Investigating the job demands and support available to Improving Access to Psychological Therapies workers

By

Sophie Westwood

Submitted for the degree of Doctor of Psychology
(Clinical Psychology)

School of Psychology
Faculty of Arts and Human Sciences
University of Surrey
July 2013
©Sophie Westwood 2013
VOLUME I: PUBLIC PORTFOLIO

Volume I of the portfolio is a public document and is comprised of 3 dossiers including academic, clinical and research.

ACADEMIC DOSSIER

The academic dossier contains academic work completed on the clinical psychology doctorate training course. It includes one essay, one literature review, two Problem-Based Learning (PBL) reflective accounts and two summaries of Personal and Professional Learning Discussion Group (PPLDG) Process Accounts.

CLINICAL DOSSIER

The clinical dossier provides an overview of my clinical experiences in each placement and provides a summary of the nature of the clinical work.

RESEARCH DOSSIER

The research dossier includes my Service Related Research Project (SRRP) with evidence that the findings were fedback to the service, a research log of my research experiences and the abstract to a qualitative group project and my Major Research Project (MRP).
# VOLUME I: TABLE OF CONTENTS

## ACADEMIC DOSSIER

<table>
<thead>
<tr>
<th>Item</th>
<th>Page</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROFESSIONAL ISSUES ESSAY</td>
<td>1</td>
<td>Disk</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>23</td>
<td>Disk</td>
</tr>
<tr>
<td>PBL REFLECTIVE ACCOUNT 1</td>
<td>44</td>
<td>Disk</td>
</tr>
<tr>
<td>PBL REFLECTIVE ACCOUNT 2</td>
<td>53</td>
<td>Disk</td>
</tr>
<tr>
<td>PPLDG PROCESS ACCOUNT SUMMARY</td>
<td>62</td>
<td>Disk</td>
</tr>
<tr>
<td>PPLDG PROCESS ACCOUNT SUMMARY</td>
<td>64</td>
<td>Disk</td>
</tr>
</tbody>
</table>

**PROFESSIONAL ISSUES ESSAY**
How do we understand the context of mental health, mental illness and mental wellbeing when people are experiencing material poverty? What psychological frameworks do we have to offer to support such people?

**LITERATURE REVIEW**
The clinical applicability and efficacy of the systemic approach for adults with intellectual disability.

**PBL REFLECTIVE ACCOUNT 1**
Relationship to change

**PBL REFLECTIVE ACCOUNT 2**
Child protection, domestic violence, parenting, learning disabilities and kinship care.

**PPLDG PROCESS ACCOUNT SUMMARY**
Year 1

**PPLDG PROCESS ACCOUNT SUMMARY**
Year 2
How do we understand the context of mental health, mental illness and mental wellbeing when people are experiencing material poverty? What psychological frameworks do we have to offer to support such people?
<table>
<thead>
<tr>
<th>Item</th>
<th>Page</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE RELATED RESEARCH PROJECT</td>
<td>72</td>
<td>Disk</td>
</tr>
<tr>
<td>An evaluation of the views and experiences of staff in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>secondary mental health services regarding the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>involvement of people who use services and carers in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the North West locality of a National Health Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foundation Trust.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESEARCH LOG</td>
<td>111</td>
<td>Disk</td>
</tr>
<tr>
<td>APPENDICES TO THE RESEARCH DOSSIER</td>
<td>112</td>
<td>Disk</td>
</tr>
<tr>
<td>Article submitted and accepted to Clinical Psychology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forum (Division of Clinical Psychology, British</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological Society) pending publication: Feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>from people who use mental health services: what can</td>
<td></td>
<td></td>
</tr>
<tr>
<td>be learned?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QUALITATIVE RESEARCH PROJECT (ABSTRACT)</td>
<td>121</td>
<td>Disk</td>
</tr>
<tr>
<td>Perceptions of Facebook</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAJOR RESEARCH PROJECT</td>
<td>123</td>
<td>Paper</td>
</tr>
<tr>
<td>Investigating the job demands and support available to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies workers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACADEMIC DOSSIER

This section contains one essay, one literature review, two PBL reflective accounts and summaries of PPLDG Group Process Accounts.
PROFESSIONAL ISSUES ESSAY

How do we understand the context of mental health, mental illness and mental wellbeing when people are experiencing material poverty? What psychological frameworks do we have to offer to support such people?

January 2012

Year 2
INTRODUCTION

‘Material’ or ‘absolute’ poverty is defined as the lack of basic necessities for survival and is calculated in the UK and Europe as household incomes below 60% of the national median income after housing costs (Parekh, MacInnes, & Kenway, 2010). This is a measure of poverty used by most researchers, the EU and the UK government (Parekh et al., 2010). The European Anti-Poverty Network stated that poverty in the EU is still at a relatively high level with nearly one in seven people at risk with higher figures for groups such as children and older people (Parekh et al., 2010). ‘Relative’ poverty exists in many developed countries in the European Union where access to basic necessities exist but social exclusion and ill health lead to poor quality of life in comparison to others in the population (European Commission, 2002). Smith (2010) commented that in Britain, poverty has been conceptualised mostly as ‘social exclusion’ (Sheppard, 2006) and Sanchez, Cronick and Wiesenfeld (2003) stated that it was difficult to avoid defining poverty by reference to a social point of view. Around 24% of women and 20% of men with the lowest income are at risk of developing mental health difficulties¹ (Parekh et al., 2010).

In the first half of this essay I² will explore how psychology has contributed towards understanding the relationship between poverty and mental health, mental health difficulties and mental wellbeing. Poverty has been shown to be a risk factor for developing mental health difficulties and different variables at the individual level such as stress, social factors and loss of control have been hypothesised to influence or explain this relationship. The attributions that people make towards people in poverty and the societal barriers that are erected might serve to maintain poverty.

¹ Note on terms: ‘Mental illness’ and ‘mental health disorder’ will be referred to as ‘mental health difficulties’ in line with the author’s preferred use of language. Where possible, ‘people who use services’ and ‘people in poverty’ will be used to emphasise that we are people before we are users of services or located in a social class or construct.

² The author will refer to themselves in the first person in order to emphasise the links between theory and practice and the impact it has on the profession of clinical psychology.
Community Psychology (Orford, 1992) and Critical Psychology (Fox, Prilleltensky, & Austin, 2009) have questioned the impact of traditional individually-focused psychology on poverty and using a socio-constructionist perspective called into question how the power of larger sociological systems cause and maintain poverty.

The second half of this essay outlines how certain psychological frameworks have been used to support people in poverty. Different approaches are suggested in relation to impacting on the individual, community and governmental levels by taking a social justice perspective into account. Community psychology was involved in the development of different types of interventions such as advocacy and self-help groups. Research methods are discussed that allow for investigation of the efficacy of mental health interventions in the community and act as a means of co-creating change with members of the community. Finally, changes to policy at the government level, the impact of ‘Improving access to psychological therapies’ (IAPT) and the role of the psychologist in political activism will be discussed. I will consider how the material in this essay relates to my practice as a Trainee Clinical Psychologist employed in the National Health Service (NHS). I will argue that in order to understand the complex relationship between poverty and mental health and develop ways to support people experiencing this, we need to look beyond researching and intervening at the individual level and consider the wider social, economic and political factors.

**Literature search**

The search terms ‘material poverty and mental illness’ and ‘poverty and mental health’ were entered into the PsychINFO and Google Scholar electronic databases. Other sources of information included relevant books from the University of Surrey library catalogue.
UNDERSTANDING THE RELATIONSHIP BETWEEN POVERTY AND
MENTAL HEALTH

Poverty as a risk factor

People in the lowest 20% of household income have increased rate of mental health difficulties compared with those in the top 20% in the UK (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2007). Many studies have shown that adults and children living in poverty experience significantly negative outcomes which include psychological distress, physical illness, parasuicide, educational attainment, political participation, poor housing and social stigma (Adler et al., 1994; Belle, Doucet, Harris, Miller, & Tan, 2000; Holding, Buglass, Duffy, & Kreitman, 1977; Lund et al., 2010; Patel & Kleinman, 2003; Wilton, 2004). Patel and Kleinman (2003) found an association between indicators of poverty and the risk of developing mental health difficulties, particularly for people with lower levels of education. They found only weak evidence to support a specific association with income levels suggesting that it was not solely economic factors that related to the development of mental health difficulties. Rather, they claimed experiencing insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health may have explained the greater vulnerability of people in poverty to developing common mental health difficulties. Evans (2004) claimed that psychological research on poverty largely ignored the physical settings in the environment that low-income children and families inhabit. Therefore a variety of environmental, social and psychological variables may be influencing the association between poverty and mental health difficulties.

There has been much unresolved controversy as to whether social causation theory, that mental health difficulties cause poverty, or if social selection theory, that social or cultural factors cause mental health difficulties, might explain the relationship between poverty and mental health (Lund et al., 2010; Orford, 1992). For example, ‘Social drift theory’, a form of social selection theory, postulated that those who develop mental health difficulties ‘drift downwards’ in social status. Hudson (2005)
However, found from a follow-up study of patients who had been hospitalised on an acute psychiatric unit in the United States (US), that the rate of people shifting to lower socioeconomic situations was the same as those shifting to higher socioeconomic situations. Hudson (2005) suggested that the increased rate of mental health difficulties associated with low socioeconomic status may be explained by a social-economic-stress model where the stress of living in poverty influences the development of mental health difficulties. Correspondingly, Wolff, Santiago and Wadsworth (2009) conducted a year-long prospective study examining the relationships among poverty-related stress, involuntary engagement stress response (IESR) levels, and anxiety symptoms. They recruited an ethnically diverse sample of 98 families living in poverty in the US and found strong evidence suggesting that IESR levels moderated the influence of poverty-related stress on anxiety symptoms. Other studies have also looked at underlying psychobiological mechanisms such as the negative effect of daily financial strain (Wadsworth & Compas, 2002) and the way that physiological stress reactions can become dysregulated (Evans, 2003).

