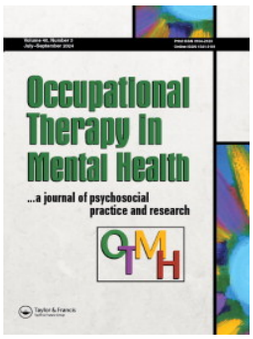

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Factors Affecting the Retention of Mental Health Occupational Therapists in the UK: A Qualitative Study with Framework Analysis

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ABSTRACT

Addressing staff retention in the UK National Health Service is crucial. This study used interviews to investigate the factors influencing mental health occupational therapists' (MHOTs) decisions to leave or remain in their positions in the UK National Health Service. Framework analysis was employed to analyze the data, focusing on how roles and organizational conditions affect job satisfaction and MHOT retention. The findings highlight that effective strategies should focus on empowering MHOTs with greater autonomy, improving communication with management, and providing high-quality training and supervision. These measures can enhance job satisfaction and retention, thereby improving mental health service delivery.

KEYWORDS

Mental health; occupational therapists; job satisfaction; workforce turnover; well-being

Introduction

Staff retention is a high priority for the National Health Service (NHS) in the UK. In 2022, the NHS faced a severe shortage of clinical staff, with around 110,000 vacancies and an average of 400 staff members leaving each week, leading to substantial costs (Farah, 2022). Recognizing the critical need to retain and support its workforce, the NHS has prioritized staff retention in both the People Plan (NHS, 2020) and the NHS Long Term Plan (NHS, 2019). These plans focus on all NHS employees and outline key strategies to improve workforce retention.

The Allied Health Professions (AHPs) constitute the NHS's third-largest workforce, primarily composed of degree-level autonomous practitioners. Predominantly, regulated by the Health and Care Professions Council

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(HCPC). The NHS operates across primary, secondary, and tertiary care settings (Mind, 2023). Mental Health Services, a vital part of the NHS, function across all three levels, providing inpatient and community support for individuals with mental health needs. These services employ professionals from various backgrounds with diverse skill sets (NHS England, 2019). These dedicated professionals deliver compassionate, high-quality care to mental health patients. However, the demanding nature of their roles often leads to increased workloads and potential burnout (Lloyd & King, 2004).

Occupational Therapists (OTs) are among the 14 AHPs and play a crucial role in the mental health workforce, assisting individuals with mental health challenges in improving their daily lives (RCOT., 2017). Maintaining a skilled OT workforce is essential for effective mental health service delivery (Scanlan et al., 2010). However, due to the intense workload and patient demands, OTs in mental health are susceptible to burnout (Painter et al., 2003; Scanlan et al., 2013), impacting their well-being and therapeutic effectiveness. This retention issue could exacerbate workforce shortages and deter new entrants into the OT field (Haig & Summerfield-Mann, 2016).

The COVID-19 pandemic has exacerbated this situation (Kirby, 2023). The pandemic has resulted in prolonged waiting times and increased demand for mental health services, placing additional pressure on the entire healthcare system, including OTs who were already at risk of burnout and poor retention. The pandemic-induced changes have significantly affected OT staff retention (Ward & Casterton, 2020). However, the existing literature on NHS retention primarily focuses on other staff groups (Ely, 2019; Finlayson et al., 2002; Longhurst, 2018), with limited research examining the specific impact of COVID-19 on mental health staff retention.

Research on NHS retention challenges has largely concentrated on broader groups or specific professions, such as nurses or physicians, with little attention to occupational therapists in mental healthcare service. Given the crucial role of occupational therapists in mental healthcare, it is concerning that their retention challenges have not been thoroughly investigated. This study aims to address this gap by focusing on mental health occupational therapists. It seeks to develop a comprehensive understanding of the factors influencing the retention of occupational therapists within different NHS Trusts across the UK's mental health services and the reasons behind their decisions to leave or consider leaving.

Methods

Qualitative approach was utilized, and a framework analysis was employed as the research method in this study. 'Frame work' is an analytical approach that can consists of several distinct but closely interconnected stages and framework analysis is a method of qualitative data analysis that was

originally developed for exploring key societal aspects and influence social policy in the UK (Furber, 2010; Ritchie & Spencer, 2002a). This method follows a well-defined procedure and became increasingly popular in the fields of health research (Lacey & Luff, 2001, Gale et al., 2013).

Sampling and recruitment

We purposively sampled participants from the Retention of Mental Health Staff (RoMHS) Study, focusing on occupational therapists' responses to retention issues within mental health Trusts. We selected 16 participants from three different Trusts. These participants worked in various services within their respective Trusts, and their years of experience varied. The three Trusts (Trusts A, B, and C) are located in different areas of England, with Trusts A and C situated in rural/urban mixed areas and Trust B in an urban area.

The larger RoMHS study, interviewed 199 mental health clinicians from six Trusts in England. This included clinicians from a variety of professional background. Participants were recruited via an email introduction to the research sent by their Trust's research and development team to all staff. This study subsampled the OTs, to perform a new analysis that related specifically to the OT profession.

