although an interesting study, it demonstrates the difficulty researchers face when trying to compare groups who work in different fields of nursing and will have had different training routes. The study did not account for the impact of the development and changing nature of the nurse – patient relationship, the impact of the core nature of the role, likely emotional pressures, patient recovery rates and contact time on job satisfaction between the three occupational groups. Due to the nature of mental illness, CMHNs take a long-term view of the person’s health and recovery, offering
support and working with them on regular and long-term basis, which may increase their understanding of the individual, their situation, and consequently reducing stress for the CMHN and giving job satisfaction as the individual develops emotionally during their recovery from illness. These factors may account for HVs reporting lower job satisfaction and higher levels of stress.

**Developing Intervention for Stress**

Cottrell (2000) conducted a small-scale action-research study examining stress and job satisfaction in CMHNs working in a semi-rural area of Wales. He hypothesised that ‘many of the problems typically categorised as “work stress” may well be symptoms of underlying and possibly unrelated organisational issues’. Fitter (1987) identified eight factors as potential sources of stress in nursing: responsibility; workload; physically arduous work; shift work; overtime and covering for absent colleagues; interpersonal conflict; responsibility for training; uncertainty and unpredictability; and, keeping up with change. Jones et al (1987) and McGrath et al (1989) identified similar factors in other studies. Sullivan (1993) and Ryan & Quayle (1999) also noted ‘that organisational constraints and administrative requirements may become more significant stressors than direct client care itself’. Using the 120-item self-report Pressure Management Indicator (PMI) (Williams & Cooper 1998), which encompasses workplace stressors, Cottrell (2000) received 32/58 postal returns. Major stressors for the study sample were: workload; managerial roles; relationships; and, the balance between home and work.

Cottrell (2000) used this information to develop protective and risk factors, and suggested a number of interventions for stress management. A matrix of organisational stress management interventions was developed, to be offered on an individual, group and organisational basis (Table 1).

Cottrell (2000) emphasised caution when using stress management interventions, in highlighting that enduring work stressors are not overlooked, as such would limit the impact of stress management. A model of supervision, based on Procter’s (1986) tripartite model of support, education and oversight, was introduced. The planned interventions were designed to facilitate emotional contact through planning time for clinical supervision and managerial review on a regular basis. Clinical supervision was introduced through a planned and systematic process of awareness raising and skills training. Study participants reported that their levels of stress were reduced, providing an atmosphere that provided greater control and autonomy, assisted with problem solving, facilitated interpersonal awareness and allowed for feedback and advice.

**Table 1:**

<table>
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<tr>
<th>Primary = stress reduction</th>
<th>to reduce exposure to psychologically harmful working conditions</th>
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<tr>
<td>Secondary = stress management</td>
<td>to enable people to utilise the skills necessary to deal with potentially harmful working conditions</td>
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<tr>
<td>Tertiary = stress treatment</td>
<td>to treat people who have been harmed in some way by work-related stress</td>
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summarised by Murphy (1986) and adapted by Schaufeli & Enzmann (1998)
Cottrell (2000) concluded that: workload and working relationships were the major stressors for CMHNs; clinical supervision was effective in helping to reduce occupational stress; and, ‘the provision of time to reflect upon practice demonstrates a Trust's commitment to an organisationally endorsed process whereby staff may address practice and personal issues as an integral part of their working day.”

Cottrell’s study (2000) thus attempts to address the stress that CMHNs are experiencing, and principally through: a model of supervision that allows for a two-way dialogue to take place between the different levels of the organisation; and, keeping the CMHN informed of what is going on regarding organisational change, allowing ventilation of staff through this process. He demonstrates that stress can be managed and reduced in the workplace through supervision and stress management.

Burnard et al (2000) surveyed 614 CMHNs in Wales, of whom 301 (49%) responded. Respondents completed a number of validated instruments measuring stress, burnout and coping, together with a demographic questionnaire. Three open ended questions were included to determine their views of the sources of stress in the workplace and to investigate which coping methods were used. They established a working hypothesis, that ‘there is evidence that community mental health nurses experience stress and burnout related to their work’, as supported by the literature (Parahoo 1991, Fagin et al 1995, Mcleod 1997, Snelgrove 1998). They asked three key questions:

- What are the three things that cause you most stress?
- What would you say was the most stressful thing that has happened to you at work in the last month?
- What factors do you feel help you to cope with your job as a CMHN?

The data was analysed using Clamp & Gough’s (1999) content analysis. The most frequently reported stressors are indicated in Table 2.