Therefore recent research has begun to examine the effect of psychobiological mechanisms as mediators of the relationship between poverty and mental health. Much of this research highlights variables that are associated with this relationship although it is difficult to infer causality due to the influence of confounding variables. Indeed, poverty affects individuals, families, communities and societies. Research that focuses solely on the individual may be failing to take into account the wider context and influences of sociological systems that contribute to the relationship between poverty and mental health.

The wider context

‘Attribution Theory’ (Feagin, 1972) highlighted the biases in society that perpetuate poverty. Feagin (1975) asked over 1000 Americans why they thought people experienced poverty and found three principal categories of attributions. These showed that people attributed poverty to either individualist (responsibility lies
within the individual), structural (societal and economic factors) or fatalistic (luck and fate) reasons. Carr (2003) suggested that psychologists could use Attribution Theory to ‘desensitise’ populations and help them to attribute situational factors to the cause of poverty. In relation to this, the ‘Social Model of Disability’ (Oliver, 1983) proposed that society erects barriers to prevent people from experiencing social inclusion. Considering people in poverty in this way might help to lift blame from them. The social stigma associated with poverty may be dramatically intensified when people also experience mental health difficulties meaning that there are multiple barriers in society that they have to struggle with.

Psychology began to make an impact on poverty in the 1960’s when theorists and writers such as Jim Orford (1992), George Albee (1968) and Ignacio Martín-Baro (1994) called for liberation within psychology. Their aim was to combat the bias in psychology that focused exclusively on the individual. They appealed for psychologists to explore and deconstruct the socioeconomic contexts of people in poverty. Community Psychology developed with a focus on doing this through examination of the ‘person-in-context’ particularly in disadvantaged areas of society (Orford, 1992). The growth of Family systems therapy, for example Minuchin (1995), incorporated working with people in poverty and moved towards a socioconstructionist approach. The American Psychological Association (APA, 2000) declared war on poverty and recent movements such as Positive Psychology (e.g. Seligman & Csikszentmihalyi, 2000) have emphasised that people are inherently capable of change which fosters hope for people in poverty to overcome their mental health difficulties. Critical psychology (Fox et al., 2009) in particular focused on reducing suffering attributable to oppression and exploitation. Over the past 40 years psychology has interacted with sociological perspectives in order to broaden the conceptualisation of poverty and mental health by incorporating wider systems and structures. As a Trainee Clinical Psychologist I am developing my ability to think systemically and apply this to families, staff teams and organisations in my Child and Adolescent Mental Health placement.
Power and lack thereof

Orford (1992) argued that the unequal distribution of power in society contributed to maintaining poverty. He suggested that more power leads to mental wellbeing whereas less leads to mental health difficulties. Marmot (2006) studied British Civil Servants and found that experiences of low levels of control and authority over decisions related to higher rates of sickness, heart disease, mental health difficulties, stress and life span. Orford (1992) commented that powerlessness at the individual level might relate to concepts such as Seligman’s ‘learned helplessness’ (Maier & Seligman, 1976) and Rotter’s ‘internal versus external locus of control’ (Rotter, 1966). Prilleltensky (2003a) developed a model of ‘wellness’ which focused on the individual, interpersonal and collective levels. He considered the cultural aspects that affected people in poverty and hypothesised that increased power to access resources, fairer treatment and empowerment can lead to mental wellness. He claimed that psychologists needed to consider how a lack of control and poor quality of life derive from social, material and political sources. Moreira (2003) agreed that clinical psychology and psychiatry continue to approach problems at the individual level and that an approach is needed that takes into account political, economic and clinical factors. This suggests that psychologists should be considering how social and political elements impact on people in poverty who experience mental health difficulties and incorporating this into psychological assessment and formulation.

The impact of consumerism

Sen (2000) commented that simple economic growth does not necessarily result in improved quality of life. Even when income is relatively low, if good health care and education is available there are notable results in the length and quality of life on the entire population (Sen, 1999). America is said to have one of the largest equity gaps where people at the bottom of the economic spectrum have shorter life spans compared to India or China where income is lower (Sen (2008). Lewis (1959)
studied Mexican families and concluded that as materialism increases so too does the disparity between the poor and rich leading to an indigent lifestyle. Moreira (2003) claimed that the influence of corporate capitalism on the global community, particularly in Western society, has resulted in a greater emphasis on consumerist values. That is, only money can obtain objects of value (Lummis, 1991). Moreira (2003) advised that this may lead to a loss of cultural values whereby people cannot meet their own needs for survival as they place increasing value on desirable yet unaffordable items. Indeed, Schumaker (2001) claimed that cultural values could be a protective factor from mental health difficulties. In this way, consumerism and globalisation could be seen as entering cultures and stripping them of their values and reducing their desire for citizenship. Moreira (2003) stated that with this loss of power and citizenship, 'nihilism' may emerge, a psychological state characterised by a lack of meaning and purpose in life (Nietzsche, 1983). It is important for psychologists to consider the impact that consumerism and globalisation has on family and community systems in poverty and how this may lead to a loss of hope and purpose. Perhaps psychologists could focus on fostering hope and helping individuals, communities and societies affected by poverty and mental health difficulties to reclaim their values and develop meaningful ways of living.

WHAT PSYCHOLOGICAL FRAMEWORKS DO WE HAVE TO SUPPORT PEOPLE IN POVERTY?

A social justice perspective

Sanchez et al. (2003) pointed out that by defining poverty in relative terms we must consider that when it comes to thinking about intervention, 'one size does not fit all'. Speight and Vera (2004) developed a social justice psychological perspective that places responsibility on psychologists to work to liberate people in poverty from oppression. Social justice means not just offering charity to people in poverty but working with them and for them to alter the status quo and gain justice. Again, this
links well to considering not just the individual but the context in which they live and the powerful structures around them that might serve to perpetuate poverty. Smith (2010) claimed that psychologists have to be careful to acknowledge the power they have over the lives of clients who are socially excluded and reflect on issues of ‘classism’ (Lott and Bullock, 2007). Likewise, Javier and Herron (2002) interpreted a ‘fear of the poor’ among therapists which might manifest itself in classist attitudes. Smith (2010) commented that supervision and guidance is required for psychologists to develop their knowledge base and explore their own social class identity in order to work in poverty-stricken communities. Supervision may also help to process the ‘trauma’ associated with working with people in poverty and to question the systemic sociocultural aspects and origins of client’s distress. Sloan (2003) commented that psychologists who are not participating in supervision in this way may be contributing to their client’s difficulties.

Smith (2010) encountered several barriers to working in poor communities and instead of delivering conventional psychological treatment she offered counselling, psychoeducation and interventions stemming from Community Psychology. This flexible way of practice relates to Prilleltensky’s (2003b) notion of ‘psychopolitical validity’. This was defined as the ability to incorporate knowledge of oppression and liberation into research and action to transform practices that are appropriate to different groups and communities. Sue (1998) stated that conventional psychological practice is culture bound and potentially unhelpful to clients from different cultures and those in poverty. Incorporating material on classism issues and cultural preparation to graduate training curricula may be helpful to overcome this (Smith, 2010; Orford, 1992). I would agree that including material on issues of classism and an opportunity to deconstruct this during Clinical training would be helpful for developing cultural competencies. In addition to this, time to reflect on these issues in the context of multi-disciplinary mental health teams in the NHS would be valuable to ensure that staff had the opportunity to process their emotions and attitudes related to their work with people in poverty.
Groups and organisations

Many ideas for intervention for people in poverty stem from Community Psychology (Orford 1992) or Critical Community Psychology (Bronfenbrenner, 1979). Advocacy has been a form of support that Community Psychology has championed since the 1980's in order to empower people who use services. Self-help organisations have grown as a means to either change public attitudes or to function as mutual assistance groups such as support groups. These can span across the lifecycle and function to provide emotional support, the provision of role models, relevant information, powerful ideology, ideas about ways of coping, an opportunity to help others, social companionship and a sense of mastery and control (Orford, 1992). Wollert, Knight and Levy (1984) suggest that psychologists can utilise their knowledge, consultation skills and a rapport-building approach to assist with the creation and development of such groups including ‘service-user’ group meetings. The ‘service-user’ movement has adopted some of these methods to assist in the growth and development of empowering people who use services in the context of their treatment, service planning, delivery and evaluation and policy making. From my experience of attending groups for people who use services I have found that often some people who use services were frustrated that they did not receive feedback from senior management after having commented on various aspects of services and their care. This seemed to generate apathy and a sense of hopelessness that anything could change. This reflects one of the main issues of the involvement of people who use services as it is vital that people who give up their time and are often unpaid to attend meetings feel that they are being heard and contributing to meaningful change.

Orford (1992) argued that psychologists could be sharing their specialist knowledge and skills with a large proportion of human service workers such as teachers and police officers. This could largely benefit the community as it is difficult for psychological services to provide enough specialist psychological help to everyone that needs it. Orford (1992) suggested that psychologists who fear a loss of control over the profession should view the sharing of psychological knowledge as central to
improving the psychological wellbeing of the community. In line with sharing knowledge, consultancy could be employed to develop change at the agency level (Orford, 1992). Orford (1992) defined this as a process whereby the consultee voluntarily contacts the consultant with special expertise to help them to provide a better service to their clients. It may be a helpful framework for sharing psychological knowledge with other professions. Psychologists possess knowledge and skills of teamwork, group dynamics and leadership (Mitchell and Purcell, 2009) which may assist them in providing consultation. Lapsley and Oldfield (2001) commented that consultancy can be useful in the promotion of change where there is resistance notably in public services. Psychologists should also be mindful of ‘the myth of the hero innovator’ (Georgiades, Phillimore, Kiernan, & Woodford, 1975) when attempting to implement change in organisations in order to avoid failure. For example, drawing on allies from within the organisation may be one way of doing this. Sharing knowledge and employing a consultancy model to do this may be an effective way for psychologists to intervene at the community or organisational level. By focusing on the wider context rather than just on the individual, organisational structures may be influenced to allow people in poverty who experience mental health difficulties to feel empowered and heard by the services that they connect with.

