

Morale of mental health professionals in Community Mental Health Services of a Northern Italian Province

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SUMMARY. **Aims** – To explore morale of psychiatrists and psychiatric nurses working in Community Mental Health Centres (CMHC) in an Italian Province, and identify influential factors. **Methods** – Thirty psychiatrists and 30 nurses working in CMHCs in Modena completed questionnaires on burnout, team identity and job satisfaction. They also answered open questions about different aspects of their work. Answers were subjected to content analysis. Regression analyses were used to identify factors that predicted morale across groups. **Results** – Psychiatrists had higher scores on emotional exhaustion and depersonalisation. There were no significant differences between the two groups in job satisfaction and job or role perception. Professionals reported positive relationships with patients as the most enjoyable aspects of their job, whilst team conflicts and high workloads were seen as most difficult to cope with. Multivariate analyses showed that being a psychiatrist and perceiving team conflicts as a main cause of pressure in the job predicted higher burnout. **Conclusions** – Simple open questions coupled with quantitative measures appear a promising tool to investigate morale of mental health professionals and identify factors determining morale. Research, training and service development should focus on relationship aspects both with patients and within teams to reduce burnout in CMHCs.

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INTRODUCTION

In recent years, the measurement and monitoring of health services workforce morale has been recognized as important to guide audits and service improvements, as indicated by a recent global survey of job satisfaction in the British National Health Services (Odigwe, 2004). While there is an established tradition of mental health service research with various studies on outcomes, satisfaction with services and perceived needs by clients in Italian Community Mental Health Services (Tansella, 2002; Ruggeri, 2002; Ruggeri *et al.*, 2004), less attention has been paid to mental health professionals delivering these services and their attitudes towards work, morale,

perceived tasks and problems to fulfil them (Curci *et al.*, 1987; Garzotto *et al.*, 1992; Costantini *et al.*, 1999; Gigantesco *et al.*, 2003). Studies in other countries (Wykes *et al.*, 1997; Reid *et al.*, 1999a, b) suggest that factors such as burnout and job satisfaction can have a substantial impact on the nature and quality of care. Research on these factors can help to identify strengths and weaknesses in a given healthcare system, particularly when compared between national systems as well as over time and across periods of organisational change (Constantini *et al.*, 1999).

Staff attitudes may reflect a specific “philosophy” of care and the problems in applying that philosophy in a given social context. The exploration of staff morale and views can therefore provide an important angle to study the characteristics and components of mental health care systems as well as essential processes within them, thus complementing research on patient outcome and user perspectives.

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Also, partnership working between different professional groups may be facilitated, if the morale and views of the professionals involved as well as the factors influencing morale are understood. Whilst constructs such as burnout and job satisfaction can be measured on established questionnaires, a qualitative approach is required to elicit what areas staff see as enjoyable or problematic. Ideally, the results of quantitative and qualitative methods should be linked to identify factors that influence morale within and across groups. Findings of such research might help to identify targets for specific interventions to improve staff morale, e.g. through training, supervision, job planning and service configuration.

The aim of the present study was to explore morale and views of mental health professionals, i.e. psychiatrists and psychiatric nurses, working in community mental health care in the province of Modena, Italy. More specifically, the study addressed the following questions:

1. What are the levels of burnout and job satisfaction of psychiatrists and psychiatric nurses, and are there any differences between the two groups?
2. How do psychiatrists and psychiatric nurses perceive their job and professional role, and are there any differences between the two groups?
3. What aspects of their work do psychiatrists and psychiatric nurses report as enjoyable and stressful?
4. What factors predict burnout, job satisfaction, and team identity in these professional groups?

METHOD

Sample

The research was conducted as a cross-sectional survey using established questionnaires and open questions which were subjected to content analysis to assess different aspects of job-related morale. The sample consisted of psychiatrists (n=30) and community psychiatric nurses (n=30) working in public outpatients community mental health centres in the province of Modena, in the Northern Italian region Emilia Romagna. The sample size was chosen according to Central Limit Theory, which suggests that in samples of thirty or more the distribution and the mean of scores will be close to the values in the population that the sample is selected from. The sample size provided relatively little statistical power to detect small differences. However, this was accepted as - in this exploratory study - we were rather interested in large effects and in combining quantitative and qualitative methods. To achieve this sample size, in Spring 2002 the questionnaire was distributed manually and

sequentially by the authors to all 38 psychiatrists working in eight different outpatient community mental health centres in the province of Modena and to a convenience sample of 43 community psychiatric nurses working in the same services, which have a catchment area of approximately 600.000 population. Of the psychiatrists, 6 did not return the questionnaires, and two returned a grossly incomplete questionnaire, resulting in valid response rate of 79 %. The rate of valid responses in the group of nurses was 70%; six did not fill in the questionnaire, and 7 did so with insufficient completeness.