Data collection

Sixteen interview transcripts were included for analysis in the study. The interviews and the transcription process were carried out by the Retention of Mental Health Staff (RoMHS) team between April 2021 and December 2021. The main research question of the interview was what works well or what is the problem for the retention of mental health occupational therapists. The interview started with an open question followed by prompts as needed, making the interview as open as possible. And the prompts involved key areas, including workload and staffing, team relationships and cohesion, leadership, supervision, and development opportunities. These prompts were designed to ensure that all major factors related to workforce retention were captured in the interview. The participants in these sixteen interviews were all front-line occupational therapists working in different adult services within three mental health Trusts, all having a substantive contract with their Trusts. Due to the Covid-19 pandemic, all interviews were conducted remotely using Google Meet, MS Teams, or telephone, rather than in person. The interviews were digitally recorded with the consent of participants and then transcribed into a text version for consequent analysis.

Data analysis

Data were analyzed using framework analysis, which sits within the family of broadly 'thematic' approaches (Gale et al., 2013). Framework analysis offers several advantages for this study, including the comprehensive capture of various aspects of the phenomena under investigation and enhancing the transparency of participants' experience interpretations. These qualities make the framework method the most suitable approach for this study. This approach was integrated with the NVivo 14 to help assist with the qualitative analysis. We followed the five stages of framework analysis outlined by Ritchie and Spencer (2002b):

Familiarization: we familiarized ourselves with the data by reading the transcripts multiple times. Additionally, researchers EW and SO, who were core members of the interview team, were particularly familiar with the data.

Identifying a thematic framework: the framework, developed from a systematic review (Yan et al., 2024) conducted by the same research team, is shown in Appendix A. The development of this framework was discussed by all study researchers and implemented into the analysis after modifications and agreement.

Indexing: the indexing was performed using NVivo software. The transcript data were systematically coded into the most suitable categories in the framework.

Charting: to better reorganize the data into a more manageable format, we used the Matrix function in NVivo (shown in Appendix B). This allowed all indexed text to be read across for within-case analyses or for the analysis of a specific theme or category for between-case analyses (Ward et al., 2013).

Mapping and interpretation: first, we made notes of the charted data for different framework categories using Word, providing a summary for each category to facilitate interpretation. Themes were then identified by examining the similarities and differences across case data. This analysis helped us discern patterns, connections, and relationships between themes, refining them further. Finally, we proposed strategies for relevant interventions.

Ethical consideration

Institutional Research Ethics Committee (reference 037255) and Health Research Authority (Reference 21/HRA/0011) approvals were received prior to data collection commencing. The NIHR Clinical Research Network portfolio supported this study.

Findings

Sixteen interview transcripts were used for qualitative analysis. All participants were professionally registered. Among them, only three were male, while the remaining thirteen were female. All participants were White British and five of the participants held advanced positions, including titles such as Service Manager and Professional Lead. Additional participant characteristics are detailed in Table 1. Five themes were derived from the data and each theme comprises several sub-themes, which are detailed in Table 2.

Theme 1: Professional dynamics and identity challenges in MHOTs

The study revealed that MHOTs experience role confusion when collaborating with other professions. This confusion can lead to disconnections

Table 1. Participants Characteristics.

	Trust A	Trust B	Trust C
Number of participants	6	5	5
Male	2	1	0
Female	4	4	5
White British	6	5	5
Professional registration (yes)	6	5	5
Advanced position	3	0	2
Community service	3	5	2
Inpatient service	3	0	2
Other service	0	0	1
Years in current role (<1yr)	2	2	2
Years in current role (1–5yrs)	4	1	1
Years in current role (>5yrs)	0	2	2
Years in current trust (<1yr)	1	1	0
Years in current trust (1–5yrs)	3	1	1
Years in current trust (>5yrs)	2	3	4

Table 2. Themes and Sub-Themes.

Key theme	Sub-theme
1. Professional dynamics and identity challenges in MHOTs	1.1 Professional identity and role ambiguity in MHOTs
	1.2 Disconnection and marginalization of the MHOT role within a multidisciplinary context
	1.3 Facilitators and barriers to professional identity for MHOTs
2. Work engagement and service challenges in MHOTs	2.1 Diminishing work engagement
	2.2 Stressors and compromises in MHOT service quality: high expectations vs. harsh realities
3. Team dynamics and organizational work environment	3.1 The significance of team support and team cohesion
	3.2 Disconnection with the leadership and management level
	3.3 Inadequate staffing levels and challenges in staffing mix
4. Job resources – enhancing professional development in MHOTs	4.1 Diverse approaches to enhancing supervision and training in MHOTs
	4.2 Challenges for supervision and training – quality, accessibility and understaffing
	4.3 Career advancement barriers in MHOTs
5. External factors – Covid impact, geographic constraint and physical work environment	5.1 Diverse perspectives on the impact of Covid-19
	5.2 The impact of geographic constraints and family consideration
	5.3 Dissatisfaction with work environment

within the team, impacting the stability of their professional identity and ultimately contributing to job dissatisfaction.