Research

Psychologists are highly trained to conduct qualitative and quantitative research which is crucial to furthering our understanding of the relationship between poverty and mental health. Furnham (2003) stated that the psychological variables that have been used to explain this relationship were not sufficient and perhaps not necessary in the sense that poverty could be more of a sociological and economic issue. Therefore certain research methods may be more applicable when estimating the extent of a problem such as poverty within a community. These could include quasi-experimental designs, case studies, qualitative research approaches and programme evaluation (Orford, 1992). However, the current evidence-based paradigm favoured
by the government deems that randomised controlled trials (RCT’s) are the ‘gold standard’ for research. Orford (1992) argued that it is practically impossible to achieve this in community intervention research due to the difficulties with controlling for confounding variables. Methods such as quasi-experimental designs however possess higher external validity than RCT’s. This is largely due to the known assignment of participants to experimental groups. Equally, allocating resources to those that need them most may also be more ethical.

Another type of research design, Action research (AR) or Participatory Action Research (PAR) has been conducted within the community and engages community members as co-researchers (Sanchez et al., 2003). It involves an integration of theory and practice that is co-generative and links professional and popular knowledge (Greenwood & Levin, 2000). AR or PAR is based on the belief that reality is socially constructed (Gergen, 1999). Community Psychology recognises the importance of language in the construction of reality, and aims to generate new meanings and actions required to transform it. The dialogue between the community psychologists and co-researchers creates a process of deconstruction and reconstruction as they advance together in reflection, research and change (Sanchez et al., 2003). Smith (2010) described a PAR housing-related activism project in which she was involved as a researcher. Some of the outcomes involved an increased sense of self-worth and self-efficacy for co-researchers. Smith and Romero (2010) claimed that PAR involves trust, a power-sharing approach and goals of collective team efficacy within a social justice framework. In considering research in disadvantaged communities where people are experiencing mental health difficulties it seems that this approach may offer empowerment, choice and tools for individuals in groups and communities to effect change. It takes into account how research can impact at a collective level and produce change for groups or communities whilst simultaneously furthering our understanding of the relationship between poverty and mental health.
Political activism

Changes at the government level through policy such as 'No health without mental health' (Department of Health, 2011) have begun to impact on access and choice to psychological therapies. For example, the government invested heavily in IAPT services which aimed to increase choice and provision to enhance wellbeing in the population. However, the Centre for Social Justice (2011; CSJ) claimed that IAPT still needed to build on this and considered that not all therapies would be able to meet the research criteria required to achieve National Institute for Clinical Health and Excellence (NICE) guidance. IAPT services are target-driven and performance based and their ability to meet the needs of people in poverty and flexibly create interventions in consideration of the social, economic and political context is perhaps questionable. However, positive practice guides are available to educate IAPT workers on how to tailor their practice to meet the needs of specific communities with a range of ethnic and cultural backgrounds (Jassi, 2008).

Smith (2010) questioned the policies, procedures and attitudes that keep poor people at a disadvantage and benefit the middle and owning classes. Economic growth is prioritised by the government meaning that public services have been privatised and public sector workers face unemployment and restricted access to health and education. It could be argued that the proposed changes to the NHS outlined in ‘Liberating the NHS: Legislative framework and next steps’ (Department of Health, 2010) will encourage practitioners to use the new paradigm of competition, choice and ‘payment by results’ to increase access to health care and drive up quality (CSJ, 2011). Counter to this, it may also be viewed that the NHS will become a fragmented public health system of different private health providers seeking to make a profit whilst employing less staff. It is not within the scope of this essay to discuss the impact of the proposed public health reforms on people in poverty with mental health difficulties but psychologists should be aware of how financial and cultural factors allow certain gates to open and close for such individuals.
Sanchez et al., (2003) encouraged psychologists to promote citizenship and enter into active political debates with stakeholders of the community in order to challenge policy under construction. Psychologists are skilled in facilitating debates to reduce tensions, create compromise and empower community members to make decisions. It could be argued that psychologists in the NHS might need to be creative and flexible in order to seek out opportunities to do this. From my clinical experience, there seems to be a growing understanding amongst the psychologists that I have met that as a profession we need to make the voice of psychology heard by government.

CONCLUSION

There seems to be much that psychology has to offer in order to understand the context of mental health, mental health difficulties and mental wellbeing when people are experiencing poverty. Recent psychological research (Patel & Kleinman, 2003; Saraceno & Barbui, 1997) has examined some of the physical, social and psychobiological mechanisms that place people in poverty at risk of developing mental health difficulties. Psychology has contributed to exploring this relationship by considering the wider context around people in poverty (Orford, 1992; Smith, 2010). Since the 1960’s psychology has produced theories such as ‘Attribution Theory’ (Feagin, 1972) and the ‘Social Model of Disability’ (Oliver, 1983) and generated ideas about lack of power and control (Orford, 1992). Prilleltensky’s (2003a) ‘model of wellness’ leads psychologists to consider how people in poverty might reduce their distress and enhance their wellbeing. The political landscape also lends itself to examination as consumerism and capitalism may be influencing the ‘vicious cycle’ of poverty. Money-based values are replacing protective cultural values which may result in a state of hoplessness (Moreira, 2003). This shows that psychologists need to be considering a wide range of systemic factors in order to understand the context of poverty and mental health.

Liberating people from poverty might involve a variety of different tools and psychology offers different frameworks to inform a variety of interventions in order to achieve this. Smith (2010) encouraged psychologists to develop an awareness of
their own social class identity, identify the barriers to working in communities in poverty and acquire knowledge and appropriate skills through supervision and learning. Psychologists can use this in areas of advocacy, self-help, sharing knowledge with others and consulting with organisations (Orford, 1992). These are practical and often low cost ways of supporting and empowering people in poverty. On a political level, psychologists could be facilitating debates regarding policies under construction such as the proposed public health reforms (Department of Health, 2011). Psychologist can use their leadership skills to drive forward new services such as IAPT to increase access and choice to psychological therapy and create bespoke and innovative interventions to engage hard-to-reach communities. Action research (Sanchez et al., 2003) may be a way of psychologists incorporating social, cultural and political contexts into the creation of new meanings to alter the reality and experience of poverty. By using the wealth of knowledge and expertise that they possess and considering the different process that occur at an individual and different structural levels, psychologists have the power and ability to effect real change alongside and on behalf of individuals, communities and societies living in poverty.

Reflections

My journey in clinical training thus far has left me relatively sheltered from the influences of poverty. However my previous experience as a support worker left me feeling disheartened and frustrated after having attempted to improve the quality of client’s lives who were living in poverty through mental health interventions. Exploring this subject has helped me to reflect on my own attitudes towards social class. As part of this, I also have to question how my values sit within the society in which I live. I am privileged in many ways in relation to my social class and opportunities that this has provided me with. I think it will be important to remain aware of this in the course of my career especially as I encounter clients from a variety of different ethnic and cultural origins. I hope, as I develop my psychological knowledge and skills throughout my career, to engage in active debate about the
future of our public services. Also, to contribute to research projects using qualitative methods or Action Research in order to undermine the relationship between poverty and mental health difficulties and help to empower people to move out of poverty and into a more inclusive society.
REFERENCES


Association, 295, 1304-1307.


LITERATURE REVIEW

The clinical applicability and efficacy of the systemic approach for adults with intellectual disability

January 2010

Year 1
ABSTRACT

The systemic approach was considered in terms of family therapy models and systemic practices in consultation with staff teams. Key definitions were defined and a search strategy implemented. Literature covering the use of these models for adults with intellectual disability was sourced and the major themes of the applicability of the approach and evidence underpinning it were explored. In terms of clinical applicability, themes of engagement, working with staff teams in therapy, service development and referrals to such services were considered. Much of the literature concerning the efficacy of this approach for people with intellectual disability was evidenced through case studies. Challenges of deciding upon outcomes and the development and pilot of an outcome tool were discussed. There were several barriers to conducting evaluation and generating quantitative data in line with current NHS policies and guidelines. These included difficulties of researching in a postmodernist paradigm, insufficient training of clinicians and small sample sizes. Implications for clinical psychologists, the majority of whom conduct systemic practice with intellectual disability in the NHS, were explored and conclusions from the review were contemplated in light of future directions for this approach.
NOTE ON TERMS

‘Learning disability’ is the most widely used term in the UK and defined in the White Paper, ‘Valuing People’ (Department of Health, 2001), as ‘a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with; a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.’ The World Health Organisation (1992) has a similar definition for the term ‘mental retardation’ in the International Classification of Diseases (ICD-10) however this language is considered offensive amongst clients and professionals alike in the UK and I will not be referring to this description in the review. I have chosen to use the term ‘intellectual disability’ based on the rationale given by Baum (2006b) who argues this can be used to create an international term understood by researchers and clinicians alike.

DECLARATION OF POSITION

Prior to my clinical training, I worked as an outreach support worker for adults with intellectual disability. I recall supporting one client in particular, whose case had recently been referred to me from another support provider. Following the sudden loss of the client’s support worker from the previous provider, I was assigned the task of supporting the client to move to temporary accommodation due to the financial abuse of one of their children. After a positive start to our relationship, the client became hostile and angry towards me. I struggled in a professional capacity to complete urgent practical tasks and on a personal level to understand how the client’s behaviour and attitude towards me had changed so abruptly. In hindsight, having taken into account the wider context and issues of loss and transition the client was experiencing, a systemic intervention could have been helpful. The emphasis this approach places on strengths and abilities of clients and staff teams has inspired me to learn more about the theory, practice and efficacy of the systemic approach for people with intellectual disability.
METHOD

I began by using the search terms ‘family therapy and intellectual disability’ in ISI Web of Knowledge, Psychinfo and the University library catalogue which yielded a sufficient number of articles. I sought out relevant articles from key texts and on several occasions, contacted the authors directly via email and telephone. My inclusion criteria comprised literature that focused specifically on adults with intellectual disability, systemic practices and family therapy in the NHS with no specific date criteria. Exclusion criteria included literature concerning children and adolescents with intellectual disability and certain systemic interventions such as parent-child training. These were excluded in order to narrow the scope of the review and focus on the main approaches used in clinical settings in the National Health Service (NHS) in the UK.