Instruments

A structured questionnaire covered socio-demographic characteristics (age, gender, marital status, etc.) and job details (caseloads, length of experience, professional responsibilities, etc.) of professionals.

Established scales were used to assess respondents' job perception and professional role (the *Team Identity Scale*) (Rizzo et al., 1970), job satisfaction (the *Minnesota Job Satisfaction Scale*) (Weiss et al., 1967), and burnout (the *Maslach Burnout Inventory*) (Maslach & Jackson, 1981).

The *Team Identity Scale* contains 16 items. Each item is rated on a five-point Likert-type scale ranging from (1) strongly disagree to (5) strongly agree. A total Team Identity Score for each respondent is obtained by the sum score of all items, with a possible minimum score of 16 and a maximum of 80.

The *Minnesota Job Satisfaction Scale* used in this study is the short version consisting of 20 items. For each item, respondents are asked to provide a rating ranging from (1) very dissatisfied to (5) very satisfied. A sum score for job satisfaction is obtained for each respondent, ranging from of 20 to 100. The *Manual for Minnesota Satisfaction Questionnaire* (Weiss et al., 1967) suggests that the items of the general scale can be grouped in those measuring (1) intrinsic satisfaction and (2) extrinsic satisfaction. Intrinsic satisfaction reflects the extent to which professionals feel their jobs fit their skills and needs. It consists of 12 items (sum scores between 12 and 60). The remaining 8 items address extrinsic satisfaction reflecting satisfaction with working conditions and economic rewards (sum scores ranging from 8 to 40).

The *Maslach Burnout Inventory* has 22 items. Respondents are asked to provide a frequency rating for each item, ranging from (0) never to (6) everyday. The scale is divided into three domains. The emotional exhaustion domain (reduction in emotional resources) has 9 items (sum scores ranging from 0 to 54). The deper-

sonalisation domain (negative attitude to patients) consists of 5 items (sum scores between 0 and 30). Finally, the personal accomplishment domain (negative evaluation of one self) comprises of 8 items, with possible scores ranging from 0 to 48. A composite global Burnout score was computed by adding up the emotional exhaustion domain score, the depersonalisation score, and the subtraction of the personal accomplishment score from the maximum possible score on this domain, i.e. 48.

Additionally, 7 open-ended questions were asked to assess the interviewee's job perception and views. The questions ask respondents to list (1) three main tasks of the jobs, (2) three main obstacles they encounter in their job, (3) three main skills they felt competent in, (4) three main skills they felt not competent in, (5) three main aspects they enjoyed in their job, (6) three main aspects they did not enjoy in their job, and (7) three main factors that caused pressure in their job.

Data analysis

The *Statistical Package for Social Sciences* (SPSS) Windows Version 11 was used to analyse the data. Kappa coefficients were calculated using the DAG_Stat spreadsheet (Mackinnon, 2000). For quantitative data, descriptive statistics are presented with frequency and percentage distributions for categorical data and means and standard deviations for continuous data. Pearson's and Spearman's rho correlations were used to assess associations between continuous variables, and the Pearson's Chi-Square for associations between two categorical variables. One-way analysis of variance (ANOVA) was used to test differences in means across groups. Throughout the analysis, an alpha level of 0.05 was used to determine statistical significance.

For the answers to open questions, thematic content analysis was conducted, using a posteriori formed categories. Two researchers (G.M.G and S.D.) separately derived categories from the qualitative information and generated preliminary themes that were re-grouped in order to obtain the minimum numbers of categories. These themes were then compared between raters, leading to some re-categorisation and an agreement on final categories to be used in the analysis. A randomly selected sample of 12 questionnaires (20% of the total analysed) were then scored independently by the two researchers with the categories agreed upon, yielding a concordance of 191 out of 215 answers rated (88.8%). In those 12 questionnaires, the kappa coefficients for the inter-rater agreement on the nine categories with a frequency of between 40% and 60% ranged between 0.60

and 0.91 indicating substantial to very high agreement.

Stepwise multiple linear regression analyses were used to determine the predictors of (1) burnout, (2) job satisfaction and (3) team identity. Demographic variables as well as variables derived from the qualitative analyses were all considered as predictors. However, only qualitative categories mentioned by respondents with a reasonable discriminative ability, i.e. a frequency >25% and <75%, were included in the regression analyses. The probability chosen for a variable to enter the model was 0.05 and to exit 0.1.

