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How do mental health nurses negotiate and manage their mental health problems in the social environment at work?

Results of a mixed methods study

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Study summary

Study aims

- To understand the relationships between mental health nurses' own mental health and their subjective wellbeing.
- To explore the ways in which mental health nurses manage their own mental health and wellbeing and how they negotiate for and use their experiences both within and outside of their work.

Presentation aim

- To discuss research findings on disclosure at work and interactions with colleagues about nurses' mental ill health

Background

Policy and practice context - why care about nurses' mental health?

Mental health nurses (MHNs) are the **largest professional group** working within the UK mental health workforce (Centre for Workforce Intelligence, CfWI, 2012).

The RCN (2014) reported a **loss of 3,300 mental health nursing posts** in recent years, particularly in England. There has been a almost 15% drop in mental health nursing numbers in the NHS between 2010 and 2016 (Campbell, 2016).

Low levels of nursing staff wellbeing have been associated with risks to patient care and safety (Gärtner et al, 2010; Maben et al, 2012).

The **Boorman review (2009)** recommended that the NHS should adopt a preventive rather than reactive approach to employee mental health, focusing on the promotion of wellbeing.

Five Year Forward View for Mental Health (Mental Health Task Force/ NHS England, 2016) - a 'staff wellbeing CQUIN' in the 2015 NHS Standard Contract.

Methods

Methods

- Explanatory sequential mixed methods - 2 phase (Cresswell & Plano Clark, 2011)
- Phase 1: Survey of RCN / MHNA members (n225) comprising 3 measures of subjective wellbeing, questions about personal and familial mental health history and questions about the impact of these experiences on mental health nursing work (Oates et al, 2016)
- Phase 2: Semi structured interviews (n 27)with a purposive sample of survey respondents who had both subjective experience of mental health problems and high subjective wellbeing, in person or over Skype (Oates, 2015)

'Following a thread'

- Use of qualitative and quantitative data to allow a rich picture to emerge
- Findings presented thematically - 'following a thread' approach (Moran-Ellis et al, 2006).
- 'Grounding' qualitative findings in the survey findings and is reflective of mixed methods epistemology.
- Both the qualitative and quantitative aspects of the study have been conducted according to standards of practice within those domains.

Limitations

- Low survey response rate
- Not achieving the desired sample size, which was not calculable.
- The means of accessing survey participants, via third parties (the RCN and the MHNA) via an online survey meant that the researcher did not have direct access to potential participants and that access was mediated via group emails and newsletters.
- The sampling limitations affect the claims to generaliseability of the study that can be made, although the final sample was demographically representative of the UK MHN population.

Figure 1: Personal experience of mental illness in the survey participants

MHNs with some personal experience of mental illness 59.9% (n142)

MHNs reporting both current and past own MHP 36% (n40)

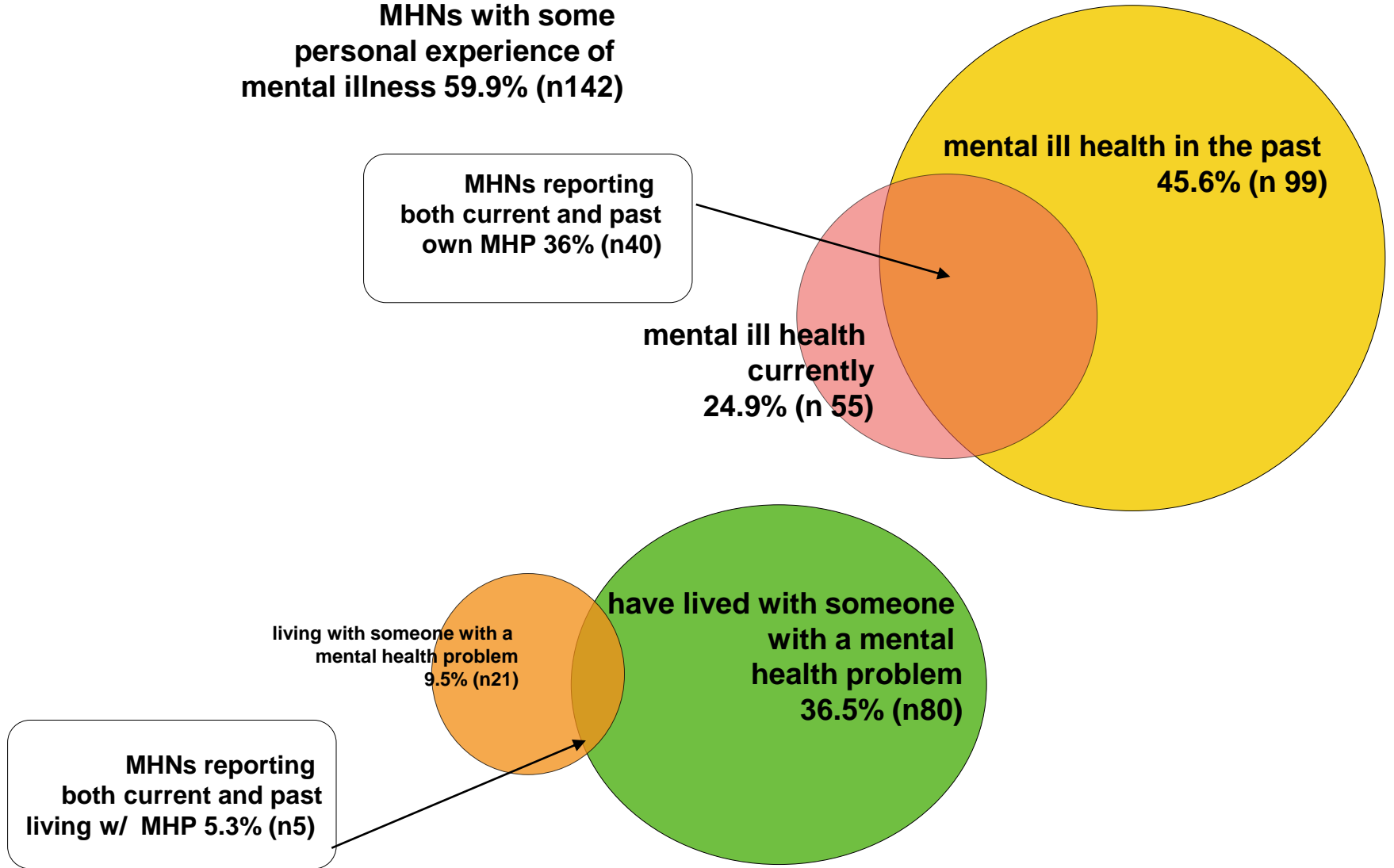
mental ill health currently 24.9% (n 55)