INTRODUCTION

The ‘systemic approach’ considers the feedback and interactional processes between two or more individuals in a ‘system’ from which patterns are generated creating the context for meanings of behaviours and events (Dallos & Draper, 2010). The strengths and abilities of systems are embraced whilst difficulties are investigated by using questions to create conversations (Haydon, 2008). The dominant models currently informing systemic practice include the social constructionist and post-social constructionist models which focus on beliefs, meanings of behaviours and the non-expert approach of the therapist (Ekdawi, Gibbons, Bennett & Hughes, 2000) and the narrative model which identifies stories that are constructed by people (White & Epston, 1990). Reflecting teams are a popular technique used in therapy under a social constructionist approach. Clinicians, either in pairs or teams, become members of the system rather than assuming expertise in it allowing them to observe and flexibly adopt different positions within the conversation (Andersen, 1987). Systemic practices for adults with intellectual disability mainly include varying family therapy approaches which have undergone a shift from structural to more narrative approaches (Dallos & Draper, 2010). A central component of systemic practice for people with intellectual disability is the involvement of support and care.
staff in ‘family’ therapy. Systemic practice has also been incorporated into consultation work with support and care staff teams and is therefore included in this review.

Family therapy approaches may be useful for people with intellectual disabilities when issues such as loss, bereavement, life-cycle transitions and sexual development are encountered (Vetere, 1993; Goldberg et al., 1995; Fidell, 2000). Family therapy services in Leeds (Halliday & Robbins, 2006) and Newham (Baum & Walden, 2006) have been developed for the purpose of treating unmet need for issues such as loss, parenthood and transition by existing services. This client group often have differing communication needs which means that they may rely on support from personal assistants and support staff in their daily lives and receive support from numerous agencies at any one time. Therefore issues of achieving meaningful engagement, working with staff teams in therapy, assessing current service provision and barriers to referral will be reviewed to assess how appropriate and relevant this approach is in clinical practice for people with intellectual disability.

The Royal College of Psychiatrists (2004) found that family therapy was provided in services for people with intellectual disability and was in demand from the professionals questioned. However, there have been few studies addressing treatment outcome with intellectual disability (Beail & Warden, 1996) and in a review of the effectiveness of psychotherapeutic interventions for people with intellectual disability, systemic therapy was not included (Willner, 2005). Stratton (2005) reported that family therapy approaches are effective, economical and sometimes cheaper than other interventions although intellectual disability was not referred to. This is reflected by the relatively recent introduction of the systemic approach for people with intellectual disability (Fidell, 2000) and the dominant service provision of family therapy for children (Halliday & Robbins, 2006).

Government policies (Department of Health, 1999) have stipulated that a minimum range of psychological therapies provided in mainstream services should include systemic therapy and that access to these services should be available for people with intellectual disability (Department of Health, 2001). Hence it is vital, with the present NHS focus to commission services based on evidence-based practice, to examine the efficacy of the systemic approach for people with intellectual disability in relation to
in relation to the use of outcome measures, evaluation of services and challenges to conducting quantitative research.

Clinical Applicability

Engagement

Fidell (1996) discussed adaptations that could be made to family therapy in order for it to be accessible and meaningful for people with intellectual disability. Haydon-Laurelat (2009a) emphasised that individuals with intellectual disability should be active participants in therapy and have an equal voice to others. Fidell (1996) commented that this could lead to other family members feeling alienated and to avoid families dropping out of treatment because of this, individual sessions should be offered initially. Baum and Walden (2006) highlighted that including the person with intellectual disability allows them to share their own account of the situation and the nonverbal behaviour of the system can be observed. In order to engage the client and enhance comprehension of therapy, Fidell (2000) recommended adaptations such as explaining to the client beforehand the nature and process of therapy; using live supervision behind a screen to check involvement of each member and utilising adaptations from child therapy such as role-play, models with dolls and drawings. Fidell (2000) reported limited use of genograms in order to avoid confusion although commented they are an empowering tool to demonstrate competence.

Halliday and Robbins (2006) adopted a reflecting team method which helped to externalise difficulties and bring new stories about relationships into the system based on the ideas of White and Epston (1990). Cardone and Hilton (2006) applied Andersen’s (1987) method of reflecting teams resulting in sharing a limited number of ideas at a time to avoid confusion. Halliday and Robbins (2006) found that clients from a case study favoured the reflective teams as there were more people to pay attention to them which is something the authors note may happen rarely in society. To achieve collaboration, the client was offered choices about the equipment, pace
and use of the reflecting team. Baum and Walden (2006) found that when using a reflecting team for non-English speaking clients, the use of an interpreter allowed the clients to hear their reflections twice which may have served to increase engagement. Cardone and Hilton (2006) illustrated in a case study that this advice helped to slow the pace of therapy by echoing the client’s language and waiting to understand the meaning behind it. Haydon-Laurelat and Nunkoosing (2010) revealed through the use of a case example, how appropriate humour helped to put the client at ease and speech and language therapists assisted with communicative inclusion. The use of case examples to illustrate effective engagement outlines how adaptations can be made in practice and much of this is focused on empowering the individual to be seen as an equal to rest of the system and engaged in the therapeutic process.

**Working with staff in family therapy**

Haydon-Laurelat, Bissmire and Hall (2009) included staff from residential accommodation services for people with intellectual disability as part of the wider system in systemic therapy. Haydon-Laurelat et al. (2009) indicated that by including staff in this way, people with intellectual disability can challenge the service provider’s values and philosophy which they often have little power over. Haydon-Laurelat (2008) described a case study whereby the client was asked about who they would prefer to participate in therapy and subsequently the residential service manager was chosen. A six-month follow-up indicated that the client felt listened to and the staff member’s presence in therapy had led to a service-level change. Similarly, Haydon-Laurelat and Nunkoosing (2010) referred to another case example whereby a letter was written to the client and copied to the staff member in therapy after the first session to emphasise that the client was in charge of and expert of their own care which has an empowering function. The example details two meetings and at a follow-up interview six months later it was found that the brief treatment led to a service level change where the individual felt listened to by staff. Information on outcome measures and evaluation was absent from the study although Haydon-Laurelat (2009a) claims that feedback in therapy can serve as an outcome measure.
Jenkins and Parry (2006) developed a structured approach influenced by systemic family therapy called ‘Network Training’. This approach brings together the client, their family and care team with the aim of improving communication and synthesise practice across service providers in the event of crisis, transitional difficulties or issues that are proving difficult to resolve. If the client chose not to be present the team considered issues of consent and ‘best interests’. Systemic techniques and narratives and a solution-focused approach was taken and strengths of the client and team members emphasised. The development of the approach was driven by clinical experience and the facilitator had experience of formulation and the systemic model. The authors described difficulties with evaluation and the financial cost of bringing the care team together for a whole day and a potential half day follow-up (Jenkins & Parry, 2006). It was found that outcomes such as participant’s expectations, changes in beliefs about the client and the impact on the support network were difficult to formally evaluate but the training events had received positive feedback and monitoring continued through care plans. Rikberg-Smyly (2006) further described this through a case example of a ‘network meeting’ in which the client did not attend. Issues were explored with the care team and family using a reflecting team and this helped to increase understanding between all parties, ultimately assisting the person with intellectual disability to take control of their life again. Rikberg-Smyly, Elsworth, Mann and Coates (2008) found from conducting telephone interviews with staff and carers following initial systemic consultation reviews that there was a positive response towards the use of reflecting teams. Overall, the majority of participants commented that the approach helped them to consider other’s viewpoints and broaden their perspective of the problem. This is in line with the theoretical aims of the approach such as considering alternative perspectives and accepting difference which demonstrates a strong link between theory and practice.

**Service provision and development**

Baum and Walden (2006), Halliday and Robbins (2006) and Cardone and Hilton (2006) have documented in detail the development of their services. Baum and Walden’s (2006) therapy team consisted of mainly white female clinical psychologists with differing levels of staff training resulting in an assortment of
systemic models used in clinical practice. Cardone and Hilton (2006) had difficulties deciding on which systemic model to choose with so little previous literature to guide them. This issue was reflected in a UK wide survey conducted by Kaur, Scior and Wilson (2009) to investigate what is offered of systemic practices in the NHS for people with intellectual disability and whether it is helpful. Fourteen services completed a self-report questionnaire comprising fifty five clinicians, most of whom were clinical psychologists. They found that a range of systemic models were employed and the most commonly reported was a ‘mixed approach’. The authors note that responses were only received from English services and this could have been because the survey was completed by one representative on behalf of the service who may have neglected or been unaware of systemic practices within their services. Other methods such as interviews, focus groups and an increase in criteria of systemic practices may have encouraged an improved response. Kaur et al. (2009) also found that while interpreters and cultural advisors were in use, just over a third of respondents had found that they had a negative effect on therapy. It is important to consider that increasing access for cultural groups, especially black and ethnic minority clients, is high on government agenda to increase social inclusion. Extended research, training and outreach work needs be done to explore these results further and adapt the use of interpreters and cultural advisors further.

