



RESEARCH

Support Workers in Community Mental Health Teams for Older People: Exploring Sources of Satisfaction and Stress

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Context: Support workers play an essential role in multidisciplinary community mental health teams for older people (CMHTsOP) in England. However, little is known about how they perceive their role or the impact this has on their levels of stress, well-being and job satisfaction.

Objectives: To compare CMHTsOP support workers' perceptions of the psychosocial characteristics of their work with those of registered CMHTsOP practitioners.

Methods: A postal survey of CMHTsOP staff in nine mental health trusts. Information was collected about job demands, controls and support using the Job Content Questionnaire. Additional data was collected on other psychosocial features of CMHTsOP working using job satisfaction and intention-to-quit measures and a set of bespoke statements which were supplemented by a subset from the Occupational Stress Indicator.

Findings: Responses were received from 43 support workers and 166 registered practitioners. Support workers reported significantly lower job demands and better co-worker support than registered practitioners. They were also significantly more satisfied with their jobs and more likely to believe that their skills and strengths were used appropriately. The majority of both groups were positive about their team's climate and their value and identity within it.

Limitations: Although the study explored the psychosocial characteristics of work that contribute to well-being, it did not directly measure stress.

Implications: Given the growing number of CMHTsOP support workers and their diverse roles, future research might usefully explore the specific tasks which contribute most to individual satisfaction and well-being.

Keywords: support workers; job satisfaction; stress; community mental health teams; older people; well-being

Introduction

Care workers without professional registration in mental health services, collectively termed support workers, are a fundamental component of any service catering for the requirements of older adults with psychiatric disorders. Under the direction of registered practitioners (licensed professional groups, for example, nurses), support workers provide essential direct care spanning individuals' functional, emotional and social needs (Wilberforce et al., 2017). However, lacking the guidance, support and requisite training pathway of an organised professional

body and invariably on lower pay and with lower status than their registered counterparts, there is a risk that they will be more susceptible to sources of stress (Cavendish, 2013). Job stress is a psychological and physiological consequence of unresolved mental strain at work and is among the leading causes of long-term sickness absence (Health and Safety Executive, 2016). Despite a proliferation of studies exploring stress amongst registered professionals, there is a dearth of literature relating to support workers (Paris & Hoge, 2010). This study seeks to address that gap and reports the findings of research with practitioners in 38 community mental health teams for older people (CMHTsOP) in nine regions of England.

Support work in community mental health teams

Multidisciplinary CMHTsOP are an internationally recognised service model, providing the first tier of specialist psychiatric care for older adults with severe and complex needs who live at home (Draper, 2000; Semrau

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et al., 2011; Wertheimer, 1997). Comprising consultant psychiatrists, nurses, social workers, occupational therapists and psychologists, teams in England are expected to work across community services to deliver an integrated and person-centred support plan which promotes recovery and maintains independence (Royal College of Psychiatrists, 2006; Wilberforce et al., 2011). These individual professional disciplines are commonly supplemented by 'assistant-grade' support workers, such as social work assistants and occupational therapy technical instructors, as well as staff in training posts aspiring to achieve registered status (Wakefield et al., 2009; Wilberforce et al., 2013). Alternatively, support workers may not be linked to any particular professional group but have a specialist focus on mental health work, such as support, time and recovery workers (Huxley et al., 2009; Wilberforce et al., 2017). Recent years have witnessed a sharp expansion of support workers in CMHTsOP in England variously funded by health and/or social care agencies (Wilberforce et al., 2013, 2017). Although previously there has been no obvious policy pronouncement seeking to extend their duties, this recent growth may be justified by evidence indicating that their contribution is highly valued by service users (Manthorpe et al., 2010; McCrae et al., 2008; Murray et al., 1997).

Support work itself is often seen as a rewarding and flexible mental health role, comprising much of the face-to-face casework that practitioners regard as most fulfilling (Wilberforce et al., 2014). In particular, support workers may have more time to develop meaningful relationships and rapport with service users than registered practitioners – an essential contributor to job satisfaction (Manthorpe et al., 2010). Nevertheless, several features of the support worker role and the CMHTsOP working environment suggest that support workers may be vulnerable to stress. First, older people with mental health problems are generally only referred to CMHTsOP if primary and/or generic social care services are unable to meet their needs. A typical CMHTsOP caseload will thus include service users exhibiting severe emotional distress, behavioural disturbance, risk of harm to self/others, self-neglect, and restricted functioning in daily activities (Tucker et al., 2014). Moreover, research has suggested that support workers are particularly likely to support service users who present with challenging behaviours and/or are considered at risk (Wilberforce et al., 2015).