Professional identity and role ambiguity in MHOTs

Participants shared their perceptions of MHOT identity, highlighting that their role as occupational therapists is primarily driven by a desire to deliver exceptional care and effect significant changes in their patients' lives. However, they noted a decline in their enthusiasm for work due to the erosion of the specialized role of OTs, which has been mainly caused by an increase in generic tasks. The participants below explained how the role of MHOTs has been diminished:

> We don't do talking therapies, we're not just doing check ins and looking at housing and things like that, we've, you know we've completely lost a huge spade of what we'd normally do so I think it would be difficult to make a good assessment of the role (B14)

It has been observed that the Community Mental Health Team (CMHT) experiences the most severe role erosion. Participants from the CMHT described themselves using terms such as 'Jack of all trades, master of absolutely nothing' (C36) and 'Catch-all team' (A15). They reported being used as backup for staff shortages, which has led to MHOTs functioning more like generic mental health practitioners rather than specialized professionals. One participant highlighted concerns about the negative impact of role erosion on new MHOTs entering the workforce.

> I've had two new OTs join the team and they're just rolling around, lack of structure and understanding and one person's been there a couple of years and still doesn't get what an OT in mental health does.(C60)

It is noted that non-specialized roles can complicate new MHOTs' understanding and adaptation to their expected professional duties, thereby hindering their effective role adoption and skill development.

Disconnection and marginalization of the MHOT role within a multidisciplinary context

Participants repeatedly mentioned significant disconnections with other qualified professionals in the multidisciplinary teams. This separation positions MHOTs on the periphery within both the AHP group and the broader multidisciplinary team. One participant highlighted the 'big divide' between professions:

> There is a big divide between qualified professionals as well. So like the psychologist, the psychiatrist, social worker, they don't come on to the ward unless there's a meeting or something. So there's a huge divide in between that I feel outside of both, so I don't fit in within the support workers on the ward or within this other part of the MDT (A43)

Undoubtedly, while the MDT is large, the lack of opportunities for OTs to integrate and collaborate with other disciplines exacerbates this disconnect. Despite OTs being supportive of their colleagues and driven by a strong internal motivation related to their role identity, the absence of external motivation further leads to the disconnect and marginalization of MHOTs.

Facilitators and barriers of professional identity for MHOTs

When discussing role identity, participants also shared their own perceptions of the facilitators and barriers associated with it. A common facilitator mentioned was the advocacy for regular interactions with patients, which resonates with the MHOTs' role understanding of the importance of deep patient engagement. For MHOTs, regular interactions with patients helps them stay grounded and focused on the core aspects of their profession, thereby solidifying their professional identity. To bridge the divide, one participant suggested adopting a joint approach with clients to facilitate collaboration with other professionals and enhance service delivery.

> I worked in one team, it was structured on a six week strict rule so that everybody worked together around that client met every week. Once a week to do, you know, mini review. Which it was great but it was like a day of meetings every half an hour about a different client and you were done in by the end of that. (B17)

The main barriers to professional identity are non-OT-specific duties, such as paperwork, which are mentioned as impacting the quality and stability of therapeutic relationships with patients. A stable therapeutic relationship is crucial for job satisfaction and is identified as a strong factor in an OT's decision to remain in a position.

> I'm having constantly change what I'm doing, it affects our therapeutic relationship and seems really unreliable. But things that will keep me there is that I am building therapeutic relationships with the patients and I am slowly supporting them, and in some ways making a difference and being that sort of source of stability. (A43)

Theme 2: Work engagement and service challenges in MHOTs

Almost all participants in this study held high expectations for the MHOT role and the services they provide. They aim to fully engage in their work, delivering high-quality services to ensure patient satisfaction and their own sense of fulfillment at work. However, a discrepancy between expectations and reality was evident throughout all the interview transcripts.

Diminishing work engagement

For OTs, professional fulfillment is achieved when they feel productive and content, effectively using their skills to make a difference in their

work. However, the term 'devalued' frequently appeared in interview conversations, indicating that MHOTs often do not feel productive or happy at work. Moreover, they struggle to perform their best and make a meaningful difference for patients or the service.

Several factors have been mentioned by participants as diminishing their work engagement. Unfair treatment compared to other workforce groups was a frequent compliant. For one, this unfairness revolves around pay, such as when nursing staff were given a pay recruitment and retention bonus to keep them. The participant did not intend to single out nursing staff and explained that it is indeed hard to retain them. The issue centers on the basic respect for individuals who work hard over a long period and in the same environment, it is not just a monetary issue but a matter of fairness.

> I particularly feel was a slap in the face. It very much felt like that and I think those are the things that will upset staff and make them feel, I'm not valued then. I've done what I could to help you and this is the thanks I get for it and I don't think it was actually, particularly about money but I think it was about the unjustness. (A10)

Lack of empowerment is another major concern, linked with role erosion. As the MHOT role becomes more generic, the significance of this role is often overlooked. A direct consequence of this is that the MHOT role is being replaced by general mental health practitioners, making MHOTs feel devalued and causing them to question the meaning of their role. This is accompanied by a lack of voice at the table or even being uninformed about what is happening within the Trust. One participant described the experience of devaluation and its consequences as follows:

> We give our opinions but I do feel they have already been decided by the powers that be and I feel it's probably having a lack of voice and a lack of being listened to and a voice in the trust probably and I think that's really annoyed people and that has pushed people to leave (C40)

In addition, another participant, who was comparatively new as an OT, raised a concern about the lack of collaborative support at work. This participant expressed feelings of uncertainty and self-doubt about professional actions and decisions, describing this as having always been 'bumbling along'. If someone would help them refine their practices and confirm the effectiveness of their work, they would be better engaged at work.