**Referrals**

Referrals to community learning disability teams are commonly problem-saturated and the client is often unaware of the reasons for referral (Nunkoosing & Haydon, 2008). Wilcox and Whittington (2003) noted that this approach does not allow for solutions to be generated easily. Arshad (2006) undertook an audit of the Leeds Family Therapy Service (LFTS) to investigate why 11% of referrals of people with intellectual disability to the service in the 1990’s had since reduced further. A mixed methods design was employed with a focus group and postal survey to investigate the barriers preventing professionals from referring people with intellectual disability to the service. Thematic analysis found that professionals failed to refer to the service for reasons such as lack of knowledge; the client not living in a family setting; fearing the family would think they had been blamed; anxieties about engagement in
therapy and the view that long-term problems such as disability are difficult to shift. Feedback from the process included the possible creation of a drop-in service; increasing advertisement of the service; representatives of services to attend meetings with varying professional groups; introduction of a leaflet for referrers to educate and further training for professionals (Arshad, 2006). This clearly shows that trainee clinical psychologists, such as Arshad, are in a valuable position to undertake pieces of service-related research that other members of the team may struggle to prioritise alongside clinical responsibilities. Arshad (2006) observed the large size and power imbalance present in the focus group which may have prevented participation. The outcome of this project demonstrates the need for further training and education of staff; Halliday and Robbins (2006) seem to have addressed this by encouraging the clinicians of the family therapy service also employed in secondary services to advertise and raise the profile of their service amongst secondary care teams.

**Efficacy**

*Evaluation and outcome measures*

Baum and Walden (2006) attempted to evaluate the effectiveness of their service in Newham and suggested that although it would be preferred to assess symptom improvement and change in attitudes of families, the latter is difficult to measure. In addition to symptom improvement, they measured achievement of therapy goals, changes in relationships and communication and the views of therapists and clients (Baum, 2006a). Data was collected in the first and last therapy session via interview from the client, therapist and reflecting team. The tool was shown to possess face validity and inter-rater reliability for pre and post treatment respectively (Baum, 2006a). Six of the nine families evaluated completed therapy; achieved their goals and some reported symptom reduction. No reasons were given for the drop out of three families and it would have been useful for this to have been followed up. At the time of publication, Baum and Walden (2006) had begun piloting the Beavers Interactional Scales (Beavers & Hampson, 2000) as an outcome tool and they were
keen to develop their own measure of self-report. Fidell (2000) cautioned when developing self-report tools to be aware of the tendency of some people with intellectual disability to comply with or contribute information despite a lack of understanding of the measure.

Arkless (as cited in Baum & Walden, 2006) questioned ten families in the Newham service and gained verbal feedback about their experiences of systemic therapy thus demonstrating testimonial validity. Clients appreciated the opportunity to talk about their difficulties yet felt the extent they had been listened to by others in the system varied and family responses ranged from useful to unfavourable. In the LFTS, Halliday and Robbins (2006) reported a change in the language used by the client’s support staff which the authors regarded as an appreciation and understanding of the client’s problem thus representing a major outcome of therapy. The clients reported that they would recommend therapy to others and behavioural changes, such as achievement of goals, used by Baum and Walden (2006) would have been appropriate as an outcome measure due to the positive adjustments that the clients made to their lifestyles following therapy. Baum and Walden (2006) suggested that future evaluation of their service could involve utilising video-cameras in therapy rooms and examining individual sessions rather than pre and post treatment measures. Wilcox and Whittington (2003) advocated measuring the extent to which the thickness of descriptions develops during narrative therapy, assessing people’s beliefs and recording witnessed events of alternative stories generated from therapy. Dallos and Draper (2010) commented that different families will have differing desired outcomes from therapy and the authors agree that varying types of media could be used to transmit evidence.

**Barriers to quantitative research**

Kaur et al. (2009) found that all services in their survey of systemic practice across the UK rated the important of an evidence-based practice yet few had published outcomes of treatment. Lack of staff training; clarity as to which outcome to measure within the system or staff team; skills within the team to carry out high quality research and small sample sizes were reported to have contributed to this. Kaur et al.
(2009) also found that there was pressure from NHS trusts to produce quantitative data for outcomes. Randomly controlled trials (RCT’s) are the favoured method of producing quantitative data (Barker, Pistrang & Elliot, 2002) and the Royal College of Psychiatrists (2004) stated that using RCT’s can be difficult with intellectual disability due to the requirements that only one psychological problem and no other co-morbid problems are present. In addition to this, age and the degree of intellectual impairment need to be controlled for in order to randomly allocate participants to homogenous groups. In effect, this means that a very small proportion of the population of people with intellectual disability would qualify for such trials resulting in difficulties with recruitment of participants and small sample sizes. Questions concerning how ethical it may be to allocate participants to a group where they may not receive treatment are also raised as part of any RCT (Dallos & Draper, 2010). Gaining informed consent, explaining random allocation, working with the family and the unfamiliarity of the research process are some of the challenges faced when conducting RCT’s (Oliver et al., 2002). Lynggaard and Baum (2006) argue that quantitative research generated by RCT’s may fail to take into account personal and cultural factors which might mean that important outcomes are missed. This is echoed by Speedy (2004) who maintained that the richness of personal experience is lost in the ‘one-size-fits-all’ approach of RCT’s and advises that archives of therapy outcomes be built over time to produce a wealth of practice-based evidence with clients as co-researchers. Similarly, Dallos and Draper (2010) claimed that the accumulation of case studies over time has shaped systemic practice and allowed for generalizable conclusions to be drawn to inform theory and practice. They cite the relevance of participant observation as part of case studies to identify patterns and meanings in conversations during therapy and the advantage of having multiple perspectives from reflecting teams in order to generate inter-rater reliability.

**IMPLICATIONS FOR CLINICAL PSYCHOLOGY**

Haydon-Laurelat and Nunkoosing (2010) described the social model of disability where society is seen as disenabling the individual. They propose that clinical psychologists could be feeding into the individual model of disability which focuses on the individual as the ‘problem’ to be ‘fixed’. Considering that clinical
psychologists are the main practitioners of systemic work in the UK for people with intellectual disability (Kaur et al., 2009) they may want to be mindful of the social, political and relational barriers such individuals face (Haydon-Laurelat & Nunkoosing, 2010) in addition to their own personal views of disability. Indeed, Halliday and Robbins (2006) emphasised that systemic practice had helped their therapy team to look beyond the ‘label’ of disability.

Conducting research is a core skill in clinical psychology practice and defines the profession. Therefore the feedback in Kaur et al.’s (2009) survey stating that lack of high quality research skills in teams was preventing evaluation of services is surprising given that most of the respondents from the survey were clinical psychologists. The consequences of failing to provide a scientific evidence-base for treatments could result in the loss of funding for services (Oliver et al., 2002). However, the efforts to evaluate and inform practice outlined in this review have been reported by clinical psychologists and they continue to further theory and practice through motivation and commitment.

SUMMARY

Fidell’s (1996, 2000) suggestions for adapting family therapy approaches to effectively engage people with intellectual disability have been drawn upon in other practices (e.g. Baum and Walden, 2006). This highlights how relevant and detailed case studies can influence clinical practice. Achieving equality and empowerment for individuals with intellectual disability has been a theme raised in several accounts (e.g. Fidell, 2000; Cardone and Hilton, 2006; Haydon-Laurelat & Nunkoosing, 2010). Halliday and Robbins (2006) also connected with service user and carer groups in Leeds to inform and educate about the systemic approach which further promotes choice and inclusion. It is encouraging to see how therapy can begin to break down social and communicative barriers that people with intellectual disability face throughout their lives. The involvement of staff from the client’s care team in therapy has been shown to be beneficial for the clients who are offered the opportunity to have their story heard in a different context (e.g. Haydon-Laurelat &
Verbal feedback from such staff members has highlighted how therapy and consultation has been useful to them and led to changes in accommodation services that will potentially benefit other clients who use those services. Therefore systemic practice has a wider benefit than just for those in therapy.

Jenkins and Parry (2006) developed consultation and network events with the aim of resolving issues that may be long-standing and difficult to shift. Clearly, engaging with the wider system and using systemic thinking can benefit the person with intellectual disability even if they choose not to be present. Cardone and Hilton (2006) refer to a scarcity of literature and resources to guide the development of their service which reflects the youth of the approach. Communication between services and sharing of best practice may assist other services in the early stages of development. Different levels of staff training and experience with systemic practice can be an asset when considering which systemic model to choose and as experience develops in the service different roles can be undertaken. Kaur et al. (2009) offered the first attempt to illuminate systemic practice in the UK and there is more work to be done to reach the services that did not respond or were not contacted. Referral rates to services could be improved through education and training for professionals referring to services (Arshad, 2006). The literature clearly shows that family therapy and consultation approaches underpinned by systemic practice are applicable for people with intellectual disability in clinical practice although there are many avenues for further development and innovation.

Lynggaard and Baum (2006) stated that there are different ways to assess the efficacy of an approach. Much of the literature in the field of contains descriptive case studies and evaluation. Case studies can demonstrate ecological and face validity but potentially lack reliability (Barker et al., 2002). Dallos and Draper (2010) contend that case studies inspire clinicians, offer insight into an approach and guide clinical practice. They have commented that evaluation on its own only provides information to commissioners of services and may fail to inform clinical practice. The policy, ‘Best Research for Best Health’ (Department of Health, 2006), stated that the NHS needs to encourage research excellence to inform clinical practice. Evidence-based practice is a priority of many commissioners of services to establish
cost-effectiveness of care (Barker et al., 2002) and this aspect of systemic work is mentioned little amongst the literature apart from Jenkins and Parry (1996) who question the cost-effectiveness of their ‘network events’ once all of the professionals have been gathered together. Dallos and Draper (2010) noted that family therapy can sometimes be costly due to the equipment and number of staff involved in therapy. Further research, evaluation of services and establishment of an evidence-base may help to provide further information on cost-effectiveness.

