Research Article

Recruitment and retention issues for occupational therapists in mental health: Balancing the pull and the push

Justin Newton Scanlan,1,2 Megan Still,1 Kylie Stewart1 and Jennifer Croaker1

1Area Mental Health Services, Sydney South West Area Health Service, Sydney, New South Wales, Australia, and 2Faculty of Health Sciences, University of Sydney, Sydney, New South Wales, Australia

Background/aim: Recruitment and retention issues for mental health occupational therapists have been the subject of significant concern for many years. This paper describes recruitment and retention issues as reported by mental health occupational therapists employed by a large Area Health Service in metropolitan Sydney.

Method: Thirty-eight mental health occupational therapists (response rate 84%) completed a survey in the first half of 2008. Key themes investigated were: overall satisfaction; attractive elements of positions; positive aspects of positions; constraints of positions; factors associated with leaving positions; supervision; professional development; career pathways; and interest in and access to management positions.

Results: Key elements that kept respondents in positions included the nature of the work, being in a supportive team and the opportunity to use occupational therapy skills. Elements that prompted people to consider leaving positions were the desire for new and different types of work, a desire to work closer to home, insufficient time or high workloads, feeling ‘bored’ or ‘stale’, organisational change or juggling multiple demands, working in unsupportive or dysfunctional teams and family or other personal factors.

Conclusions: The results supported the development of a ‘push and pull’ conceptualisation of recruitment and retention issues, including job-related (intrinsic) and non-job-related (extrinsic) issues. This conceptualisation allows organisations to closely examine factors that attract practitioners to positions and those that support or damage staff tenure.

KEY WORDS mental health, psychiatry, recruitment, retention.

Introduction and literature review

Attracting and retaining a skilled occupational therapy workforce is crucial to effective mental health service delivery. Surveys of mental health occupational therapy managers (Craik, Austin & Schell, 1999), and Australian (Lloyd, King & Bassett, 2002) and British (Craik, Chacksfield & Richards, 1998) practitioners have all highlighted recruitment and retention as a key priority for the profession’s future.

Acknowledging current and impending skilled staff shortages, workforce development is cited as a key component of the recent NSW Community Mental Health Strategy 2007–2012 (NSW Department of Health, 2008). NSW Health has also committed to implementing the NSW Workforce Action Plan (NSW Department of Health, 2005); this plan identifies a need to build and strengthen our health-care workforce now and in the future. Similarly, the National Health Workforce Strategic Framework (Australian Health Ministers’ Conference, 2004) provides structure to guide health workforce policy development and implementation at a national level.

Research into recruitment and retention issues for occupational therapists in rural and remote services (Mills & Millstead, 2002), rural mental health staff (Wolfenden, Blanchard & Probst, 1996) and mental health nurses (Robinson, Murrells & Smith, 2005) has identified similar themes impacting on the workforce, including the importance of supervision and support, enabling opportunities for education and development, and career development and remuneration.

Other specific elements identified as contributing to poor tenure specific to occupational therapists in a range of settings include lack of role definition (Lloyd et al.,...
poor perceived professional prestige (Falk-Kessler & Ruopp, 1993; Moore, Cruikshank & Haas, 2006), the influence of ‘generic’ work (Lloyd, King & McKenna, 2004), inadequate professional support or continuing education (Spence, Wilson, Kavanagh, Strong & Worrall, 2001; Steenbergen & Mackenzie, 2004; Trynennaar & Perkins, 2001) and stress and burnout (Bassett & Lloyd, 2001).

Few studies have investigated precisely what attracts occupational therapists to work in mental health and why they stay (Hayes, Bull, Hargreaves & Shakespeare, 2008). When asked to rank factors important to both the recruitment and the retention of mental health occupational therapists, managers reported staff supervision systems, and training and development opportunities as most salient (Craik et al., 1999). Alternatively, mental health occupational therapists identified burnout, workload and unsatisfying career paths (Lloyd et al., 2002) as impacting on recruitment and retention, and while highlighting the impact of a positive student placement on potential recruits, they acknowledged the difficulty in finding such placements.