### Table 2:

<table>
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<tr>
<th>Stressor</th>
<th>Frequency</th>
<th>Percentage</th>
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<tr>
<td>Workload / time-related issues</td>
<td>101</td>
<td>14.6%</td>
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<tr>
<td>Client-centred issues/general</td>
<td>43</td>
<td>16.7%</td>
</tr>
<tr>
<td>Support from colleague / manager etc...</td>
<td>285</td>
<td>42.9%</td>
</tr>
<tr>
<td>Paperwork / administration</td>
<td>96</td>
<td>13.9%</td>
</tr>
<tr>
<td>Client-centred issues - behavioural</td>
<td>26</td>
<td>10.1%</td>
</tr>
<tr>
<td>Paperwork/admin</td>
<td>22</td>
<td>8.6%</td>
</tr>
<tr>
<td>Supervision</td>
<td>66</td>
<td>9.9%</td>
</tr>
<tr>
<td>Client-related issues</td>
<td>79</td>
<td>11.4%</td>
</tr>
<tr>
<td>Paperwork/admin</td>
<td>22</td>
<td>8.6%</td>
</tr>
<tr>
<td>Other agencies / disciplines</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Interests / hobbies</td>
<td>48</td>
<td>7.2%</td>
</tr>
<tr>
<td>Case overload</td>
<td>56</td>
<td>8.1%</td>
</tr>
<tr>
<td>Team/Trust changes</td>
<td>21</td>
<td>8.2%</td>
</tr>
<tr>
<td>Role as a CMHN</td>
<td>40</td>
<td>6.0%</td>
</tr>
<tr>
<td>Poor resources</td>
<td>52</td>
<td>7.5%</td>
</tr>
<tr>
<td>Inter-personal problems</td>
<td>20</td>
<td>7.8%</td>
</tr>
<tr>
<td>Role as a CMHN</td>
<td>40</td>
<td>6.0%</td>
</tr>
<tr>
<td>Lack of supervision / support</td>
<td>30</td>
<td>4.3%</td>
</tr>
<tr>
<td>Inter-personal problems</td>
<td>20</td>
<td>7.8%</td>
</tr>
<tr>
<td>Happy home life</td>
<td>32</td>
<td>4.8%</td>
</tr>
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They divided the sources of stress into two broad categories: those which are related to the demands of working with patients, and those related to other aspects of the work. A picture of CMHNs perceiving themselves to be overworked, struggling with paperwork / administration issues, too many clients and concerns about their client group, emerged. This study thus reinforced the findings of the Claybury study (Carson et al 1995). Difficulty arising from relationships with clients was identified as the main stressor for the CMHN, concurring with Coffey's (1999) study of forensic CMHNs.

CMHNs reported using a variety of coping strategies, which included peer support, personal approaches, good communication skills and clinical supervision. Whilst being complementary about the support received from colleagues and managers, having a ‘satisfactory and supportive life outside of the job’ was regularly cited as a strategy for coping with stress. CMHNs appeared to favour informal approaches to coping with stress, with only a small number favouring clinical supervision – a finding that is supported by other studies (Trygstad 1986, Carson et al 1995, Coffey 1999). The most favoured coping strategy found in all of these studies was support from colleagues, managers and other professionals.

They concluded that the effects on individuals of stress and inadequate methods of coping may be problems of mental or physical health and a reduction in job satisfaction. For the organisation, the effects of stress may be many, including high absenteeism, poor job performance and reduced efficiency and effectiveness, low staff morale and high staff turnover (Rees & Cooper 1990). They also concluded ‘that a range of factors such as organisational pressures and factors related to working with patients are important in determining stress levels, and that informal rather than formal support networks are the preferred methods of coping’.

**Review of the Major Studies: summarising the findings**

Edwards et al (2000) reviewed the literature relating to stress and burnout experienced by CMHNs: 17 papers were identified, of which 7 focused on community mental health teams (CMHTs) and 10 focused on CMHNs. They cited that ‘there is a growing body of evidence that suggests that many CMHNs are experiencing considerable stress’ (Parahoo 1991, Carson et al 1995, Fagin et al 1995, McLeod 1997, Snelgrove 1998) and that the causes of stress in the workplace are complex and multi-factored. The evidence suggests that stress and burnout not only affect the level of performance and the success of interventions by mental health workers but also job satisfaction and ultimately their own health (Carson & Fagin 1996). Mental health care workers face additional strain by the very nature of their professions and as a result may be more at risk than their colleagues who work in a more physical environment (Moore & Cooper 1996, Nolan et al 1995). Increased workloads, understaffing, job insecurity and continuing, rapid organisational change have all been identified as major sources of stress amongst mental health workers. So too has the increasing intensity of work with more highly disturbed and potentially violent and dangerous patients (Thomas 1997).