Second, although support workers are supervised by registered practitioners (who, in England, retain clinical responsibility for service users' treatment), the community-orientation of their work means that (relative to support workers in hospital settings) direct oversight of their daily work may be limited (McCrae et al., 2008). Indeed, whilst CMHTsOP support workers' work is guided by care plans formulated by registered practitioners, the way in which these plans are enacted, and any decisions that need to be taken *in situ*, are left for support workers to adjudicate. In addition, their supervision may be complicated by the involvement of a

range of personnel beyond the supervising practitioner, including consultant psychiatrists, the team manager and other senior practitioners (Wilberforce et al., 2017). The potential for conflicting demands or confused guidance is apparent.

Third, whereas a range of professional frameworks, standards and support networks exist to support registered practitioners' practice, there are very few standards for support workers outside those stipulated by their employer (Cavendish, 2013). Consequently, job roles are remarkably diverse. Lacking clearly prescribed duties, role ambiguity is a likely occupational hazard. Particular concerns arise when support workers are asked to undertake tasks traditionally seen as within a registered practitioner's remit without the requisite training (Royal College of Nursing, 2006). At the point at which work is delegated to them, support workers accept a legal duty of care for undertaking that work, even if overall clinical responsibility is retained by the registered practitioner (Royal College of Nursing, 2006, 2015). Furthermore, in terms of social networks, in CMHTsOPs dominated by registered practitioners and consultants, it is unclear whether support workers perceive the team's working environment to be supportive.

That said, assistant-grade staff have formed a recognised component of the mental health workforce for decades, and some frameworks exist to mitigate these risks. For example, mental health nurses are obligated to follow strict principles when delegating duties to support workers (Royal College of Nursing, 2006, 2015). However, whether these are sufficient to protect support workers from the potential sources of stress is not clear.

A framework for exploring the causes of stress

The occupational psychology literature provides important theoretical frameworks for investigating sources of stress and job satisfaction. The Job Demand/Control (JDC) model (Karasek & Theorell, 1990) has been used for almost 40 years to explain the psychosocial characteristics of work that contribute to well-being, and has been demonstrated to predict stress and a raft of associated physical and psychological morbidities (Van der Doef & Maes, 1999; Wilberforce et al., 2014).

Job demands relate to the psychological pressures of work caused by over-work, conflicting demands and high levels of responsibility. By contrast, job controls relate to the extent to which individuals perceive that they have discretion over the content of their work, the environment, decision-making and skills. Crucially, the JDC model hypothesises that high job demands alone do not necessarily predict poor job outcomes. Indeed, where high demands coincide with high job controls, work can be challenging but ultimately rewarding. In contrast, where high demand is coupled with low control, workers may feel trapped by pressures they are ill-equipped to meet. The original JDC model was subsequently modified to include the interaction with perceptions of support, reflecting the potential buffering from stress provided

by supportive line management and the wider social environment (Johnson & Hall, 1988).

The paper aims to explore whether support workers and registered practitioners within CMHTsOP have different perceptions of the psychosocial features of their work environment and the extent to which their experiences of work differ.

Methods

Sample and data collection

As part of a wider study of CMHTsOP working (Challis et al., 2014), staff in 38 CMHTsOP across England were invited to complete an anonymous postal questionnaire. The aims of the wider study were to identify core features of national variation in the structure, organisation and processes of CMHTsOP and to examine if different models were associated with different costs and outcomes (Challis et al., 2014). These 38 teams spanned nine mental health trusts (National Health Service organisations providing health and social care services for people with mental health disorders) and were purposively selected to ensure variation in CMHTsOP to meet the aims of the wider research programme. Nine CMHTsOP had already participated in another strand of the wider study, and managers in these teams were asked to circulate questionnaires to team members. The managers of the remaining teams (29 CMHTsOP) were approached by telephone and asked to provide details of their staff mix, further to which individual team members were sent copies of the questionnaire by post. As the research team did not personally give out all the questionnaires, it was not possible to specify the exact number distributed. However, this was estimated to be around 500.

The questionnaire included a range of standardised measures and bespoke questions relating to psychosocial characteristics of work, job satisfaction and features of working in CMHTsOP. Socio-demographic data were also collected. Stamped-addressed envelopes were provided for participants to return completed questionnaires directly to the research team. Data collection concluded in 2012.

Measures

Participants' perceptions of the psychosocial characteristics of their work were captured using the Job Content Questionnaire (JCQ), developed by Karasek (1979) as a standardised measurement instrument to support the JDC framework. This consists of 22 questions organised into five subscales as shown in **Box 1**.