In their study of rural occupational therapists in mental health, Mills and Millstead (2002) developed a model of ‘retention equilibrium’. This model presented retention issues as a matrix of professional and personal factors and incentives to leave or incentives to remain. Incentives to remain included development of professional skills, autonomy and independence, good working relationships, friendships and the lifestyle associated with rural environments. Incentives to leave included the lack of professional development, lack of support or recognition, pay and conditions, family-related factors and the feeling of ‘homesickness’.

A recent review of recruitment and retention issues in NorthWestern Mental Health, Victoria, by Hayes et al. (2008) prompted senior occupational therapists in Sydney South West Area Health Service (SSWAHS), New South Wales (NSW), to consider recruitment and retention issues for the local workforce, especially given a number of persistent vacancies within the Area Mental Health Service (AMHS). Senior staff felt a structured survey was needed to better understand the workforce in SSWAHS.

SSWAHS includes 14 hospitals and an array of community health and tertiary-referral facilities located across 16 local government areas: from the densely populated inner west, through to suburbs and semirural regions of south west Sydney, and serves a population of approximately 1.33 million, representing 20% of the NSW population. The NSW Health Allied Health Workforce report (NSW Department of Health, 2007) for June 2007 indicates SSWAHS employed 183 occupational therapists. At the time of the survey, 45 occupational therapists were employed within the AMHS in a range of clinical and management roles. The AMHS is operationally divided into two clusters, a North East cluster, stretching from the inner city to Bankstown, and a South West cluster, encompassing Fairfield through to Bundanoon.

The research questions guiding this project were: (i) What are the primary factors that encourage occupational therapists to remain in positions in mental health? (ii) What are the primary factors that prompt occupational therapists to leave positions in mental health? (iii) What supports and incentives could be implemented to support retention of the mental health occupational therapy workforce in SSWAHS?

Method

During the first half of 2008, mental health occupational therapists in SSWAHS were invited to participate in a survey investigating recruitment and retention issues. The survey was, with permission, based on the Hayes et al. (2008) study.

The survey covered 10 sections: (i) demographics, (ii) information about current work role, (iii) current position (satisfaction, what attracted them to the position, positive and negative elements and what would make the person consider leaving), (iv) professional supervision, (v) professional development (satisfaction, access, needs and constraints), (vi) previous positions (what kept the person in the position, constraints and why the person left), (vii) future positions (what will attract the person to future positions), (viii) career pathways, (ix) interest in and access to management positions and (x) general feedback. Most questions were open-ended. Demographic and current position questions gave a range of response options and ‘satisfaction’ questions were rated on a four-point scale ranging from ‘very unsatisfied’ to ‘very satisfied’.

All occupational therapists in the AMHS (n = 45) were sent a copy of the survey. Following two general reminders, a total of 38 were returned (response rate: 84%). No directly identifying information was collected however, all data were scanned and identifiable responses removed by the second author (MS) to maintain anonymity.

This project met the criteria set out by the National Health and Medical Research Council (2003) for quality improvement projects not requiring Human Research Ethics approval, and was undertaken within the Area Health Service’s Quality Improvement rubric.

De-identified responses to each question were analysed by the authors and themes were identified. Classification of themes occurred through both deductive and inductive processes. Categories developed by Hayes et al. (2008) guided initial data analysis and additional categories were included where relevant. This process allowed for more direct comparison between our study and Hayes et al. (2008); however, the authors collectively reviewed categories to ensure that interpretations were consistent and took special care to ensure that the categories remained true to the data.

To aid interpretation, some questions covering similar content were grouped. These were: (i) What attracted
you to your current position? What will attract you to future positions? (ii) What are the positive aspects of your current position? What factors have kept you in positions in the past? (iii) What are the constraints of your current position? Please describe constraints of any positions you have previously held. (iv) What factors would make you consider looking for another position? What factors have prompted you to leave positions in the past? All other questions were interpreted individually.