Leitier & Harvie (1996) reviewed research articles in relation to stress and burnout. Their review suggested that ‘burnout occurs as a result of problems arising through excessive demands associated with caseloads or personal conflict that interfere with opportunities to attend thoroughly to the needs of the service recipients’. They concluded that these problems are ‘often exacerbated by insufficient support from colleagues, family or the nature of the work.'
itself’. Mental health nurses and CMHNs have been identified as ‘the professional groups with the highest sources of stress along with speech therapists’ (Rees & Smith 1991). Jones (1987) concluded that two major factors emerged as potential sources of stress for mental health nurses: patient contact and administrative / organisational factors. Other specific sources of stress include: staff shortages; conflicts with patients, relatives and staff; a lack of resources; interpersonal involvement; difficulties in nurse relationships; poor supervision; and, home / work conflict (Trygstad 1986, Travers & Firth-Cozens 1989, Dawkins et al 1985).

Parry-Jones et al (1998) looked at the impact of care management practice on social workers, community nurses and CMHNs in Wales. Their research indicated increases in stress and decreases in job satisfaction, which was associated with increased workload and administrative duties combined with reduced time for service-user and family contact. Due to a small response rate, it is not possible to generalise this study.

In 1993, the Sainsbury Centre for Mental Health collected data on the current organisation and operation of the CMHTs. They identified 517 teams in 144 district health authorities. 60 individuals from 302 teams responded by supplying data on job satisfaction, team role clarity, personal role clarity, team and professional identification, sources of pressure and reward, and features of practice (size and composition of caseloads). Overall, team members reported team and personal role clarity and positive identification with both the team and their discipline (Onyett et al 1997). Major concerns were threats to their efficacy arising from a lack of resources, work overload and bureaucracy. Team members cited contact with team colleagues and multidisciplinary working as being the most rewarding part of their job along with working directly with service-users and being clinically effective (Onyett et al 1995). 44% of respondents were in the 'high' burnout category for emotional exhaustion, as based upon the norms for mental health workers. This included 45% of community nurses, 54% of social workers and 63% of consultants. CMHNs had significantly higher caseloads, though caseload size, composition and the frequency with which service-users were seen were neither associated with job satisfaction nor burnout (Onyett et al 1997).

Wykes et al (1997) examined the levels of stress and burnout that affect community mental health staff. There were indications that staff experienced high levels of burnout due to work stressors. Further evidence supports the view that burnout is the consequence of increased workload, increased administration and a lack of resources.

Parahoo (1991) conducted a study in Northern Ireland and identified 30 factors that contributed to CMHN job satisfaction and 36 that did not. It was cited that the most frequently identified factors contributing to job satisfaction were ‘working independently’, ‘being ones own manager’ and ‘being an independent practitioner’. 70% of respondents rated their job satisfaction as ‘high’ or ‘very high’.

Edwards et al (2000) concluded that stressors intrinsic to the job were: increased workload; administration; time management; inappropriate referrals and safety issues, especially where seeing potentially dangerous or suicidal patients. Role stressors were identified as: role conflict; uncertainty and changes in role or levels of responsibility. Other stressors were concerning relationships, including the lack of supervision. Organisational stressors included the structure of the organisation.
and the climate of NHS reforms, general working conditions, a lack of support and lack of funding.

Edwards et al (2000) conducted a study on stressors, moderators and stress outcomes, with the following objectives: to examine the variety, frequency and severity of stressors amongst CMHNs; to describe the coping methods used to reduce work based stress; and, to determine stress outcomes. A number of validated questionnaires were used including a tool designed by the authors and used by Burnard et al (2000). The ten most and ten least stress inducing factors were identified from the findings using the CPN Stress Questionnaire (Revised). The top four for each category were:

**Most Stressful:**
- Not having the facilities in the community that I can refer my clients to
- Trying to keep up good quality care in my work
- Having too many interruptions in the office
- Long waiting lists for client access to services

**Least Stressful:**
- Not been able to rely upon support of colleagues
- Having to carry drugs around
- Communication problems with colleagues
- Receiving supervision that I don’t find helpful