Two additional measures were collected. First, respondents were asked to rate their overall job satisfaction on a six-point Likert scale with response options ranging from extremely satisfied to extremely dissatisfied (adapted from Andrews & Withey, 1976). Second, two bespoke items were combined to create an intention-to-quit measure. These captured participants' thoughts about quitting and whether an actual job search was underway, with each rated on a four-point Likert scale: strongly agree, agree, disagree and strongly disagree.

Box 1: Structure of the Job Content Questionnaire (Karasek, 1979)

- **Job demands** comprises five items describing the degree of work-related pressure;
 - **Skill discretion*** contains six items describing skills acquisition and utilisation;
 - **Decision authority*** is formed of three items describing control over key decisions affecting respondents' work;
 - **Supervisory support** comprises four items describing support received from managers; and
 - **Co-worker support** consists of four items spanning instrumental and emotional support from 'people worked with' (both support workers and registered practitioners).
- *The sum of skills discretion and decision authority gives a measure of **Job controls**.

Finally, respondents were asked to rate the extent to which they agreed with a number of bespoke statements about the way in which their team worked, which were derived from workshops with CMHTsOP practitioners in the North West of England. These included statements about the team climate, whether practitioners felt valued, the use of team members' skills and expertise, staff members' identity and career development opportunities. These were supplemented by five questions from the Occupational Stress Indicator (Cooper, Sloan, & Williams, 1988) which were regarded as particularly pertinent to the research aim.

Data analysis

Data were coded and entered into SPSS (version 22). Simple descriptive statistics, graphical displays and appropriate tests of significance (t-tests and chi-squared) were undertaken. Support workers responses relating to individual psychosocial characteristics of work, job satisfaction and features of working in CMHTsOP were compared with responses from registered practitioners (nurses, occupational therapists and social workers combined as a single group). Support workers' responses relating to the analysis of the JDC model were compared with those of each of the three registered practitioner disciplines independently (nurses, occupational therapists and social workers).

Ethical approvals

The study was granted ethical approval by an NHS Research Ethics committee (10/H0306/43), and additional research governance procedures required by individual Trusts were fulfilled.

Results

Completed questionnaires were received from 295 CMHTsOP staff (estimated response rate 59%), of whom 43 were support workers and 166 registered practitioners (nurses, occupational therapists and social workers). As shown in

Table 1, although there were some differences between the two groups in terms of gender, age and length of time within the team, none of these were statistically significant.

Table 2 presents the two practitioner groups' mean scores on the five psychosocial characteristics of work measures. A statistically significant difference was identified for two of these: job demands and co-worker support. Specifically, support workers reported significantly lower job demands and better co-worker support than registered practitioners.

Job satisfaction and intent-to-quit

Table 3 shows that support workers were found to be significantly more satisfied with their jobs than their registered practitioner colleagues. Furthermore, proportionately fewer support workers than registered practitioners reported an intention to quit.

Table 1: Sample sociodemographic characteristics.

		Support workers n (%)	Registered practitioners* n (%)
Gender	Male	5 (11.6)	36 (21.7)
	Female	38 (88.4)	130 (78.3)
Age (years)	<35	5 (11.6)	20 (12.2)
	35–54	28 (65.1)	119 (72.6)
	≥55	10 (23.3)	25 (15.2)
Employment status	Full time	29 (69.0)	120 (73.6)
	Part time	13 (31.0)	43 (26.4)
Years employed by team	<2 years	8 (21.1)	25 (16.6)
	2–9 years	16 (42.1)	82 (54.3)
	10 years+	14 (36.8)	44 (29.1)
Team size	≤10	5 (11.6)	24 (14.5)
	11–20	31 (72.1)	110 (66.3)
	21+	7 (16.3)	32 (19.3)
Total		n = 43	n = 166

* Registered practitioners: social workers, occupational therapists and nurses.

Features of CMHTsOP working

Table 4 presents information on the respondents' experience of working in CMHTsOPs. Overall, there were more similarities than differences between the support workers' and registered practitioners' experiences, with most respondents being largely positive about the team climate and their value and identity within it. Two items relating to team climate, however, showed statistically significant differences. First, proportionately more support workers than registered practitioners described the 'feel' or climate of their team as satisfactory. Second, proportionately more support workers than registered practitioners reported that their team spent time together reflecting on how the team operated. Similarly, on the one item in the 'feeling valued' domain where a statistically significant difference was found, support workers expressed more satisfaction with the amount of participation they had in decision making than registered practitioners, whilst in the identity domain proportionately fewer support workers than registered practitioners felt torn between the values and goals of their role/profession and those of the team.