Additionally, ratings of satisfaction were analysed for group differences utilising the Mann–Whitney U-test for non-parametric data. The group differences investigated were (i) new graduate and more experienced clinicians; (ii) those in entry-level positions and those in senior positions; (iii) those in occupational therapy-specific positions and those in generic positions; and (iv) by location (comparing the two clusters of the AMHS).

Guided by the third research question, the authors then considered the various themes which emerged from the analysis in order to develop a conceptual framework for recruitment and retention issues for occupational therapists in mental health. Such a conceptual framework would support and guide the development of specific workforce strategies within the AMHS to promote retention of occupational therapists.

Results

Participants

Most respondents were young. Of the 37 who reported their age, 30% were 25 or under, and 22% were aged between 26 and 30 years. Overall, 81% were 40 years or under.

Average length of service as an occupational therapist was 7.7 years (range: 4 weeks–35 years; median = 5 years, standard deviation (SD) = 8.0 years) and average length of service in mental health settings was 5.8 years (range: 4 weeks–35 years, median = 4.25 years, SD = 5.6 years). Most participants (68%) had spent their entire careers working in mental health.

Twenty-two respondents (58%) were in grade 1 (entry level) positions, 11 (29%) were in grade 2 positions and the remainder (n = 5; 13%) were in higher-level positions.

Ten respondents (26%) worked part-time; five in grade 1 positions and five in grade 2 positions.

Overall satisfaction

Respondents generally reported that they felt either somewhat satisfied (n = 21, 55%) or very satisfied (n = 8, 21%) with their current position. Only one person reported they were ‘very unsatisfied’ in their current position. No differences were found between new graduates and more experienced therapists (U(36) = 92, Z = –0.68, P = 0.499), people in entry-level and graded positions (U(36) = 129, Z = –1.41, P = 0.157), people in occupational therapy-specific positions and people in generic positions (U(36) = 156, Z = –0.54, P = 0.592) or people at different locations (U(36) = 128, Z = –1.45, P = 0.148).

Attractive elements of positions

TABLE 1: Attractive elements of positions

<table>
<thead>
<tr>
<th></th>
<th>Current position (n = 37)</th>
<th>Future positions (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>Rank</td>
</tr>
<tr>
<td>Interesting caseload/challenging work</td>
<td>22 (59%)</td>
<td>1</td>
</tr>
<tr>
<td>Skill development</td>
<td>17 (46%)</td>
<td>2</td>
</tr>
<tr>
<td>Location</td>
<td>13 (35%)</td>
<td>3</td>
</tr>
<tr>
<td>Interest in mental health</td>
<td>11 (30%)</td>
<td>4</td>
</tr>
<tr>
<td>Supportive team/relationships</td>
<td>11 (30%)</td>
<td>4</td>
</tr>
<tr>
<td>Variety</td>
<td>9 (24%)</td>
<td>6</td>
</tr>
<tr>
<td>Career development</td>
<td>9 (24%)</td>
<td>6</td>
</tr>
<tr>
<td>Quality improvement/Research</td>
<td>4 (10%)</td>
<td>8</td>
</tr>
<tr>
<td>Money</td>
<td>3 (8%)</td>
<td>9</td>
</tr>
<tr>
<td>Supervision</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Infrastructure/resources</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Vision/dynamism</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Flexibility</td>
<td>2 (5%)</td>
<td>10</td>
</tr>
<tr>
<td>Occupational therapy–specific position</td>
<td>2 (5%)</td>
<td>10</td>
</tr>
<tr>
<td>Type of position</td>
<td>2 (5%)</td>
<td>10</td>
</tr>
<tr>
<td>Workload</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Best practice models</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

—, no response in this category.
to their current position and what would attract them to positions in the future.

Interesting work and the opportunity for skill development were the top two attractions for both current and future positions. Location was also reported as an important attraction for many therapists. Many entry-level therapists reported ‘interest in mental health’ as an important attraction.