Stressors and compromises in MHOT service quality: high expectations vs. harsh realities

In this study, MHOTs are burdened by their own expectations and the demanding nature of their roles, grappling with heavy caseloads and numerous service users. This situation severely affects their well-being,

leading to significant stress and even loss of sleep. MHOTs in advanced positions feel this issue more acutely, as they have witnessed OTs under their supervision struggling to provide high-quality service despite overwhelming caseloads. Under the pressure of these demands, MHOTs liken their role to assembly line work, with one participant drawing a metaphor of working in a sausage factory.

> I felt like there was a time when I was a crafts person and that I'd got the ingredients and that I could, you know, make you a nice meal of sausages. Whereas now I've got the same ingredients but I've just got to get them through quicker and it's less quality. And also the people are likely to come back again because they didn't get the proper service that they should have had in the first place. So that's bad for the person. Ethically bad I think. I don't want to it to be bad for the person. But it looks good on the stats.(B17)

Theme 3: Team dynamics and organizational work environment

A good work environment can greatly contribute to organizational dynamics. Here, the term 'work environment' does not refer to the physical setting but to aspects such as team cohesion, staffing levels, staffing mix, and the connection with the leadership and management levels within the organization.

The significance of team support and team cohesion

It is encouraging to note that all participants in this study express gratitude for having and working in a very supportive team, and it is indeed the support that has kept them still in their posts. Participants explained that being part of a supportive team, where they receive acknowledgment from both colleagues and management, helps them work toward common goals. This support enables them to achieve a work-life balance, manage stress levels, and feel respected.

The support from colleagues extends beyond professional duties to include friendships and more relaxed communication. This is particularly essential in high stress working environments, as these relationships can help alleviate work intensity and provide vital emotional support.

> It's really important to have that supportive network of someone at least to talk to and being able to have a laugh in these kind of roles cause actually sometimes it is tense. It is stressed and we've all got lives outside of work. (A45)

Some participants in advanced positions shared specific examples of their approaches to supporting OT team members in their daily work, such as inviting the whole team to go out for coffee every Friday lunchtime or organizing a picnic (A11). These small gestures might not

significantly change people's lives, but the acknowledgment can effectively support them in their hard work.

> In my team if anyone works an extra hour or an extra two hours I would always pay them on bank (compensate somebody with additional pay), just to recognize, I mean it's not going to change their life but it's just that acknowledgement that actually you've worked over so you need to be rewarded for that in some way. (A11)

Participants from Trust C specifically mentioned that geographic factors contribute to their particularly supportive team. The relatively rural location makes the team more stable, as people usually do not move around much. As a result, team members often know each other for a long time, providing excellent peer support.

Disconnection with the leadership and management level

Although participants reported receiving support from their teams that motivate them, a disconnection with the leadership and higher management level has been described. This disconnection is mainly reflected as communication gaps and disinterest from top management, evidenced by poor communication and inadequate practical considerations that fail to address the practical needs of MHOTs.

In terms of communication, MHOTs lack representation in higher management meetings, resulting in a significant gap in advocacy and voice for their profession within the broader organizational transformation.

> I just think there's a lot going on with the transformation that seems to be going on in this ether of management that we don't always hear the full, it doesn't really filter down to the actual people on the ground level I guess that are doing the job and it's going to really impact what we're doing in the long-term.(C40)

Most of the funding and service models, created at the top, do not always align with the needs of patients from MHOT's practical perspective. This kind of impractical implication, such as the recovery model below, causes MHOT to lose track of its role.

> So our team's called recovery but it used to be called continuing needs. Which I know we don't want to make people dependent on us. So this recovering model of get them in, make them well, send them out. You know it might work in an IAPT kind of situation where you're mild to moderate. But we really work in moderate to severe. (B17)

Some Trusts have adopted approaches to attempt to alleviate this disconnection. For example, an initiative requires regular meetings to provide opportunities for ground-level staff to communicate directly with management. Similarly, a different Trust established a system that allows open discussions with the involvement of the leadership team. Participants also

described the characteristics they wish to see in the organizational structure: flattened, democratic, visible, approachable, and welcoming of participation.

Inadequate staffing level and challenges in staffing mix

The overwhelming workload is frequently mentioned by participants, driven by several factors. Staff shortages are the primary concern, especially noticeable during the pandemic, exacerbated by higher rates of sick leave, which further worsened the situation. Additionally, MHOTs have been burdened with extra responsibilities, including care coordination duties, administrative tasks, and HR matters, contributing to the heavy workload.

The community mental health teams face extremely heavy workloads, as reflected by participants from various Trusts. The reduction in inpatient beds may be a contributing factor, naturally transferring caseloads to community services. Consequently, MHOTs are joining other teams, such as crisis teams from community services.

> Because their workload has just grown and grown and grown and grown and there's no extra resource and people just get to the point where they just can't, like they're just burnt out and they can't do a good job with that anymore and it affects their wellbeing. So quite a few people have come to the crisis pathway because it's a team held caseload.(C27)

The challenges have also existed in staffing mix, with the major problem in the use of agency staff. Agency staff often receive double pay and engage less in communication, may contributing to unpredictability and less structured environments. For example, they are sometimes asked to lead shifts without adequate knowledge of the specific procedures or ongoing plans, which complicates daily operations.