mental ill health in the past 45.6% (n 99)

living with someone with a mental health problem 9.5% (n21)

MHNs reporting both current and past living w/ MHP 5.3% (n5)

have lived with someone with a mental health problem 36.5% (n80)



Disclosure

Table 2: Disclosure of mental health problems- summary of survey results

Disclosure of Mental health problems to:	n	never	occasionally	sometimes	always
my service users	258	62%(161)	29%(76)	8%(21)	0
my colleagues	241	27%(64)	41%(98)	29%(69)	4%(10)
my manager	241	36%(86)	20%(47)	25%(60)	20%(48)

Disclosure

Table 3: Disclosure of mental health problems- survey results

		n	never	occasionally	sometimes	always
Do you disclose your personal experience of mental health problems	to service users	55	75%(41)	22%(12)	4%(2)	0%
	to colleagues	55	13%(7)	56%(31)	27%(15)	4%(2)
	to your manager	54	24%(13)	20%(11)	28%(15)	28%(15)
Do you disclose your home experience of living with mental health problems	to service users	19	74%(14)	11%(2)	16%(3)	0%
	to colleagues	20	50%(10)	30%(6)	20%(4)	0%
	to your manager	20	50%(10)	15%(3)	30%(6)	5%(1)

Degrees of disclosure dependent on setting

- dependent on shared history
- dependent on settings
- dependent on closeness and friendship

‘I think it’s working in forensics. Because I worked there to start with, working with paedophiles where you don’t tell them anything about you, that when I moved on to that it took me ages to give a little bit. It took a long time to realise I don’t have to be so guarded.’ (Diana)

‘Yes, I think it depends on the situation because it’s not like, I mean me and the peer support worker that I worked with we did a group together that was like a kind of recovery group and in those circumstances there was, we would have warm up, you know, bits of the group and we would take part in the group as much as the clients in those circumstances it felt right and it felt, you know, comfortable to share some things’ (Ruth)

Disclosure to colleagues

Making personal rules about disclosure:

- Taking cues from peer support workers
- not to colleagues as 'I've left that part of my life behind'
- disclosing in the third person