RESULTS

As compared to the 30 nurses, the sample of 30 psychiatrists was significantly older (mean 45.6 years of age, sd 5.9 vs. mean 35.6, sd 5.5; $F=44.06$ [1,55], $p<0.001$), had a greater percentage of males (50% vs. 13.3%: $\chi^2=9.32$, [1], $p=0.002$), had a longer experience of working in mental health (mean 16.7 years, sd 5.9 vs. mean 7.5, sd 5.7: $F=36.36$, [1,57], $p<0.001$), and had higher caseloads (mean n° of cases 116.9, sd 39.2 vs. 13.7, sd 7.0: $F=174.86$, [1,56], $p<0.001$).

Table I shows the psychiatrists' and nurses' scores on measures of burnout, team identity and job satisfaction. According to Maslach & Jackson (1993), the Italian norms for mental health staff for high burnout are characterised by a score of 22 or more on emotional exhaustion, 6 or more on depersonalisation and 30 or less in personal accomplishment. Average burnout is indicated by 13-21 on emotional exhaustion, 3-5 in depersonalisation and 31-37 in personal accomplishment. Our data show that both psychiatrists and psychiatric nurses have average burnout, with psychiatrists scoring significantly higher in the domains of emotional exhaustion and depersonalisation. The difference between the groups on the burnout sum score was marginally significant.

With respect to job satisfaction, there was no significant difference between the two groups on intrinsic satisfaction, extrinsic satisfaction, or overall job satisfaction sum scores. Both groups had mean sum scores indicating a neutral attitude (a score of 18 on the extrinsic, of 36 on the intrinsic and an overall score of 60 show a neutral attitude, with higher scores corresponding to a more satisfied worker). There was no significant difference between the two groups in the perception of their job and their professional role.

When the data on psychiatrists and nurses were pooled, there were positive correlations between emotional exhaustion and respondents' age ($r=+0.33$,

Table I. - Burnout, job satisfaction and team identity of psychiatrists and psychiatric nurses.

	Psychiatrists (n=30) Mean +- SD	Psychiatric nurses (n=30) Mean +- SD	Difference between the two professional groups
Extrinsic job satisfaction	23.0+4.8	24.3+4.0	F=1.20, (1,57), p=0.277
Intrinsic job satisfaction	38.7+8.0	39.7+5.7	F=0.25, (1,57), p=0.616
Total job satisfaction score	61.8+12.0	64.0+9.1	F=0.60, (1,58), p=0.441
Emotional exhaustion	21.2+9.8	14.3+9.4	F=7.59, (1,56), p=0.008
Depersonalisation	7.2+4.0	4.8+4.9	F=4.46, (1,56), p=0.039
Personal accomplishment	36.7+5.8	34.9+7.5	F=1.00, (1,54), p=0.322
Total burnout score	39.5+12.8	32.1+18.0	F=3.53, (1,58), p=0.072
Total team identity score	50.9+3.8	53.7+4.9	F=5.88, (1,58), p=0.18

p=0.014), total number of years employed in mental health since qualifying ($r=+0.28$, $p=0.036$), and the number of different jobs in mental health since qualifying ($r=+0.45$, $p<0.001$). Depersonalisation was also correlated positively with total number of years employed in mental health services since qualifying ($r=+0.27$, $p=0.044$), and the number of different jobs in mental health services since qualifying ($r=+0.39$, $p<0.002$). Personal accomplishment, intrinsic satisfaction, extrinsic satisfaction, overall job satisfaction, and team identity sum scores did not correlate significantly with any of the demographic or professional characteristics of respondents.

Table II reports frequency and percentages of the themes mentioned by psychiatrists and nurses in the open-ended questions. Only categories mentioned by more than fifteen per cent of the sample are reported.