**FUTURE DIRECTIONS**

Considering the difficulties with conducting RCT’s, there are suggestions as to which outcomes might be measured in therapy and developments of outcome tools and pilots are underway (Baum, 2006a). Further investigation into current service provision may highlight other tools and evaluation procedures currently in use. The attempts cited in this review to evaluate services and monitor outcomes have begun to determine the efficacy of systemic practice for people with intellectual disability. Overwhelmingly, the cases outlined in the literature highlight the benefits of a systemic approach for a client group who may not be considered in different contexts or given an equal voice by their families or support and care staff.

Conducting this review has been an informative and inspiring experience and I have admired the dedication of practitioners. Baum and Walden (2006) urge other professionals with an interest in systemic work to collaborate with other professionals. Kaur et al. (2009) reflect that services may be under-funded preventing clinical developments and initiatives. The current post-modernist research paradigm calls for evidence-based practice to inform commissioners funding services. Ideas could be formed of how to evidence in other ways and above all motivation and enthusiasm from researchers is needed (Oliver et al., 2002). Self-report and questionnaire formats have been typically used to research in family therapy (Dallos & Draper, 2010) and the development of appropriate outcome tools for people with intellectual disability is in the early stages. An outcome tool (SCORE-40) and a briefer version (SCORE-15) have recently been developed to reflect current practice consistent with social constructionist ideas and assist with research (Stratton, Bland,
Janes & Lask, 2010). It is an exciting development aimed to demonstrate the efficacy of family therapy and the SCORE-15 allows the clinician to gather data in a format easily understood by all. Further research needs to be conducted in order to assess whether this tool could be adapted for people with intellectual disability. It seems that using systematic methodology to generate data is a goal to strive for in order to generate enough practice-based evidence to form a solid evidence base. Indeed, quantitative research may be possible once sufficient qualitative measurement is achieved (Barker et al., 2002). Nevertheless, steps have been taken by practitioners in the field to generalise their results from case studies to theory and clinical practice. The gap between practice-based evidence and evidence-based practice needs to be bridged in order to effectively establish the efficacy of the systemic approach for people with intellectual disability. Laying the foundations to secure a future for systemic practices for people with intellectual disability in the NHS has begun and I hope one day to add my own contributions.
REFERENCES


PROBLEM-BASED LEARNING REFLECTIVE ACCOUNT I:

Relationship to change

March, 2011

Year 1
INTRODUCTION

In the following account I will discuss my involvement in the group task of presenting on the subject topic 'relationship to change'. The group consisted of six females, including myself and the group facilitator, and one male. Having recently started the course, we had exchanged the basic details of our lives and friendships were forming between us. Whilst considering the outcome of the task and the process that led us there I reflected on what I had learnt. This included my personal response to the task; the development of the group and group processes; the role I took within the group and the outcome of the task. I reflected about how this experience had affected my clinical practice and professional role as a trainee clinical psychologist working within a multi-disciplinary setting.

PERSONAL RESPONSE

As a group, we began by broadly discussing our initial ideas concerning the subject topic ‘relationship to change’. I thought about the changes that have occurred in my life and my thoughts instantly turned to my family. Having experienced multiple changes in my family such as divorce, serious illness and the separation of the family I felt drawn towards thinking of the difficult times where I had experienced negative emotions. I began to wonder about my role in the family as it had undergone multiple changes, especially recently, and I considered my response. I was not comfortable at the time to speak in detail about these changes to the group as I was unsure of how they would be received and whether I would be able to contain my emotional response. I therefore protected myself and spoke in general terms about family change in relation to systems theory and processes within the family (Dallos & Draper, 2010). This experience helped me to realise that I was confused about my role in the family as it has undergone changes and I felt uncertain of how to manage and balance the current pressures of my family and the clinical psychology training course. This, coupled with a curiosity of being the client in therapy, led me to seek
counselling in order to explore this situation which is pertinent to my own relationships to change. Having received a few sessions to date, I have had the opportunity to explore issues of shame and responsibility in my own family and reflect on how it might impact on other family systems and individuals. Therefore this exploration will further my clinical practice and allow me to empathise from a position of experience with individuals or families experiencing similar issues. I would however be careful to appreciate their experience as unique and different from my own and consider diversity issues such as culture, age and sexuality.

GROUP DEVELOPMENT AND PROCESS

Firstly, we explored positive and negative changes that we had each experienced. The shock of change, different factors affecting change and how it may affect others in the systems surrounding an individual all arose from these discussions which seemed relevant to our work as trainee clinical psychologists. I reflected how this might impact on engagement in therapy with clients when they may be undergoing changes in their lives which could occupy a lot of their energy and emotional resources. I have recently worked with a client with complex mental health difficulties on placement who has been experiencing family crisis and I have considered their relationship to the changes they have been experiencing. Setting realistic and achievable goals in therapy has been important to instil hope (Padesky & Greenberger, 1995) and being flexible with the agenda during our sessions has assisted with monitoring their levels of distress and risk.

As a group, we then set ourselves a homework task to make a change for a week and reflect on our relationship to that change. I chose to try and meditate daily, something which we may encourage our clients to do as part of group-based mindfulness cognitive therapy for depression (Segal, Teasdale & Williams, 2002), but failed as I realised I lacked motivation and had other priorities to attend to. I learnt that when setting homework and goals for clients, a trusting and open working alliance is needed in order to assess their motivation to change. Some of the barriers highlighted in one of the models researched by one of the group members included
the perceived need to change and suggested completing a cost-benefit analysis of the proposed changes (Burrowes & Needs, 2009). Another model, called the transtheoretical model of change, considered that motivation to change is a dynamic process that can change over time (Prochaska & DiClemente, 1984). Being mindful of these concepts will help me to assess motivation for change in clients entering therapy and be aware that their motivation may fluctuate during this process.

We proceeded onto structuring the presentation and deciding on the content. An initial structure was set for the presentation, based on theories and ideas we had each researched and we agreed to individually present these as part of the presentation. Each group member had different visions for the format and content of the presentation and when it came to synthesising these ideas there was clearly tension and conflict in the group. Whilst some of us were focusing on theories and links to practice, others were more concerned with the personal aspect of their relationship to change. I have since taken into consideration that we began the task a week behind our colleagues and also met after a full day of lectures as opposed to other groups who started in the mornings. This might have resulted in a shared feeling of anxiety to catch up with the other groups and time pressure to complete the presentation before the deadline. Had I thought more about this at the time and shared it with the group, perhaps this might have helped to ease some of the pressure and tension within the group.

It seemed that as a group, we were highly sensitive to offending each other and individually, being held responsible for making a decision that wasn’t favoured by all of the group members. This seems to relate to the group development theory of forming, storming, norming and performing (Tuckman, 1965). The storming stage seemed relevant to the group at this point and we were each trying to express our independence and mould the group to our own ideas. Some of us in the group, including myself, were focused on what was expected from the marker’s perspective which restricted our creativity and personal exploration of our relationship to change. Being creative will be important to working in developing services and generating innovations and initiatives with limited funding and resources. However, we did share the purpose of generating a ‘take-home message’ for the audience by thinking about how the task and subject was relevant to our clinical practice and by
incorporating a case study to run as a theme through the presentation. This helped to ease the tension and form cohesion to focus on our journey to the completion of the presentation. In hindsight, I am disappointed at how anxious I felt about what was expected by the markers, which was probably due to wanting to prove my competence at the beginning of the course. From this experience, I am endeavou ring to reflect in action during my clinical practice to respond to the needs of the clients (Lavender, 2003) and when working in professional teams or academic groups. I believe this process will be useful when working in teams or groups because it will help me to consider the perspectives of others and the processes that take place in meetings and supervision. This is especially pertinent in my current placement, across several locations, as service re-designs are taking place and I am aware of being sensitive to staff and clients in order to provide support whilst they are undergoing swift and dramatic changes in services and staffing levels.

It was suggested by another group member that my initial personal research into systems theory didn’t seem to link in with the rest of the content and theoretical ideas. I accepted this as I wanted to ease some of the tension in the group and agreed that it may seem too large a topic to condense into four minutes of the presentation. This reflected my role as a ‘peace-keeper’ which I am aware I take on in my family and sometimes in work and social settings in order to avoid conflict and often to attempt to move processes forward. I realise that conflict is necessary sometimes in order to develop in relationships and a healthy way of expressing feeling and opinions. I will be aware of how this role might impact on my leadership style and role within professional teams and academic groups.

Following feedback from the other group member, I instead chose to present on the role of clinical psychologists as consultants to staff teams undergoing change. This had recently been presented at an academic psychology meeting I had attended on placement and caught my interest. This meant that my section of the presentation did not have a personal aspect to it and I should have noticed that this might seem incongruent with the other member’s sections that included both a theoretical and personal perspective. The facilitator commented on this which was useful and emphasised to me the value of having an observer of the group process. The group moved forward at this point and we worked separately on each piece of the
presentation. However we failed to contemplate the consequences of having different sections developed by individual members as the result seemed disjointed.

Conversations were occurring outside of the group sessions concerning the tension and frustration we felt due to the difference of ideas and opinions concerning the content and purpose of the presentation. We overcame this together by agreeing as a group to bring concerns to the group where they could be discussed openly. Therefore we were addressing problems as we encountered them and problem-solving to achieve our end goal which was a useful experience to take into working in a multi-disciplinary setting where differences of opinion have often been present in my current placement.