Further, statistically significant differences between support workers and registered practitioners were observed in the domain of skills and expertise. Proportionately more support workers than registered practitioners agreed that work was allocated according to a person's skills rather than their professional background and that their particular expertise and skills were used appropriately within the team, whilst support workers were proportionately less likely than registered practitioners to state that they were asked or expected to do things outside their role. Finally, support workers were significantly more likely than registered practitioners to report that they were satisfied with the career development prospects in their current job.

Additional analyses were undertaken exploring support workers' responses relating to the JDC model compared with each of the individual registered practitioner disciplines. Support workers (n = 43) had the lowest mean job demands score and the second highest mean job control score (after nurses, n = 118). Occupational therapists (n = 25) and social workers (n = 23) had the lowest job control scores.

As noted earlier, it is the combination of high demands and low controls that is empirically associated with the worst health outcomes associated with stress (e.g. cardiovascular problems). In this sample, occupational

Table 2: Psychosocial characteristics of work.

Psychosocial characteristics of work	Support workers Mean (SD*)	Registered practitioners Mean (SD*)	t (df, F)**	p-value***
Job demand	29.97 (4.95)	36.73 (5.08)	7.501 (199, 1.074)	<0.001
Skill discretion	35.71 (3.08)	36.02 (3.66)	0.511 (203, 0.675)	ns
Decision authority	34.67 (4.81)	34.64 (5.57)	0.026 (202, 2.623)	ns
Supervisory support	12.37 (2.29)	12.11 (2.39)	−0.627 (200, 0.285)	ns
Co-worker support	13.60 (1.68)	12.98 (1.66)	−2.157 (205, 0.736)	0.032

* SD – standard deviation. ** Two-sided independent t-test (degrees of freedom, F value). *** p ≤ .05.

Table 3: Global satisfaction scales.

Global satisfaction scales	Support workers Mean (SD*)	Registered practitioners Mean (SD*)	t (df, F)**	p-value***
Job satisfaction	4.29 (1.27)	3.80 (0.99)	-2.647 (201, 5.353)	0.009
Intention to quit	3.57 (1.58)	4.44 (1.38)	3.512 (203, 1.646)	0.001

* SD – standard deviation. ** Two-sided independent t-test (degrees of freedom, F value). *** p ≤ .05.

Table 4: Features of working in CMHTsOP.

	Support workers Agree* Total n (%)	Registered practitioners Agree* Total n (%)	p-value**
<i>Team climate</i>			
There is an atmosphere of openness and trust within the team	31 (72.1)	131 (78.9)	ns
The psychological 'feel' or climate of our team is satisfactory	34 (81.0)	106 (64.2)	0.039
The team is flexible and adaptable	36 (85.7)	148 (90.2)	ns
The team feels stable	22 (52.4)	81 (49.4)	ns
The team tends to welcome new ideas	34 (81.0)	130 (79.3)	ns
Communication and the way information flows around the team is satisfactory	38 (88.4)	132 (79.5)	ns
We spend time together reflecting on how the team operates	35 (81.4)	108 (65.1)	0.040
The way changes and innovations are implemented is satisfactory	26 (60.5)	81 (49.1)	ns
Professional differences often get in the way	5 (11.6)	37 (22.6)	ns
<i>Feeling valued</i>			
Colleagues from other professions within the team have a good understanding of my role	40 (93.0)	139 (84.2)	ns
My particular professional expertise is valued by the team	41 (97.6)	154 (93.3)	ns
I feel that my experiences are not really listened to	5 (11.6)	32 (19.4)	ns
The opinions of some team members seem to carry more weight than those of others	19 (45.2)	97 (58.8)	ns
I am satisfied with the amount of participation I have in decision making	31 (72.1)	87 (52.4)	0.020
<i>Skills and expertise</i>			
Work is allocated according to a person's skills rather than professional background	35 (81.4)	96 (58.5)	0.006
We often disagree about which team members should do which tasks	4 (9.3)	36 (22.0)	ns
I am often asked/expected to do things that are outside my professional role	11 (25.6)	75 (45.5)	0.018
My particular professional expertise is used appropriately within the team	40 (95.2)	136 (82.9)	0.049
<i>Identity</i>			
I identify with the public image or goals of my team	38 (90.5)	132 (80.5)	ns
I often feel torn between the values and goals of my profession and those of the team	7 (16.3)	69 (41.8)	0.002
I am able to practice as an autonomous professional within the team	39 (90.7)	154 (93.9)	ns
I feel professionally isolated	4 (9.3)	24 (14.5)	ns
<i>Career development</i>			
I am satisfied with my career development prospects in my current job	30 (71.4)	88 (53.7)	0.038

* Agree (agree and strongly agree) versus disagree (disagree and strongly disagree).