> So at the start of the day, usually the nurse in charge would just sort of make a plan of the day, make sure everyone's doing everything they should, and all the appointments are covered. But because agency staff come in and are asked to lead a shift and they don't know what they're doing. So lots of times, because I'm probably one of the longest lasting members of staff, even though I feel like I don't know what I'm doing. (A43)

Additionally, there are concerns about hiring inexperienced or newly qualified OTs who may not be prepared to handle complex tasks, such as patient discharges. There is also an issue with retaining staff who lack the necessary skills and should not be accepted into their roles. This is particularly notable in rural areas, where recruitment challenges are more pronounced.

The imbalance of the staffing mix was mentioned in the ethnic composition, with one participant (A45) reflecting that most of the MHOT

staff are white and middle-class, which may affect cultural diversity and perspectives within the team.

Theme 4: Job resources – enhancing professional development in MHOTs

Adequate job resources have been identified as crucial for satisfying MHOTs. These resources vary in source. In this study, we primarily focused on the training, supervision, and career development opportunities available to MHOTs.

Diverse approaches to enhancing supervision and training in MHOTs

The supervision and training delivery across different Trusts varied slightly, but all received praise from participants. Trust A provides targeted training for all AHPs and prioritizes supervision, ensuring that the training and supervision are effective, technical, and that time for these activities is protected.

> I did my sensory training, which was wonderful and I did all that within, and the quite technical kind of diagnostic training all within the first year which is probably about 300% more than I got in 10 years in other place.(A61)

Trust B offers a wide range of training opportunities, including non-OT specific training, while maintaining high standards for both content and supervision. To keep staff well-informed, they effectively disseminate training information via email, ensuring that everyone receives the necessary updates. Trust C provides structured supervision from a variety of sources, including managers, peer groups, psychologists, and other OTs. Any cancelations are promptly rescheduled to ensure continuity.

Challenges for supervision and training – quality, accessibility and understaffing

Participants reported experiencing challenges with receiving supervision and training. First of all, their feelings about the quality of supervision varied. Some were dissatisfied, describing the process as 'tick in a box' (A45). Additionally, MHOTs responsible for providing supervision expressed a strong need for training to enhance their supervisory skills.

The main challenge with training opportunities is their accessibility and visibility. Although training options, including e-learning systems, are available within the Trusts, they are often poorly advertised and communicated. This results in staff missing important announcements due to an overload of emails. Furthermore, MHOTs find it impractical to keep up with all this information due to time constraints.

> I have to say when I've been busy I've sent an automatic divert to junk mail in the past because I haven't got time to read it and it fills your mailbox. So, I've started,

> cos you can't read once they're in junk mail you have to mess about, dragging 'em back in the inbox. … So, I think the Trust relies on everybody having time to read the comms. The clinical staff haven't got the time a lot of the time. (B10)

The heavy workload without backup staffing is another barrier for MHOTs in receiving supervision and training. High workload and understaffing mean that staff often cannot find time for training, which affects both managers and their teams across various bands. In the UK, the roles of OTs are typically classified by Band level: Band 2-4 for entry-level positions, Band 5-7 for qualified practitioners, and Band 8+ for senior leadership roles (Southwestyorkshire.nhs.uk, 2022b).

For MHOTs across different bands, the challenges vary considerably. Those in higher bands with management or leadership roles often seek more specialized training in management and leadership. Conversely, those in lower bands face limited access to certain trainings or advanced interventions due to restrictions based on their level criteria. Meanwhile, the absence of rotation opportunities for lower band staff limits their exposure to different specializations and settings, potentially hindering professional growth and the development of adaptation skills.

Career advancement barriers in MHOTs

Compared to the adequate training and supervision opportunities, career progression for MHOTs is less positive. Most participants agree that there are limited opportunities for advancing to higher bands, causing MHOTs to leave their positions. This mostly happened in higher band progression, and opportunities for MHOTs to advance from band 6 to band 7 are extremely limited. The primary pathway to band 7 involves a leadership role, which many clinicians are reluctant to pursue due to increased managerial responsibilities that divert attention from patient care.

> I have dozens and dozens of eminently experienced, highly qualified, highly capable, calm, rational practitioners who are just stuck at band 6 because, you know, if you wanna be a band 7 basically you've got to a be a team leader and very few people want that hassle if they're clinically minded.(A61)

Theme 5: External factors – Covid impact, geographic constraint and physical work environment

Diverse perspectives on the impact of Covid-19

The main challenge brought by COVID-19 is increased workload and staff shortages. The pandemic has led to higher sickness levels and absenteeism, increasing workloads for remaining staff. However, there has been a shift toward more flexible working practices, including the use of new technology. MHOTs have distinct perspectives on this shift. Some believe

remote work allows therapists to gain insights into patients' living environments, enhancing relational care (A45). Others express concerns that some staff might use remote work to reduce patient contact intensity, potentially neglecting patients needing more frequent or intensive support.

> There's some others that I think feel like it might have given them a bit more of a, it's a bit more of an excuse to have some time off and do less, I don't know in a weird way it seems as though there's people who are kind of, there's people who've, they think oh actually I can just do a monthly phone call to this client I don't have to do any more.(B14)

The remote work has reduced travel time and potentially increased productivity. However, this shift has also led to challenges such as "Zoom fatigue," a risk of reducing face-to-face patient interactions which can feel isolating for staff and possibly detrimental to patient care as well.