Since there were significant differences between psychiatrists and nurses on the burnout domains of emotional exhaustion and depersonalisation, it was decided to run three regression analyses on the pooled sample of psychiatrists and nurses to assess predictors of morale. The independent variables were age, gender, group of professional (psychiatrist/nurse), and all qualitative categories mentioned by respondents with a frequency of >25% and <75%. The analysis showed that emotional exhaustion was predicted by two variables: respondents' profession (being a psychiatrist) and reporting team conflict as a source of pressure in their job, explaining an overall variance of 22%. The same variables predicted 14% of the total variance in the overall burnout sum score. On the other hand, reporting high workload and generic clinical activities (e.g. dispensing medication, answering phone calls of patients, talking to patients' relatives, providing general information) as one of the main tasks of their job were the only two predictors of depersonalisation (20% of the total variance explained). For team identity, a regression model was found explaining 16% of the variance and having as predictor variables the perception of

individual treatment program activities as a main task of the job and lack of time as an obstacle to perform the job's task. For job satisfaction, a stepwise regression analysis did not identify significant predictor variables. Table III shows coefficients and significance levels of the regression analyses.

DISCUSSION

This exploratory study has obvious methodological shortcomings. Main limitations are the small size of the sample increasing the probability of Type II error, its local nature which does not allow to generalise the findings beyond the investigated region, and the use of Italian versions of rating scales, i.e. the Minnesota Job Satisfaction and the Team Identity Scale, which have not been validated in Italian. Also, the cross-sectional approach assessed views that may not be stable over time, and required us to use a statistical model for prediction that does not reflect real prediction over time, with an – in parts – questionable distinction between independent and dependent variables.

A first significant finding of this study is the higher level of burnout of surveyed psychiatrists as compared to psychiatric nurses. This was reflected by the emotional exhaustion and depersonalisation scores that were significantly higher for psychiatrists than for nurses, which has also been found in a study in Rome (Costantini *et al.*, 1999). In our study, the differences between the two groups held true in multivariate analyses suggesting that the findings are not due to different personal characteristics such higher age and bigger caseloads of psychiatrists. Speculative explanations include limited chances to change job plans, progress in professional careers or move to other services; a relative loss of the traditionally higher status of psychiatrists; and initially high expectations that may have been disappointed over time as suggested by Ranz *et al.* (2001) based on a study of 80 staff

Table II. - Tasks and problems reported by psychiatrists and psychiatric nurses.

	Psychiatrists (n=30)	Nurses (n=30)	TOTAL AND % (N=60)
1. THREE MAIN TASKS OF THE JOB			
Individual treatment plan (ITP) related activities	14	19	33 (55.0%)
Generic clinical activities	17	9	26 (43.3%)
Technical competence	2	22	24 (40.0%)
Reception desk activities	0	22	22 (36.7%)
Teamwork	9	6	15 (25.5%)
Rehabilitation tasks	4	10	14 (23.3%)
Organization and management	12	1	13 (21.7%)
Networking with other agencies	9	1	10 (16.7%)
Bureaucracy and administration	3	6	9 (15.0%)
2. OBSTACLES ENCOUNTERED IN PERFORMING THESE TASKS			
Team conflicts	15	10	25 (41.7%)
Lack of time	12	4	16 (26.7%)
High caseload	9	6	15 (25.5%)
Lack of resources	5	8	13 (21.7%)
Difficulties in networking with other agencies	9	2	11 (18.3%)
Organizational problems (e.g.: shifts)	7	4	11 (18.3%)
Conflict with management	7	4	11 (18.3%)
3. SKILLS RESPONDENTS FEEL COMPETENT IN TO PERFORM THE TASKS			
Good therapeutic attitude	19	21	40 (66.7%)
Professional competence	16	8	24 (40.0%)
Propensity for team work	12	7	19 (31.7%)
Experience	6	9	15 (25.0%)
Professional demeanour	1	9	10 (16.7%)
4. SKILLS RESPONDENTS FEEL NOT COMPETENT IN TO PERFORM THE TASKS			
Capacity to address team conflicts	12	8	20 (33.3%)
Professional training	7	5	12 (20.0%)
Relational skills	6	6	12 (20.0%)
5. THINGS RESPONDENT ENJOY IN THEIR JOB			
Emotional contact with patients	18	20	38 (63.3%)
Teamwork	15	9	24 (40.0%)
Humanitarian aspects	14	9	23 (38.3%)
6. THINGS RESPONDENT DO NOT ENJOY IN THEIR JOB			
Team conflicts	15	6	21 (35.0%)
Bureaucracy	12	4	16 (26.7%)
Lack of organization	5	7	12 (20.0%)
Conflict with management	7	4	11 (18.3%)
High workload	6	3	9 (15.0%)
Lack of resources	3	6	9 (15.0%)
Lack of time	6	3	9 (15.0%)
7. THINGS RESPONDENTS FEEL CAUSE PRESSURE IN THEIR JOB			
Team conflicts	13	12	25 (41.7%)
High workload	13	7	20 (33.3%)
Lack of time	9	3	12 (20.0%)
Bureaucracy	9	1	10 (16.7%)
Worrying for patients	2	8	10 (16.7%)
Crisis interventions	7	2	9 (15.0%)

psychiatrists members of the *American Association of Community Psychiatrists*.