**Positive aspects of positions**

Responses to these questions can help to identify what keeps people in positions. Table 2 highlights the importance of positive team dynamics in retaining occupational therapists in the workforce. The nature of the workload was also important with many people commenting on ‘interesting work’ being a positive aspect of their positions.

**Constraints of positions**

A range of constraints were reported. The divergence of constraints for current and previous positions is interesting. For example, while ‘high workload’ was a key issue related to current positions ($n = 24, 65\%$), only four people (15\%) reported that it was a constraint of previous positions. One of the reasons for these differences might be that when answering the ‘constraints of previous positions’ question, people tended to list only one or two, perhaps the most memorable, of those constraints, whereas current constraints may have greater currency for respondents. Also notable is that although ‘distance from home’ was a key constraint for previous positions ($n = 6, 23\%$), this was not raised by respondents when discussing the constraints of their current position.

Other constraints reported included: structure and organisation of work (organisational change or juggling multiple roles: current position: $n = 20, 54\%$; previous position: $n = 7, 27\%$); social/emotional work environment (current position: $n = 8, 22\%$; previous position: $n = 8, 31\%$); physical work environment and resources (current position: $n = 16, 43\%$; previous position: $n = 4, 15\%$); limited career development (current position: $n = 6, 16\%$; previous position: $n = 4, 15\%$); lack of support (current position: $n = 6, 16\%$; previous position: $n = 4, 15\%$); and insufficient use of occupational therapy skills (current position: $n = 5, 14\%$; previous position: $n = 6, 23\%$).

**Factors associated with leaving positions**

Respondents were asked to report on why they left previous positions and what might prompt them to leave their current position. Results are summarised in Table 3. Lifestyle reasons (predominantly location of workplace) were key factors.

When reporting on why they left previous positions, more people reported positive reasons such as desire for a different type of work or career development opportunities, than those who reported negative reasons such as a ‘dysfunctional team’ or unsatisfactory management.

**Supervision**

Most respondents were ‘somewhat satisfied’ ($n = 16, 42\%$) or ‘very satisfied’ ($n = 13, 34\%$) with professional supervision. Although there was not a mid-point option, three people (8\%) marked between ‘somewhat unsatisfied’ and ‘somewhat satisfied’. Those people in the North East cluster of the AMHS were more satisfied with supervision than those people in the South West cluster ($U(35) = 65.5, Z = –3.107, P = 0.002$). This finding is likely to be related to significant delays in proceeding with recruiting to key vacant senior positions that could enable professional supervision. No significant differences were found in level of satisfaction with supervision between new graduates and more experienced clinicians.
(U(35) = 105, Z = 0.00, P = 1.00), those in occupational therapy specific positions and generic positions (U(35) = 88.5, Z = -1.519, P = 0.129), or those in entry-level positions and those in senior positions (U(35) = 110, Z = -1.77, P = 0.077) although there was a trend towards those in senior positions being more satisfied with supervision. Of those people who reported that they were unsatisfied with supervision (n = 6, 16%), most indicated that this was due to limitations in accessing supervision.

Respondents also provided explanations for their level of satisfaction. Eighteen (49%) made only positive comments about supervision, 15 (40%) made only negative comments and four (11%) made both positive and negative comments. One person did not provide any comments. Positive comments included: the supportive nature of supervision (n = 14, 38%); flexibility/versatility of supervisor (n = 8, 22%); and the practical nature of supervision (n = 5, 14%). Negative comments about supervision included the informality or irregular nature of supervision (often related to time constraints of the supervisor or supervisee: n = 10, 27%) and a preference for a different supervisor (n = 5, 14%).