In conclusion, individual reactions to the challenges posed by the pandemic have varied widely. While some have adjusted to the new norms, others have struggled with the changes. Interestingly, there is no significant evidence suggesting that the pandemic has directly influenced decisions to leave or stay in positions among the colleagues observed.

Even though there is no direct relationship between COVID-19 and MHOT retention was found in this study, the pandemic has played an indirect and positive role in promoting NHS recruitment. This may apply not only to MHOTs but to all NHS employees. People witnessed NHS's ability to manage a global health crisis and realized the stability and safety of working for the NHS, as one participant explained:

> I think it allows people to reassess their lives and think actually lots of jobs are up in the air at the moment and we are a stable employer, people have seen how good the NHS works and how amazing they've been in terms of the COVID vaccination and everything else, and it's been the best recruitment (A11)

The impact of geographic constraints and family consideration

Distance from family, travel expenses, and commuting are crucial factors influencing OTs' decisions. This particularly impacts MHOTs working in rural locations, as they have fewer nearby options and must consider their families when thinking about moving. There is no gender difference in this case, both female and male participants indicated this is an essential factor in staying at their current workplace. Therefore, it is easier for Trust to retain them.

Dissatisfaction with work environment

When asked about the physical work environment, most participants expressed dissatisfaction and reported having negative experiences with it.

> Things like having to hot desk (assigned desk or workplace) and not having anywhere to put my stuff, and having to have resources and not having anywhere to put it. And then, I mean, I'm currently in a large room which is very noisy and it's meant that I've actually gone home with my laptop and thought, I can't work here.(B31)

The noisy environment and lack of isolated workspace make it difficult for people to concentrate on their jobs and contribute to a sense of devaluation.

Discussion

The exploration of factors contributing to MHOTs' intention to stay in post or leave has highlighted five key themes based on the initial framework: 'professional dynamics and identity challenges in MHOTs', 'work engagement and service challenges in MHOTs', 'team dynamics and organizational work environment', 'job resources – enhancing professional development in MHOTs', and 'external factors – covid Impact, geographic constraint and physical work environment'. Each theme, along with its subthemes, is linked to our primary concerns about the influencing factors that either retain MHOTs in their roles or push them to leave. We have also identified clues of interplay among various factors, further highlighting their interconnection.

Factors identified influencing MHOT retention

Several factors were identified that directly or indirectly impact MHOT's intention to stay or leave. These factors can generally be divided into two categories: positive factors that pull people back into position and negative factors that push people to leave.

Working in a supportive team and being surrounded by supportive people is the most significant pull factor for staying. This is the main reason almost all the participants in this study stated for why they stay. Even when suffering from a heavy workload or an intense work environment, a supportive team can provide a protected space to breathe and recharge. This is echoed by Scanlan et al. (2010), who found that having a supportive team is a key factor in encouraging MHOTs to stay. In addition, adequate job resources, including supervision and training opportunities, are other pull factors that encourage MHOTs to stay. This is directly linked to professional development, and all Trusts in this study deliver good training and supervision to MHOTs, which satisfies their willingness to learn more skills. However, the need for improving the quality of supervision and increasing the accessibility and visibility of training opportunities is also noted in this study, providing direction to further strengthen the delivery of supervision and training for MHOTs. The importance of

high-quality supervision has been noted in other studies (Ashby et al., 2013), as it gives MHOTs time to reflect on their role and put theory into practice. Furthermore, there is a reason that naturally pulls MHOTs to persist in being a MHOT – their passion for mental health and patient care. This acts as a source of motivation for the MHOT workforce. Therefore, ensuring that MHOTs can maintain regular interaction with their patients can further solidify their professional passion and encourage them to remain in their positions. The last pull factor is an external reason – family considerations. This factor mainly impacts MHOTs who work in Trusts in rural or non-urban areas, where there is limited availability of other Trusts nearby. In such cases, they are less likely to consider moving because they need to take care of their families, making them a quite stable part of the MHOT workforce.

In terms of push factors, role erosion is the most significant. Role blurring and erosion of traditional professional boundaries is a common experience in multidisciplinary mental health teams (Brown et al., 2000). In this study, we also noticed that the burden of non-OT-specific duties and more generic tasks has led MHOTs to feel like they are becoming mental health practitioners instead of specialized professionals. And this issue is particularly severe in community mental health teams, as already documented by Culverhouse and Bibby (2008). The erosion leads to a sense of devaluation among MHOTs, who may gradually consider leaving their positions. Additionally, the failure to provide high-quality care and the inability to make a significant difference in patients' lives due to heavy workloads, understaffing, and time pressure, puts a lot of stress on MHOTs. This acts as another push factor, making MHOTs less engaged in their work and unable to achieve personal fulfillment. Another significant push factor is the disconnection with leadership and management. MHOTs are willing to participate in service improvement but often feel they have no voice at the table or are not listened to. This communication gap between MHOTs and top-level management leads to impractical implications that cannot be implemented in MHOT work, making MHOTs feel unsatisfied and devalued. Meanwhile, overwhelming workloads and inadequate staffing levels lead to burnout among MHOTs, pushing them to quit their jobs as well, as evidenced by Hayes et al. (2008) and Lexén et al. (2020). This situation has been exacerbated by COVID-19, creating a vicious cycle where the pandemic causes higher staff sickness rates and increased referral rates, further increasing workloads on fewer MHOTs. In this study, it is noted that MHOTs in CMHT suffered the most due to the reduction of inpatients beds, making them the most vulnerable group. Not only are staffing levels a concern, but the issue of an unreasonable staffing mix also acts as a push factor. The major problem is the overuse of agency staff, the inability to retain experienced MHOTs, and the recruitment of

inexperienced newly qualified MHOTs. Barriers to career progression are another push factor, especially reflected in the limited availability of higher band progression, such as from Band 6 to Band 7.