As far as job satisfaction is concerned, our sample did not show high levels of job dissatisfaction as it has been suggested by Piccinelli *et al.* (2002) and found by Gigantesco *et al.* (2003) in their Roman sample surveyed with a newly *ad hoc* designed rating scale (although the

lowest level of job satisfaction in their sample pertained to ward staff, not included in our study).

The main themes reported in the answers to the open-ended questions may partly reflect the 'ideology' of the investigated services and the values of the professionals within them. Psychiatrists and nurses reported similar aspects as relevant in their jobs, and most of the identified

Table III. - Results of stepwise multiple regression analyses on measures of morale with significant predictors in 60 mental health professionals. Factors included were age, gender, professional role and qualitative categories reported by respondents with a frequency of >25% and <75%.

Dependent variable	Predictor variable	Regression coefficient	P value	Adjusted R ²	Explained variance
Emotional Exhaustion	Being a psychiatrist	0.33	p =0.014	0.13	0.21
	Team conflict as pressure source	0.29	p =0.022	0.08	
Depersonalisation	High caseload	0.22	p =0.016	0.10	0.20
	Generic clinical activities	0.33	p =0.015	0.10	
Overall burnout	Being a psychiatrist	0.27	p =0.038	0.07	0.14
	Team conflict as pressure source	0.26	p =0.048	0.07	
Team identity	Lack of time as obstacle	0.22	p =0.016	0.10	0.16
	Individual treatment program related activities	-0.28	p =0.028	0.06	

factors appear not specific for the professional role of a psychiatrist or nurse. Relationship aspects with patients are considered the most enjoyable part of the work. A positive collaboration in team work is also highly valued and these findings are in line with what Reid *et al.* (1999a) have found in a qualitative study with a similar design conducted on thirty mental health professionals in London. Also, the “human” element of the profession appears central and perceived as more important than technical competence and other potential sources of stress such as lack of time, high bureaucracy, high caseloads, and dealing with patients at risk of committing violent acts, which also featured in the study sample, but not prominently. In general, psychiatrists stated more often to be affected by management-related concerns and bureaucratic aspects of the job, as reflected by the rank of these categories in open ended questions (number 1, 5 and 6); while nurses tended to highlight a heavier and, at times, more stressful emotional involvement with clients, as shown in the category “worrying for patients” (in question number 6), which may be seen as consistent with the finding of lower depersonalisation scores in this professional group.

In multivariate analyses, team identity was predicted by the emphasis on the therapeutic alliance with the patient in an individual treatment plan, and burnout was predicted by the perception of team conflicts. Both variables explained a significant amount of the total variance in the dependent variables, and might be further investigated in future research. Such research should explore the specific aspects of therapeutic relationships in community mental health care and processes of team work in CMHCs (Priebe, 2000). Interventions should be designed and tested to improve both staff morale and patient out-

come, which will most probably be linked. The emphasis on relationship aspects of the job in open-ended questions suggests that these might be addressed to improve staff morale. A focus on relationship aspects may have the advantage to be relatively independent of organisational and structural issues, such as caseload sizes, which due to economic restrictions may be difficult to influence. Training in skills to establish and maintain positive therapeutic relationships and interventions to reduce team conflicts may be of particular importance. This might involve new coping strategies, problem solving skills and supervision groups led by an external facilitator as suggested by Reid *et al.* (1999b). In terms of training, communication skills may be more important than excellence in technical aspects of care delivery and more efforts should be put on strategies to prevent and solve team conflicts. In any case, new initiatives focussing on relationship aspects appear needed to reduce burnout amongst staff, in particular psychiatrists, in community mental health care. A more positive working environment may be required to improve the quality of care and attract talented young doctors to work in the field.

Studies like this may be repeated to assess changes over time and help to understand differences between regional and national systems of care delivery. The same methods and a similar design have been applied in related studies in sites in Austria, England and Germany, which will enable direct international comparisons. For large-scale surveys, however, a transparent, brief and sound methodological approach comprising quantitative and qualitative methods should be established. This study shows that a combination of established scales and simple open questions subjected to content analysis may be a reasonable way forward. Yet, more conceptual and

methodological work is needed before monitoring of staff morale can be regularly conducted and routinely used for quality management and service development in community mental health care.

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