### Professional development

Most people reported good access to training and reported that they were ‘somewhat satisfied’ (n = 22, 58%) or ‘very satisfied’ (n = 10, 26%) with professional development opportunities. Thirty-six (95%) reported that they could access SSWAHS internal training, 29 (76%) reported they could access internal in-services and 29 (76%) reported they could access funding and paid leave to attend external courses. A smaller proportion (n = 24, 63%) reported access to discipline-specific training opportunities. No differences in satisfaction were found between new graduates and more experienced clinicians (U(36) = 84, Z = -1.01, P = 0.312), people in entry-level positions and those in senior positions (U(36) = 118.5, Z = -1.77, P = 0.077), people in occupational therapy-specific positions and generic positions (U(35) = 121.5, Z = -0.79, P = 0.432), or according to location (U(36) = 148, Z = -0.80, P = 0.423).

Respondents reported on perceived constraints of receiving training. Of the 33 respondents, the majority (n = 21, 63%) reported time as the primary constraint. Mostly this was perceived time, for example ‘I feel guilty leaving [my workplace] to attend training’, rather than lack of management support for taking time off. Other constraints were listed as cost (n = 6, 18%), lifestyle factors or location of training (n = 6, 18%), lack of administrative/management support (n = 5, 15%) and lack of relevant training opportunities (n = 5, 15%). Constraints associated with being part-time were raised by 50% of part-time workers.

Thirty-two respondents also provided information on their perceived training needs. There were no clear distinctions between the training needs of new graduates and more experienced therapists. The five most commonly reported areas were occupational therapy assessment (n = 15, 47%), management (n = 7, 22%), cognitive behavioural techniques (n = 7, 22%), supervision (n = 6, 19%) and occupational therapy interventions (n = 5, 16%).

### Career pathways

The majority of respondents (n = 20, 56%) reported that there were good opportunities for new graduates within the area mental health service, although many (n = 10, 28%) highlighted the need for support and the potential risks associated with new graduates working in isolated positions.

When asked about opportunities for career progression, an equal proportion (n = 14, 44%) of the 32 people

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**TABLE 3: Factors associated with leaving positions**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Current position (n = 37)</th>
<th>Previous positions (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>Rank</td>
</tr>
<tr>
<td>Lifestyle reasons</td>
<td>16 (43%)</td>
<td>1</td>
</tr>
<tr>
<td>If job problems developed</td>
<td>12 (32%)</td>
<td>2</td>
</tr>
<tr>
<td>Higher income</td>
<td>10 (27%)</td>
<td>3</td>
</tr>
<tr>
<td>Desire for a different type of work</td>
<td>9 (24%)</td>
<td>4</td>
</tr>
<tr>
<td>Career development opportunities</td>
<td>8 (22%)</td>
<td>5</td>
</tr>
<tr>
<td>Dysfunctional team</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Unsatisfactory management</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>To develop further skills</td>
<td>5 (14%)</td>
<td>6</td>
</tr>
<tr>
<td>Lack of occupational therapy profile</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Job dissatisfaction</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Workload</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>If current job problems are not resolved</td>
<td>2 (5%)</td>
<td>7</td>
</tr>
</tbody>
</table>

—, no response in this category.

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who provided responses reported ‘good’ and ‘limited’ opportunities. Initial hypotheses that newer graduates or those in entry-level positions may perceive that there are more opportunities than those people with more experience or in higher grade positions were not supported (Fisher's exact test: $P = 0.10$ and $P = 1.00$ respectively). The other key theme emerging from responses to this question was the limited opportunity to progress in clinically based positions ($n = 9, 28\%$), although there was some hope that a recent change in award structure might change this ($n = 3, 9\%$).

**Interest in and access to management positions**

Respondents were asked whether they were interested in management positions. Of the 34 people who provided responses, 23 expressed interest, although a significant proportion indicated no interest in positions that were purely managerial without a clinical caseload.

Barriers to accessing management positions were also explored. Of the 29 individuals who responded to this question, eight (28\%) reported they felt there were no barriers. The most common perceived barriers were a small pool of senior/management positions (especially specific occupational therapy positions, $n = 8, 28\%$), lack of training, support or opportunities to gain experience ($n = 7, 24\%$), and personal reasons ($n = 5, 17\%$), of which working part time was the most significant.