The interconnected factors influencing MHOT's retention and job satisfaction

In this study, we noticed that no single factor independently determines MHOT's retention. Instead, interactions, chain reactions, causation, and complementarity among different factors create a ripple effect on people's decisions.

For instance, there is an interplay between inadequate staffing levels and overwhelming workloads. Short staffing puts a heavier workload burden on the remaining staff, causing more people to leave and exacerbating the staffing shortage. This aligns with findings in the nursing workforce by Al-Kandari and Thomas (2008).

Adequate job resources, including supervision, training, and career progression, create a chain reaction that enhances professional development and professional identity. This makes people feel invested and valued, thereby increasing job satisfaction (Kalleberg, 1977) and making them more likely to remain in their positions.

A causation relationship also exists. For example, if MHOTs have more voice within the MDT or AHP, they are more likely to be heard by top management and to participate in service improvement, which enhances their engagement at work and improves job satisfaction (Appelbaum et al., 2013).

Lastly, complementarity among factors plays a role. For instance, when MHOTs experience stress from a heavy workload or worry about their ability to provide high-quality service and consider quitting, support from colleagues, supervisors, or managers can greatly back them up and encourage them to stay in their positions.

In conclusion, all these factors and their interlinked relationships affect MHOT's job satisfaction, with some leading to improvements and others having a negative impact. As noted in De Sousa Sabbagha et al. (2018), if people are satisfied with their job, they are likely to stay. Conversely, if their level of dissatisfaction exceeds a certain threshold, they will intend to leave. Therefore, it is essential to maintain a delicate balance to ensure MHOT retention.

Strategies to enhance MHOTs' retention and job satisfaction

Firstly, it is essential to empower and grant more autonomy to MHOTs, as empowerment is a crucial factor affecting job satisfaction (Jung et al., 2017). If MHOTs continue to be marginalized within the MDT, their roles

will be overlooked, and the workforce will become further diminished. Without a voice at the table and proper empowerment, it will be challenging for top-level management to understand and address their needs and concerns. Additionally, MHOTs should be given more autonomy in their work rather than being assigned generic tasks. This will allow them to thrive and fully utilize their professional capabilities.

Secondly, to address the disconnection between MHOTs and top management, it is crucial to identify where the gaps exist. This study has identified a communication gap, highlighting the need for middle management to act as a bridge between MHOTs and higher-level management. Definitive MHOT leadership can fill this role by ensuring cohesive planning and direction across the trust, preventing fragmentation and aligning all MHOTs toward common goals rather than working independently. This leadership should also observe the struggles on the ground and report them to top management, thereby creating a vital link that facilitates understanding and action.

Thirdly, MHOTs are eager to receive training and supervision, as career development is a key aspect of their roles (Fone, 2006). Therefore, it is important to address the issue of job resources to improve their job satisfaction (Scanlan & Still, 2019). To improve training opportunities, the accessibility and visibility should be increased by using a more straightforward portal, allowing staff to easily monitor and follow training updates. Additionally, providing more leadership and management training for MHOTs in advanced positions, and appropriately unlocking training restrictions for some lower-level MHOTs, is crucial. Additionally, since supervision is essential for MHOTs' professional development, it is important to enhance the quality and effectiveness of supervision. Effective supervision should go beyond administrative tasks by incorporating an appraisal process with clear parameters and boundaries. Furthermore, integrating line management with clinical supervision can further enhance professional growth.

Limitations

One of the limitations of this study is the small sample size, involving only three Trusts and including just 16 interviews. However, the participants came from three different Trusts located in various areas and worked in diverse services within these Trusts, which introduces some variability in the captured experiences. Meanwhile, no new themes were found when coding the final transcripts, ensuring saturation in this study as much as possible.

The sample had a gender imbalance, with only three male participants, and a service imbalance, with ten out of sixteen participants from

community teams. Considering the majority of MHOTs are female and work in community teams (HCPC, 2021), we made our best efforts to involve male participants and MHOTs working in various services in this study.

It is important to note that all the participants were current MHOTs who were working and in post. While their views are crucial to understanding the factors associated with retention and may provide some clues about intent to leave. In the future, research will have to consider the views of former employees to provide a more comprehensive view.

Moreover, all participants in this study were White British, potentially omitting valuable perspectives from MHOTs with diverse cultural backgrounds. This limitation restricts the applicability of the findings to a diverse workforce. To address these issues in future research, it is essential to involve a larger number of participants from various cultural backgrounds and a broader range of services. Such diversity would enhance the representativeness and applicability of the sample, providing a more comprehensive understanding of MHOT experiences across the UK.