** χ^2 test – when less than 5 in a cell Fishers Exact test used – and p ≤ .05.

therapists and social workers were at most risk. Nurses faced relatively high job demands but were protected by relatively high control over their workload. By contrast, support workers were at the lowest risk of stress due to experiencing the lowest job demands alongside average job controls.

Discussion

This study explored how support workers and registered practitioners perceive their work in CMHTsOP, particularly sources of stress and satisfaction. The results suggest that support workers report levels of autonomy on a par with qualified practitioners but with lower levels of responsibility (job demands) than often accompany this feature. Support workers also reported significantly greater co-worker support than registered practitioners. Furthermore, they reported higher job satisfaction and less intention-to-quit and were more likely than their colleagues to report that their skills and strengths were used appropriately.

The results of this study challenge existing evidence which suggests that support workers might be particularly susceptible to stress (Cavendish, 2013) and are likely to experience less autonomy than their registered practitioner colleagues (McCrae et al., 2008). Several factors may help to explain these findings. First, it is possible that, compared with other registered practitioners, support workers feel less encumbered by the demands of case responsibility, including reporting potential hazards to management, which has been demonstrated to produce risk averse and risk management practices in mental health nurses (Manuel & Crowe, 2014). Indeed, it seems likely that freedom from such responsibilities affords support workers the opportunity to operate more creatively, including practicing a more relational approach which can enrich the experience of both the support worker and service user (McCrae et al., 2008; Wilberforce et al., 2014). Second, although in comparison with support workers employed in social care settings (Manthorpe et al., 2010) the CMHTsOP support workers in this study appeared to receive less direct supervision, they reported higher levels of autonomy, suggesting this lack of supervision was not perceived as daunting.

Interpretation of these findings can be enriched through comparison with qualitative data collected as part of the same study (Wilberforce et al., 2017). Analysis of semi-structured interviews ($n = 42$) with support workers and other registered practitioners both strengthen and challenge the results presented here. For example, registered practitioners reported that support worker roles were largely appropriate to their grade and with suitable flexibility over tasks delegated to them, which accords with the findings presented here. However, support workers themselves provided examples of where they were expected to take on responsibilities beyond those with which they felt were appropriate to them, even occasionally being put in positions which felt unsafe. Similar findings have also been reported elsewhere (Cavendish, 2013; Royal College of Nursing, 2006). Whilst in this study there appeared to be adequate supervision for support workers, broadly

in line with the qualitative research, the latter nevertheless also identified situations in which support workers felt unable to access their managers at the time that they were needed. Such findings suggest that some individual support workers were experiencing work strain with some examples of substitution of professional roles by support workers without the essential oversight needed. This suggests a rationale for maintaining role boundaries unless explicitly managed and supported.

A number of limitations must be acknowledged. First, although the JDC model (Karasek & Theorell, 1990) explains the psychosocial characteristics of work that contribute to well-being, it does not measure stress directly. The features outlined in this study therefore represent variables that influence stress levels, rather than depicting the level of stress that respondents actually experienced. Second, the use of the term 'professional' in some bespoke questions may have been interpreted by some support workers to mean 'registered with a professional body' (which they are not). Third, the breadth of measures included provided the opportunity to explore variation on a range of variables. However, such extensive exploratory work might raise concerns about Type I error due to the extent of hypothesis testing. This said, the study had a number of strengths, including its size, which in encompassing 38 CMHTsOP spanning nine mental health trusts across England gives confidence in the generalisability of the results. Furthermore, the high response rate meant that comparisons could be made between practitioner groups.

Concluding comments

The results presented here suggest that support workers employed in CMHTsOP were generally positive about their experience, which, given their expanding numbers and the current drive to develop their capacity (Johnson & Buzzi, 2016), is encouraging. However, the picture is complex. Given the heterogeneity of community support workers' roles and duties, it would be informative for future research to explore the specific tasks they undertake which most contribute to their stress or well-being. For instance, the aforementioned qualitative research identified evidence that support workers can build positive relationships with service users and carers who have had problems engaging effectively with other community services (Wilberforce et al., 2017). However, the demands and satisfaction of such specific roles have not yet been evaluated. A comparison of the impact of setting, such as between CMHTsOP and generic local authority community teams, might also be worthy of exploration.

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Competing Interests

The authors have no competing interests to declare.

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