**Discussion**

Although much of this information was already anecdotally understood by the investigators, being able to quantify what impacts on recruitment and retention was invaluable. Key factors that encouraged mental health occupational therapists to remain in their position included the nature of the work, being in a supportive team and the opportunity to use occupational therapy skills. Factors associated with a desire to leave positions included the desire for a different type of work or a new challenge to develop additional skills, a desire to work closer to home, insufficient time or a high workload, feeling ‘bored’ or ‘stale’ and a mismatch between work and family commitments.

Outcomes from this survey are similar to those recently reported with similar populations (Craik et al., 1998; Hayes et al., 2008; Lloyd et al., 2002). However, this survey was undertaken with staff currently employed by one AMHS in metropolitan Sydney and findings may not generalise. Furthermore, the survey was designed to inform human resource planning and as such may be criticised as not being of high scientific rigour.

In considering the overall themes emerging from the analysis of responses, and building on the concept of ‘retention equilibrium’ (Mills & Millstead, 2002), the ‘push and pull’ conceptualisation of retention was developed. This conceptualisation includes four elements: ‘intrinsic pull’, ‘intrinsic push’, ‘extrinsic pull’ and ‘extrinsic push’.

Intrinsic factors are those related to the person’s current position. Intrinsic pull factors are those that keep a person in their position. These can be positive (a sense of job satisfaction, a supportive team environment), negative (feeling ‘trapped’ in a position through inertia, fear of the upheavals associated with leaving a position) or neutral (a good location). Intrinsic push factors are those that prompt a person to want to leave their position. These could be unsatisfying or boring work, unsuitable location, unsupportive teams or role dysphoria. Intrinsic push factors make the individual want to leave their position, but do not necessarily make them want to look for another position.

Extrinsic factors are those not directly related to the current position. Extrinsic pull are those factors that attract a person to move to another job. Extrinsic push factors can generally be considered life events unrelated to work, for example, moving house, having children or changes in relationship status. These factors, while usually unrelated to work, can also prompt the person to consider leaving their current position.

Figure 1 outlines the balance of these four elements. Intrinsic pull works to keep a person in their current position and the other three elements all work to make a person consider leaving. For a person to remain in their position, intrinsic pull factors must outweigh the other three elements. The ‘push and pull’ conceptualisation contributes greater detail to what specific features of employment may support or damage staff tenure. This may enable the organisation to implement more targeted retention strategies.

The nature of the work, being in a supportive team and the opportunity to use occupational therapy skills were the most significant intrinsic pull factors for our respondents. Additionally, autonomy and flexibility, opportunities to develop new skills and good management were cited as significant.

Important extrinsic pull factors reported by respondents included the opportunity for different, interesting or challenging work; the opportunity to develop new skills; better location; the perception of a supportive team; and career advancement or more money. The notion of a ‘supportive team’ being an extrinsic pull factor is curious. Many people reported that this factor attracted them to their current position or would attract them to positions in the future. This highlights the importance of personal recommendations or experience with teams.

The examination of extrinsic pull factors suggests means of retaining current staff and attracting a future workforce. Giving students exposure to the interesting and challenging work in a supportive team environment is central to the AMHS’s recruitment efforts. This strategy is well supported by these survey findings and previous literature (Crowe & Mackenzie, 2002; Gilbert & Strong, 1997). Furthermore, enabling professional and organisational support has been previously identified as a key initiative for retaining staff (Wolffenden et al., 1996).
Intrinsic push is an important element for consideration in planning retention strategies. For our respondents, key intrinsic push factors were insufficient time or high workloads (especially in teams covering high levels of vacancies), feeling ‘bored’ or ‘stale’ in the position, organisational change or juggling multiple demands, working in unsupportive or dysfunctional teams, and unsatisfactory location.

Intrinsic push factors are those that could be prioritised for action by the AMHS, as these are clearly linked with people leaving positions. While some of these are difficult (dysfunctional teams) or impossible (location) to change, they warrant organisational focus. For example, the issue of location may be mediated by targeting recruits graduating from locally based training schools or enabling incentives that mitigate issues of location.