Considering coping strategies: 93% of the CMHNs felt they could discuss their work-related problems with their work colleagues and found this a way of alleviating their work-related stress; 86% found their managers to be supportive. The most and least commonly used coping methods were:

**Most Common:**
- Having a stable home life, separate from my work
- Life outside of work, that is enjoyable, healthy and worthwhile
- Talking to people I get on with
- Looking forward to going home at the end of the day

**Least Common:**
- Having team supervision
- ‘One to one’ supervision
- Reminding myself that others have placed their trust in me
- Having a satisfying sex life

On the GHQ12, 35% of CMHNs crossed the threshold of ‘psychiatric caseness’ (having or developing a mental illness) and there was significant positive correlation between GHQ12 scores and the MBI emotional exhaustion scale, the MBI depersonalisation subscale and the total Rosenberg Self-Esteem score. The MBI scales indicated high burnout rates for the CMHN sample group.

Having used a number of validated stress and burnout questionnaires, this is a very good, comprehensive and in-depth study of the levels of stress experienced by CMHNs in Wales, complementing the companion study of Burnard et al (2000).

**In Conclusion**

In the United Kingdom (UK), there have been a large number of reports that between 25-50% of National Health Service (NHS) staff have experienced significant personal distress (Weinberg & Creed 2000). There exists a substantial body of evidence to suggest that high stress levels are endemic throughout the NHS (Anderson et al 1996) and that many of the stressors may be unique to health care (Payne & Firth-Cozens 1987).
In the last 10 years there have been a number of studies of the impact of stress and stressors in the psychiatric nurse’s work-place (Carson et al 1994, Fagin et al 1994, McLeod 1997, Snelgrove 1998, Ryan & Quayle 1999, Cottrell 2000, Edwards et al 2000, Burnard et al 2000, Majomip et al 2003). The conclusion of each study indicates that mental health nursing in both ward and community settings is stressful to the workforce. High levels of stress and burnout have been identified, especially in community mental health nursing. Carson et al (1994) conducted one of the largest studies of mental health nurses, finding a number of factors that could lead to stress for community-based workers. This was quite unique, as previously nurses had worked in large institutions where there were a number of staff to call for support and the hospital provided facilities for the day care of the patients. The fact that at the time of their study the large hospitals were in a state of closure may have been a contributing factor adding to the stress levels of the CMHN.

Organisational issues, such as managerial roles within the service and work-related relationships, has also been seen to be a major stressor for the CMHN. Lack of support and training opportunities within a climate of change increases the stress experienced.

Parry-Jones et al (1998) found, since the implementation of the NHS and Community Care Act, that stress levels had increased and levels of job satisfaction had decreased as more demands were made of the CMHN’s time. It was clear that these stressors were not indicative to that study sample, as evidence exists to support that they were not alone with those problems (Brown & Leary 1995).

Snelgrove (1998), in her comparative study of community nursing staff, demonstrated the difficulties of research when comparing workers from different nursing fields. While they may all work in the community, their roles and client groups vary greatly. Her study supported the work of Guppy & Gutteridge (1991) as a representation of ‘accentuated stress due to working in an organisation such as the NHS with stress-related nursing duties’.

Edwards et al (2000) reviewed the literature on stress, burnout and stressors and drew together all of the studies to date. Edwards et al (2000) went on to replicate the Carson et al (1994) study, drawing similar conclusions in that CMHNs are suffering from high levels of work-related stress and high levels of burnout. A number of stressors have been identified by all of the studies undertaken in this field and further research needs to be carried out on larger groups of CMHNs in gaining a clearer picture.

In conclusion, I feel that the studies that have been reviewed have demonstrated that CMHNs do experience a high level of stress in the working environment and this can lead to burnout. These studies confirm that CMHNs continually juggle a multitude of responsibilities demanded by their various roles. These studies have also highlighted the adverse impact of occupational stress on health and life expectancy.

Dissatisfaction with their work and a lack of personal achievement have led to feelings of depersonalisation, not relating well to their client group and severe long-term feelings of a lack of personal achievement.

As CMHNs are central to the Government’s community care policies, more care will have to be given to the emotional needs of the people who will deliver care if these care policies are to succeed. There is a need to address the stress that is experienced by CMHNs – whether through initiatives such as anxiety management and relaxation
courses for the staff (and thus not only for service-users), and through effective clinical supervision and support systems. While it may be difficult to reduce the stressors that exist within the service, we can effectively treat the stress it produces, reducing both the amount of stress and burnout that is experienced.

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