While this study primarily employed a qualitative approach with framework analysis, triangulation was considered to strengthen the validity of the findings. Triangulation consists of data source triangulation, method triangulation, investigator triangulation, and theory triangulation (Carter et al., 2014). Data source triangulation was integrated by interviewing MHOTs in different Trusts and service areas. Future studies could involve more MHOT individuals, such as former OT employers, to gain additional perspectives. Although the involvement of multiple researchers confirmed the breadth of the findings, future studies could employ more powerful interview tools to gain a deeper understanding of the research.

Conclusion

In conclusion, this study has highlighted the complex interplay of factors influencing Mental Health Occupational Therapists' retention, identifying key themes such as team support, job resources, professional passion, and family considerations as significant pull factors. Conversely, role erosion, heavy workloads, leadership disconnection, staffing issues, and career progression barriers act as push factors. Effective retention strategies should focus on empowering MHOTs with greater autonomy, enhancing communication between MHOTs and management, increasing career progression opportunities past band 6, and improving access to high-quality training and supervision. Addressing these areas can foster a supportive and satisfying work environment, especially in a time when the stability and safety of working for the NHS have become more apparent after the pandemic. This, in turn, can ultimately promote MHOT retention and enhance mental health service delivery.

Author contributions

EW and SO were involved in the design of the original study. Data collection was completed by EW and SO, and data analysis and interpretation were conducted by WY and EW. The draft of the paper was primarily written by WY and then reviewed by EW and SO. All authors reviewed and edited the manuscript and approved the final version.

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Appendix A

Appendix A1. Final framework used in the qualitative analysis

1	MHOT's well-being at work
1.1	Job satisfaction
	1.1.1 Relationship between job satisfaction and MHOT retention
	1.1.2 Understanding job satisfaction among OTs in mental health team
1.2	Professional identity
	1.2.1 Role identity and collaboration: perspectives from MHOTs in a multidisciplinary context
	1.2.2 The influence of patient relationships on the professional identity of MHOTs
	1.3.3 Role ambiguity and its impact in MHOT practice
1.3	Work engagement
	1.3.1 Factors contributing to MHOT's engagement at work
	1.3.2 Challenges and devaluation in MHOT workforce
	1.3.3 Stressors and compromises in MHOT service quality
2	Organizational work environment
2.1	Supportive team and team cohesion
	2.1.1 Experiences within a supportive/unsupportive team
	2.1.2The role of supportive team and team cohesion in MHOTs
2.2	Workload, staffing mix and staffing level
	2.2.1 Description of overwhelming workload and heavy care coordination duties
	2.2.2 Situation of inadequate staffing level in the team
	2.2.3 The challenges of staffing mix for MHOTs
2.3	Leadership and organizational culture
	2.3.1 Disconnection with the leadership and management level within the organization and suggestions
	2.3.2 Story of the leadership and management practices in difference services
	2.3.3 Challenges of changing organizational Structure
3	Job resources
3.1	Supervision and training opportunity
	3.1.1 Supervision and training delivery for MHOTs
	3.1.2 Challenges MHOTs face in receiving supervision and training opportunities
	3.1.3 Understanding the significance of the quality of supervision
3.2	Career progression
	3.2.1 Career progression challenges for MHOTs
	3.2.2 Specific career progression barriers for MHOTs at different bands
4	Other
4.1	Covid impact
4.2	Other external factors

Appendix B. An extract from NVivo to show the indexing process

	A : 1. MHOT's well-being at work	B : 1.1 Job satisfaction	C : 1.1.1 Relationship between job satisfaction and MHOT retention	D : 1.1.2 Understanding Job Satisfaction among OTs in Mental Health Team	E : 1.2 Professional identity	F : 1.2.1 Role Identity and Collaboration - Perspectives from MHOTs in a Multidisciplinary Context	G : 1.2.2 The Influence of Patient Relationships on the Professional Identity of MHOTs	H : 1.2.3 Role ambiguity and its impact in MHOT practice	I : 1.3 Work engagement	J : 1.3.1 Factors contributing to MHOT's engagement at work	K : 1.3.2 Challenges and Devaluation in MHOT workforce	C
1 : A10	8	2	1	1	2	2	0	0	4	2	1	
2 : A11	2	0	0	0	1	0	1	0	1	0	1	
3 : A15	2	0	0	0	1	0	0	1	1	0	0	
4 : A43	9	2	1	1	3	1	2	0	5	1	3	
5 : A45	7	3	0	3	2	1	1	0	2	1	0	
6 : A61	2	0	0	0	1	0	0	1	1	0	1	
7 : B03	2	1	0	1	1	1	0	0	0	0	0	
8 : B10	1	0	0	0	1	0	1	0	0	0	0	
9 : B14	4	1	1	0	2	0	0	2	1	0	1	
10 : B17	9	0	0	0	3	2	1	0	6	1	3	
11 : B31	6	0	0	0	2	0	0	2	5	0	3	
12 : C27	7	1	1	0	0	0	0	0	6	4	1	
13 : C35	5	1	1	1	3	3	0	0	2	1	1	
14 : C36	13	0	0	0	4	0	1	3	9	3	6	
15 : C40	8	1	1	1	3	0	1	2	5	0	3	
16 : C60	8	0	0	0	7	0	2	5	1	0	1	