**OUTCOME OF THE TASK**

The feedback we received as a group praised us for incorporating a diverse range of theories and including individual contributions to the presentation. However, the criticism stated that we failed to reflect on the group process and the individual parts of the presentation did not link well together and seemed ‘disparate’. I agreed with the feedback and felt that I should have voiced my concerns over the rigid delivery of the content. For example, I have been taught and advised on several occasions to refrain from reading from scripts whilst presenting and yet I did not raise this as an issue when we were practicing. I did not want to pressure the group further due to the time constraints we were under and I was trying to be sensitive to other member’s preferences. In the future I will try to assert my experience and skills in order to enhance performance but do so in a sensitive way taking into account others strengths and experiences.
MY ROLE WITHIN THE GROUP

At the outset of the task, I considered my role in past groups. I have tended to take on a leadership position and was aware that others in the group might naturally be drawn towards this role too. We tried to work as a group without a leader by incorporating each member’s views however in reality this posed problems with decision-making. Therefore the leadership role shifted between different group members which most likely echoed the lack of congruence in the presentation itself. The only male member of the group commented about his struggle with wanting to assume the leadership role but not dominate the group and I thought about how he may have felt as the only male in the group. In my experience in both academic and clinical settings, women have outnumbered men, which might have implications for how men feel accepted in the profession and relate interpersonally with female colleagues. As mentioned earlier, I felt that I tended to take a ‘peace-keeper’ role at the time by agreeing with our male colleague to ease tensions when his views were contrasting to the rest of the group to ensure that he felt his views were being listened to. Being able to balance the ‘leader’ and ‘peace-keeper’ role will take practice and I think I will need to be confident in my decisions in order to gain respect and trust.

CONCLUSION

Having completed the task and received the feedback, we reflected on the task as a group and the majority, including myself, commented that it had been a frustrating process. We spoke about the lack of a group leader and were still undecided as to whether this would be helpful for the future given the abstract purpose of the group. We discussed our achievements and how we had formed as a group and developed through conflict and that doing this allowed us to appreciate the strengths of the group and form cohesion instilling us with confidence for future tasks and discussions. I chose to present on clinical psychologists in a consultancy role because I have experienced the difficulties that staff teams face and the confusion and apathy
about how to resolve situations that seem impossible to solve. In the wider context of the NHS, with many financial savings and service re-designs, it will be vital to adapt to change swiftly and manage teams successfully with limited resources whilst leading in a way that inspires them to change and work effectively together.
REFERENCES


PROBLEM BASED LEARNING REFLECTIVE ACCOUNT II:

‘Child protection, domestic violence, parenting, learning disabilities and kinship care’

February 2012

Year 2
INTRODUCTION

In the following account I will discuss and reflect on my personal and professional learning and development group’s (PPDLG) involvement in the problem-based learning (PBL) task entitled, ‘Child protection, domestic violence, parenting, learning disabilities and kinship care’. The group comprised five females and one male. Although the PPDLG facilitator was not involved in the PBL task they assisted the group during one of our PDLG sessions to reflect on our past and current experiences of completing PBL tasks. The current PBL task took place in the context of the second year of clinical training and the group had been formed for over one year. The task was focused on the Stride family and we were asked as clinical psychologists to assess whose problem we considered the complex child protection issues to be and why. We were required to pay attention to a number of issues such as parents with learning disabilities, domestic abuse, emotional neglect, ‘good enough’ parenting, risk assessment and professional systemic issues. In this account I will focus on how the task was approached by the group, the decision making and creativity involved, the feedback that was received, our reflections of the task and my role within the group.

APPROACHING THE PBL TASK

The task was introduced to the group during the first term of the second year of clinical training. We had a few weeks to prepare for the task which involved presenting our response to the complex child protection problem to the rest of the cohort and a few members of the course team who would be evaluating us. We began the task by deciding on our work ethic and shared goals as a group. We had a few other on-going university commitments to attend to at that time and decided to limit the amount of time we spent on the task in order to manage our time effectively. This was in great contrast to the previous PBL task that we had completed one year previously where we were highly anxious and in hindsight, spent too much time preparing which only served to increase our anxieties further. We reflected on this
difference after having completed the second PBL task. We seemed to agree that having developed friendships with one another over the past year, realising that we were not competing with each other and considering the amount of work that realistically had to be done in order to complete the task meant that we were less anxious and more task-focused. I believe that this demonstrated the groups movement through the ‘forming’, ‘storming’ and ‘norming’ stages of Tuckman’s (1965) theory of group development to the current ‘performing’ stage.

As a group we decided to divide certain aspects of the task that we had been asked to think about between different group members according to our individual areas of interest. I researched into issues related to parents with learning disabilities as I had previously worked as an outreach support worker for people with learning disabilities which included some people who were parents. I thought about the people that I had supported especially one who had been financially and emotionally abused by their adult child. I reflected on how I had experienced strong emotions in relation to this case as I believe the client had projected strong feelings of anger onto me. I contemplated how failures of support and health services to meet this client’s needs might be reflective of Mr and Mrs Stride’s situation. Mental health professionals might also feel anger, sadness and complex emotions when systemic failures leave them in a powerless position to meet individual and community needs.

I read documents such as the ‘Government best practice guide for parents with learning disabilities’ (Department of Health, 2007), found guidance relating to how parent with learning disabilities could be supported effectively (Department of Health, 2006) and read around child protection issues (Booth, 2000). I shared my ideas with the group and we discussed the contributions that each member had brought in relation to their researched area. This was a helpful way to begin the task as it meant that we were learning in relation to our individual interests whilst considering our other priorities in relation to clinical training and managing out time effectively.
DECISION MAKING AND CREATIVITY

Following on from our research we spent the next couple of meetings deciding on what to include in the presentation and considering its format. I was pleased that we spent time considering and focusing on exactly what we would include in the presentation and how it would link together as we failed to do this in our previous PBL task. We had tried to include too many ideas in the previous PBL task and as a result, the presentation failed to link together and lacked creativity. This time we had agreed to try and be creative and push ourselves as individuals and a group. For example, in the previous task we had not wanted to use role-play due to our uncertainties of what was required of us and I was nervous about performing in front of my peers. Keeping this in mind, we were keen to use role-play for this task and I wanted to challenge myself and be more creative. I felt that as a group we were able to sacrifice some of our individual ideas and sections of research in order to meet the shared goal of producing a clear, coherent and considered presentation.

I noticed that at this point that it mattered less as to who was the designated ‘leader’. We struggled with last year whilst the group was forming and storming (Tuckman, 1965) and we were now making decisions with the group’s best interests at the forefront of our minds. My experience of multi-disciplinary teams (MDT) on my adult and child mental health placements thus far has shown me that it is not always easy to have a shared goal and make decisions in this way. I have been exploring this in supervision recently with my Clinical supervisor and perhaps one reason for this might be that each profession in an MDT possesses its own history of how it has come to be in the team and insecurities and anxieties about the future of its role there.

We had decided to use role-play as the media for our presentation and allocated different roles to each group member according to their preference. Each role represented some of the research on specific areas that we had conducted. Crucially, we had to make a decision about which areas to cover and I reflected that it was probably at this point that I helped to move the group forward by asserting that covering a few topics in greater detail as opposed to all of them in little detail would result in a richer and coherent presentation. I opted to play Mrs Stride in the role-play
and I knew this would be a challenge as I wanted to ensure that I portrayed her in a sensitive and sincere way. We wanted to make the presentation interesting for the audience to watch as we were aware that they would be sitting through six presentations of the same task. We therefore decided to use a well-known format from a TV programme to attempt to keep the audience’s attention and display our creativity.

Nearer to the time of presenting we were only able to rehearse the presentation as a whole group once. This again was in great contrast to the previous PBL task where we had rehearsed several times with lots of cue cards and notes to prompt us. I believe that we were less anxious in our recent task which meant that we were more confident of our abilities to complete the task and more supportive of each other. We had decided to use PowerPoint to include references and key ideas although I had considered that this might not be necessary and that it might be reflective of our anxieties to conform to the scientist-practitioner model. I had previously mentioned to the group that we could use this PBL task as an opportunity to explore the reflective-practitioner model further as I believe that we do not have much opportunity to do this on placement and in some university assignments. I felt that my voice had been unheard as the group eventually decided to use PowerPoint although when we delivered the presentation we were unable to use it due to technical difficulties. We did not receive any negative feedback from our assessors in relation to this. In future I will try to assert myself more and voice my ideas in a considered way. I think that I may have failed to do this on this occasion in the current PBL task due to fear of generating conflict in the group. I think that in some MDT meetings on placement my voice is sometimes absent from general case discussion. I hope to become more confident and offer my professional opinion and clinical judgement to MDT case discussion as I develop in my clinical training.

FEEDBACK

We delivered the presentation and received positive feedback from our assessors. Interestingly, some of the feedback noted that our use of a TV programme approach
Volume I: Academic Dossier

could have been to trivialising or exploiting the Stride’s difficulties. However, the assessors commented that they thought we had used this approach sensitively. We had not considered that this approach might be viewed in this way and this could be seen as a weakness of the group. In future, I will endeavour to encourage the group to consider how the presentation of our ideas may be perceived from different perspectives.

Having completed the task, we were able to spend one of our PPDLG sessions reflecting on how we had experienced the task. We spoke about how Mr Stride’s voice had been lost and no-one in the group had wanted to play the abuser. This coupled with a comment from our facilitator that we had also lost the child’s voice in the presentation caused us to consider how and why these voices might be unheard in clinical practice. We were able to reflect on each group member’s strengths and we questioned who, in the context of child protection issues, might focus on Mr and Mrs Stride’s strengths. We reflected on the fact that none of the PPDLG groups including ourselves had made a final decision about whether the children should be removed from the parents. I believe that in clinical practice this would be a highly stressful and emotional decision and perhaps we were protecting ourselves by avoiding it during the task. We discussed our anxieties about having to make clinical judgements with regards to ‘good enough’ parenting and child protection issues when some of the guidance is unclear and our own experiences are limited.