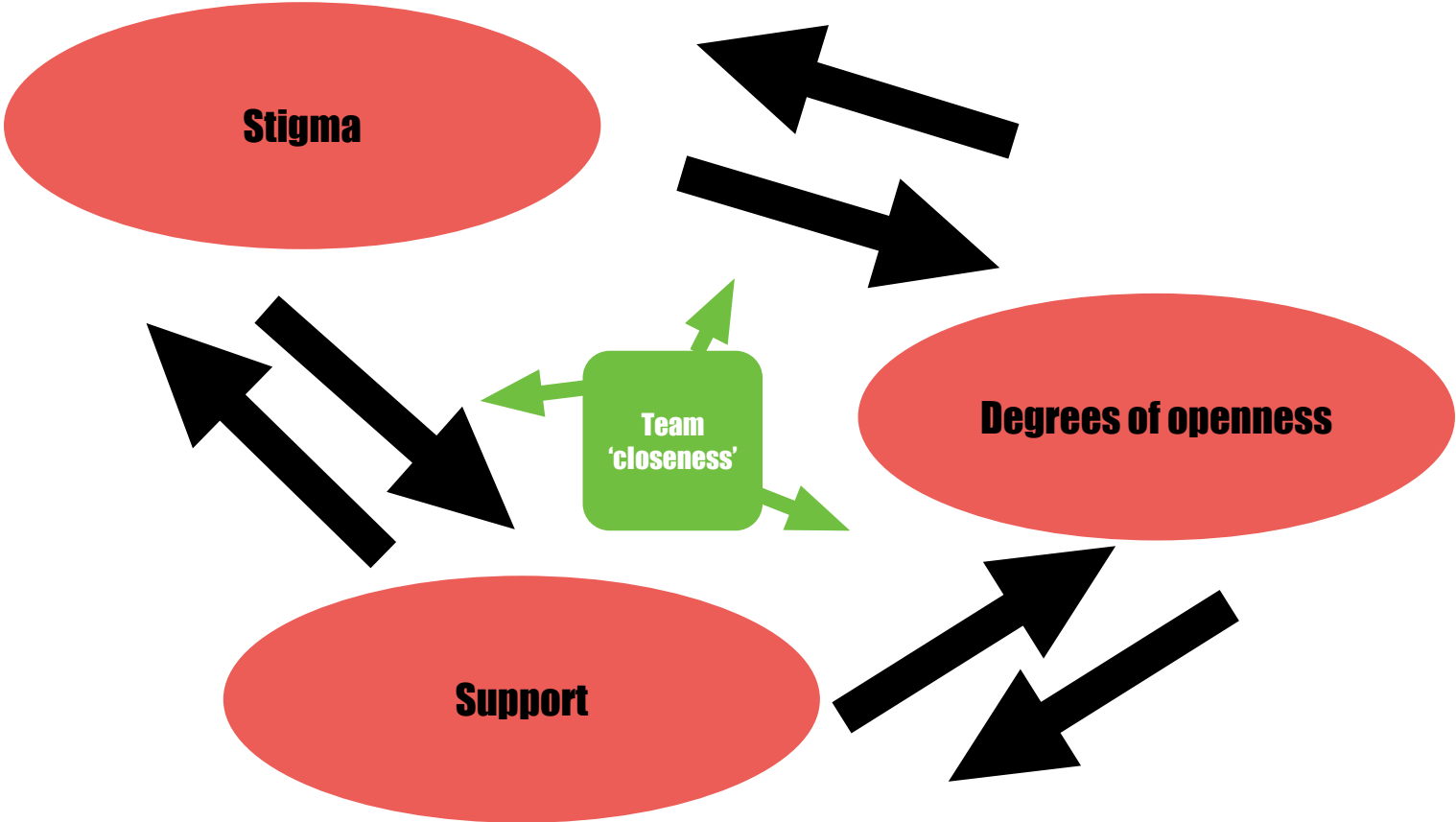
'I've not talked to any colleagues about it no because I don't think the situations require that. I will try to help patients reflect on things by using my experiences but not in a direct way like in a third person type of way say I knew somebody who suffered too. Do you know what I mean? If I wanted to have a conversation with the patient about something that happened in my life I would put it in a third person.'(Rob)

Perceived effect of MHP on work

Table 1: Effect of mental health problems on work - summary

Experience of mental health problems affects:		never	occasionally	sometimes	always
work with service users	in a positive way	23%(67)	14%(41)	38%(113)	25%(73)
	in a negative way	48%(120)	21%(52)	30%(73)	0.1%(3)
work with colleagues	in a positive way	32%(80)	22%(56)	35%(89)	11%(28)
	in a negative way	44%(101)	27(61)	26%(59)	3%(8)
managing work load	in a positive way	38%(89)	25%(58)	30%(71)	7%(17)
	in a negative way	43%(112)	17%(44)	34%(87)	6%(15)

Figure 1: Colleagues' responses to mental health problems



In summary

- In order to access support from colleagues the mental health nurse had to be ‘open’ about their experiences and their needs.
- The degree to which the mental health nurse or colleagues were open regarding mental health problems depended on the stigma that mental health problems had within their workplace.
- Whilst mental health problems per se may not be stigmatised, taking time out and the effect this had on others’ workloads was stigmatised.
- The stigma associated with mental health problems or time out could affect the amount of support available from colleagues.
- At the same time, the amount of support a person might need or get could also be stigmatising, when those team members who were being supported and managed by the whole team, through team management of their workload and their risks.
- Stigma, degrees of openness and support were mediated by ‘team closeness’, the extent to which teams had a collective sense of wellbeing and shared identity.