A key limitation of this survey was only surveying current incumbents. Thus, definitive statements about why employees left the organisation are impossible to make. However, it is hypothesised that high levels of intrinsic push may lead to an individual deciding to leave the profession all together. The concept of ‘burnout’ may relate to situations where the person experiences high levels of intrinsic push in the absence of intrinsic (or extrinsic) pull. Key elements of burnout have been reported as: (i) nature of clients; (ii) lack of resources; (iii) lack of supervision and training; (iv) lack of rewards and career structure; (v) lack of professional identity; and (vi) lack of a clear occupational therapy role in some settings (Bassett & Lloyd, 2001). All of these could be considered intrinsic push factors. Previous research findings that role dysphoria (lack of professional identity, concerns over role blurring or the distinct contribution of occupational therapy) may prompt occupational therapists in mental health to consider leaving their positions (Hughes, 2001; Lloyd et al., 2004; Paul, 1996) were not strongly evident in our study; however, this issue should remain on the research agenda as it may be of particular relevance for those occupational therapists who have left the mental health workforce.

Additionally, these data do not support the idea that supervision and good access to ongoing professional development are strong intrinsic pull factors. However, the absence of these does seem to create significant intrinsic push. This suggests that respondents reasonably expect that services will provide them with access to quality supervision and training. The presence of these supports may not be seen as positives, but their absence was considered negatively by respondents. A systematic review (Hunter & Nicol, 2002) noted that no investigation has been conducted to evaluate the impact of continuing professional development on recruitment and retention outcomes; however, this was considered an important factor in seven of the 13 studies reviewed.

Extrinsic push factors are probably least amenable to organisational intervention, but may be counteracted by strong intrinsic pull that the organisation can support, for example flexible working arrangements. The most common extrinsic push factors for our respondents were related to family commitments, particularly having children.

It may not be possible to modify every factor that may impact on staff wanting to leave. However, results from this survey do warrant exploring creative solutions to potentially difficult situations. Recruiting and training staff is time-consuming and costly, and retaining staff oriented to the organisation is preferable than constantly seeking new recruits. Perhaps one way of facilitating...
people to expand their skills, utilise different skill sets and experience different work settings and cultures would be to enable more streamlined transition pathways within the AMHS. This may mean that the extrinsic pull of positions within the area health service would be greater than the extrinsic pull of positions in other area health services.

Conclusion

Despite perceived limitations of this survey, results were clearly informative and warrant further investigation. The results from this study are also likely to be useful for other professional groups in mental health; however, exploration of the unique needs of these professional groups is also necessary.

Recommendations for local implementation in SSWAHS include (i) further investigation of easily enabling staff to move between teams, (ii) expansion and enhancement of an internal professionally specific education program, (iii) expansion of opportunities for external discipline specific education, (iv) review of current supervision and support structures to better support therapists with a broad range of experience and skills and (v) further investigation of the impact of organisational issues such as workload and team environments on mental health occupational therapists.

The impact of educational or professional development strategies, supervision, and role dysphoria or poor perceived professional prestige on recruitment and retention warrants replication in a wider sample of mental health occupational therapists. This would enable a broader perspective to be gathered and may enable the development of a national approach to workforce development strategies for mental health occupational therapists. Additionally, the impact of the NSW Health Service Health Professionals (State) Award (NSW Industrial Relations Commission, 2008) which allows for career progression through clinical specialisation rather than a pure management path, on retention will be interesting to investigate.

Future research should replicate this study with a wider range of mental health occupational therapists, especially those from outside of publicly funded specialist mental health services (for example, those in non-government mental health support agencies and in the private mental health sector) as well as with other professional groups in mental health. Additionally, the outcomes associated with strategies implemented to improve recruitment and retention of the mental health workforce should be evaluated. Up to this point, this type of evaluation has been very limited. Such research will further enhance our understanding of the needs of the mental health workforce and will support the development of broad-based strategic approaches to workforce planning and development across mental health services as a whole.

References