Mental illness in the team

'Because it was one thing to say we're trying to reduce stigma among people that we're working with but in terms of within our own team and the wider our mental health service, I think we're really poor. I think that we don't want to admit because, you know, the sick clients that I see coming in will say all sorts of things and yet when you're talking to the person on the phone if they're phoning in sick or whatever, they're clearly saying I'm stressed, I'm depressed, I'm anxious, whatever, you know, but they'll not openly admit to that. ' (Norman)

' I think because we're working in the area, mental health is not that uncommon, and maybe we are open and able to talk about it more.'
(Heather)

Mental illness in the team

‘I think that’s wrong, somehow because of what we’re doing and that what we say we’re supposed to be doing for the patients.’ (Norman)

- Collegiate openness with regard to mental health problems was seen as a marker of professional integrity for Fiona:

‘I decided this time around I wouldn’t make any bones about it, I would talk about having been depressed, I would talk about how it was for me and I would use that to every single advantage that I possibly could for the benefit of whoever really because we can’t expect...you’ve got to walk the walk, there’s no point talking the talk.’ (Fiona)

Mental illness in the team

‘And the difficulty is, when you’re working you can see when she’s becoming very unwell, and how things start to deteriorate, and then you do start to worry about patient care, and how things are being managed, especially when you have less and less staff. So I can understand why things are done to intervene, as such. But, sometimes I think it’s difficult, because you work in such a small team, things are said that shouldn’t necessarily be shared. And it’s partly because a lot of us have known each other for a very long time.’ (Ellen)

Mental illness in the team

‘Sometimes it can be the way in which you hear your colleagues talking about patients. Makes you... makes me wonder... I wonder what they would say if it was me who was feeling anxious, or, if somebody’s... I don’t know... off on a long term sick...

I’m just thinking, actually, there was a chap in my previous job who was off on a long term sick for most of the time that I worked there, which was nearly two years, due to mental health problems. And he was very much, kind of... initially, it was, kind of... people were angry about the fact that he wasn’t there to be able to do his job. There wasn’t very much compassion for him in his situation. And then he was just, kind of, forgotten.

But I think, whether part of us think, well, we’re trained professionals, we should be able to manage our own mental health; I don’t know. And I think quite a few professionals aren’t very, kind of, sympathetic or empathic towards each other, particularly if it impacts on their case load or if it impacts on their work load’

(Yvonne)

Difference between ward and community?

'...at times we thought what can we do to support her but other times she needed to go off sick. The manager would send her home. But I think on the ward you are more tightly bound together, you do build relationships. You're watching each other's back a lot of the time.' (Diana)

'I think we do, probably, a much better job at that than many other teams that I've worked in would do. I think, because we're more...we're quite understanding that we have lives and we're human beings. We're not just there to do our jobs; we...we've all got baggage and stuff that comes with us. So, I think that we do manage it fairly well.' (Joanna)

Link to previous literature

- The importance and **value of team working** is a recurrent theme in the wider literature on mental health nursing and the experience of mental health nurses (Cleary, 2012; Delaney and Johnson, 2014).
- ‘Resilience’ in crisis care mental health nurses is fostered by the **protective nature of the team** (Edward, 2005).
- Degrees of collegial support depended upon how long nurses had worked together before the illness and also on individual personalities and attributes (Joyce, Hazleton & MacMillan, 2009)
- Joyce et al, 2012 - ‘textbook knowledge’ of mental health problems is often disregarded when faced with colleagues’ problems.
- Glozier et al (2006) - returning to work following mental health problems was much more stigmatised than returning from time out with another condition, diabetes
- Tei-Tominaga, Asakura and Asakura (2014) - nurses hold more stigmatising beliefs about other nurses with mental health problems compared to colleagues with physical health problems.
- Ross and Goldner (2009) - nurses can act as perpetrators of stigma and that nurses with mental health problems may be shunned by colleagues.

What this study adds

- Disclosure to managers and colleagues is not the norm
- Participants described a range of experiences, and in general the survey responses on the impact of subjective experience of mental health problems on working with colleagues were positive.
- There was a distinction made though, between certain settings and certain types of mental health problems, with anxiety and depression being less problematic than bipolar disorder for example.
- Stigmatised colleagues' mental health problems if they meant that their own workload would increase and if they may put service users at risk.
- The stigma from others, or self stigma and embarrassment also stemmed from a notion that mental health nurses should know how to look after their own mental health.
- For these nurses, being mentally ill calls into question personal and professional integrity.

Implications

- These insights into the beliefs underlying stigma are invaluable to those tasked with addressing stigma within a mental health employer.
- The impact on workload and on service user safety must be addressed as well as the perceived impact on professional status and confidence.
- How we address mental health nurses' mental health problems **MUST** reflect their expertise and experience as mental health professionals

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