We considered that by role-playing other professions who we portrayed as very psychologically-minded we might have represented an ‘ideal’ view of how the Stride family’s difficulties could be overcome. We discussed our frustrations with working with other professionals and how difficulties in MDT working may affect quality of care for our clients. This highlighted some of the professional systemic issues that might present barriers for clients such as the Stride family and prevent them from receiving the correct support from services. I am currently on my child and adolescent mental health placement and have seen the level of anxiety that child protection issues raise for all professionals involved and how this then manifests in the dynamics of the MDT.
MY ROLE WITHIN THE GROUP

I felt that I had attempted to take a step back and position myself differently in relation to this task. This was due to an increased awareness of some of the high standards that I set myself in relation to my academic performance and also in other areas of my personal life. I felt uncomfortable and slightly guilty at times when I knew that I could be contributing more to the task and felt that I might have been contributing less than other members. This was an uncomfortable position for me to be in. I tried to balance these thoughts with the knowledge that as a group we had each put a limit on the amount we were contributing to the task and that spending more time focusing on the reflective-practitioner model would be beneficial for our presentation and further our creativity. I was pleased with the outcome of the task and I have learnt that in some tasks, I might adopt different roles (Belbin, 1993). Indeed, as a clinical psychologist I will be involved in many tasks requiring different skills, knowledge and levels of input. Working in the NHS means that time is often limited and it might be worthwhile for me to learn to be content with meeting ‘good enough’ standards when required. After all, if I cannot accept this in myself, how will I be able to accept and model this successfully for my clients?

CONCLUSION

My own experiences of working with people with learning disabilities and completing this task has emphasised the importance of person-centred, accessible and supportive services for people with learning disabilities. I feel that at this stage in my clinical training I am becoming more politically aware and developing an interest in how wider community and governmental systems influence people’s lives. Elements of this have been pertinent to the Stride family’s difficulties and I wondered how services and government policy might have been serving to perpetuate Mr and Mrs Stride’s difficulties rather than alleviate them. In hindsight, I would have enjoyed discussing this in more depth in relation to this PBL task and I
will endeavour to introduce this into future discussions and PBL tasks if appropriate. I have learnt from this task that as a group we can push the boundaries of our creativity and attempt to maintain a work-life balance by prioritising the tasks that we are required to complete for clinical training and thus managing our time effectively. There seemed to be much less conflict in the group during this task in comparison to the previous PBL task which I think is reflective of our effective development as a cohesive group.
REFERENCES


PERSONAL AND PROFESSIONAL LEARNING
DISCUSSION GROUP PROCESS ACCOUNT
SUMMARY: YEAR 1

September 2011
PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP
PROCESS ACCOUNT SUMMARY: YEAR 1

In this account, I considered my experience of the Personal and Professional Learning Discussion Group (PPLDG) during the first year of my clinical training as a Trainee Clinical Psychologist. The group consisted of five other Trainee Clinical Psychologists and a facilitator who was a member of the course team. I reflected upon the group’s process of ‘forming, norming, storming and performing’ according to Tuckman’s (1965) model of group development. The activities that we were required to complete as a group included a problem-based learning task, developing and sharing our ‘cultural genograms’ and recording a group discussion. Despite missing the final activity of the year, I considered my own role and contributions within the group alongside the role and contributions of other group members and how they may have changed over the course of the year. Other events during the year which included the National Health Service (NHS) re-design of community mental health services impacted on individual group members and this was discussed and reflected on towards the latter part of the year. My personal response, relationships with other group members and what I feel I had learned from the PPLDG were explored. All of the above was considered in relation to the development of my clinical practice and participating as a member of a multi-disciplinary team in an NHS context.

REFERENCE:

PERSONAL AND PROFESSIONAL LEARNING
DISCUSSION GROUP PROCESS ACCOUNT
SUMMARY: YEAR 2

July 2012
PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP
PROCESS ACCOUNT SUMMARY: YEAR 2

In this account I have attempted to explore and reflect on my experience of the Personal and Professional Learning Discussion Group (PPLDG) during the second year of my Clinical Psychology training. I have been mindful of my clinical practice in the National Health Service, the group’s development and my personal development as a Trainee Clinical Psychologist throughout the account. My PPLDG comprised five females, one male and a female facilitator. I reflected on the PPLDG’s return to the second year of clinical training and the addition of a new facilitator. As the year progressed, the PPLDG completed a Problem-Based Learning (PBL) task and we reflected as a group that we thought we had dealt with the task in a more efficient and confident manner than the previous PBL task in the first year of clinical training. Shortly after this, one of the PPLDG members became ill and was unable to complete the rest of the academic year. As a group, we discussed and reflected on the loss of the PPLDG member. Meanwhile, I had gained experience of planning and facilitating a group on my Child and Adolescent clinical placement which broadened my knowledge of theories of group development and process. Towards the end of the academic year, we discussed the issue of personal disclosure within the PPLDG and reflected on the group process and development over the course of the year.
CLINICAL DOSSIER

This section aims to provide an overview of my experiences in each clinical placement that I have completed over the course of the clinical psychology doctorate training programme. A brief description of each clinical placement is described including the nature of the clinical work undertaken.

Complete case reports and a more detailed account of my placement experiences are included in Volume II of this portfolio. All case material has been anonymised to preserve the identity of the clients, families and services. Full written consent was obtained from each client to include anonymised summaries of our work in this portfolio and this was checked by each of my clinical supervisors.
SUMMARY OF CLINICAL EXPERIENCE ON PLACEMENTS

November 2010 – Present

Years 1, 2 & 3
OVERVIEW OF CLINICAL EXPERIENCE ON PLACEMENTS

During my clinical training I have worked with a diverse range of client groups including working-age adults, children and young people, people with learning disabilities, older adults and children and people experiencing a first episode of psychosis. Clients have varied according to ethnic origin, age, gender, presenting difficulties and socioeconomic backgrounds. The following experiences outlined in this account will emphasise the aspects of each placement which have contributed to my personal and professional development as a Trainee Clinical Psychologist.

Adult Mental Health (AMH) Placement

Community Mental Health Team: October 2010 - September 2011

During this placement I worked with a total of 14 clients with a range of severe, enduring and complex presenting difficulties. At the beginning of the placement I learnt to conduct a thorough psychological assessment in a collaborative manner with the client. I explored different methods of working integratively with a variety of therapeutic interventions stemming from models such as cognitive-behavioural therapy, schema therapy, dialectic behaviour therapy and compassion-focused therapy. I received specialist supervision for working with two clients with a diagnosis of Obsessive Compulsive Disorder and for completing two neuropsychological cognitive assessments. I completed a service-related research project investigating staff views and experiences of the involvement of people who use services. I delivered a presentation to a carers group on the Improving Access to Psychological Therapies services and Cognitive-Behavioural Therapy. Due to the re-organisation of community mental health teams, I observed the restructuring of the service which included the redundancy of my Clinical supervisor. This placement taught me a great deal about managing multi-disciplinary team dynamics, the importance of flexibility and my own resilience in the context of this.
Children and Young Peoples (CYP) Placement

Child and Adolescent Mental Health Service (CAMHS): October 2011 - March 2012

During my CAMHS placement I worked with 16 clients and their parents and families either alone or in a joint capacity with other professionals such as Occupational Therapists and Social Workers. The clients ranged from the ages of six to eighteen and presented with a variety of moderate to severe difficulties. I incorporated systemic, behavioural and CBT approaches into my clinical work and discussed this and psychodynamic concepts in supervision. I participated in the Family Therapy clinic and Family Therapy supervision on a fortnightly basis. I planned and facilitated a six-week group of two-hourly sessions for six young people ages between 12 and 18 based on CBT for OCD. I supervised an Assistant Psychologist who co-facilitated the group and separately, undertook a school observation to inform my own clinical work. I delivered a presentation of a clinical case to the MDT and conducted a teaching session for the MDT based on feedback from the OCD group and the group process. I built service links with the Hospital Play Specialist and regularly attended MDT meetings.

People with Learning Disabilities (PLD) Placement

Community Team for People with Learning Disabilities (CTPLD): April 2012 - September 2012

The PLD placement involved working with 11 clients, their families and staff teams in a diverse range of setting such as client’s homes and day centres. The client’s learning disabilities varied from moderate to severe and profound. I received individual specialist Cognitive Analytic Therapy supervision and attended a weekly two-hour CAT supervision group. I used CAT with two clients and applied systemic, behavioural and CBT approaches to the rest of my clinical work. I worked jointly with a Challenging Behaviour Specialist and completed a functional behavioural analysis. I conducted four cognitive assessments, three of which were for dementia. I planned and delivered a teaching session to a staff team at a day centre on working with people with learning disabilities and dementia.
Older Adults (OA) Placement

Memory Assessment Service (MAS): November 2012 - September 2013

I worked with eight clients ranging from the age ranges of 50’s through to 80’s presenting with memory difficulties. I received specialist neuropsychological supervision from one Clinical supervisor and received supervision from another Clinical supervisor in relation to psychosocial interventions. I completed eight neuropsychological assessments which included an initial interview, neuropsychological testing and feedback. I also worked with my Clinical supervisor to complete joint assessments when required. I was involved in certain service development issues such as the establishment of referral routes into neuropsychology, generation of a neuropsychology leaflet for patients and discussion regarding the relevance and appropriate use of specific neuropsychological tests. Additionally, I co-facilitated a Cognitive Stimulation Group with an Occupational Therapist on an inpatient ward for approximately eight people with a diagnosis of dementia. I co-facilitated a training session for MDT staff on the use of a cognitive screening measure.

Specialist Placement

Early Intervention for people with Psychosis (EIP): December 2012 – September 2013

This placement involved working with people aged between 14 and 35 years experiencing a first episode of psychosis. I attended daily risk ‘zoning’ MDT meetings and weekly clinical case discussion MDT meetings. I completed a neuropsychological assessment of a person with memory difficulties in the context of an experience of psychosis and conducted nine psychological assessments. Part of this work involved assessing whether clients were suitable for the EIP service and working in collaboration with other EIP practitioners. I completed seven pieces of intervention work based on an integrative style with a predominantly CBT approach. I completed an audit of GP referrals to the EIP and delivered a teaching session to MDT staff from three services on the topic of ‘wellbeing at work’.
RESEARCH DOSSIER

The research dossier contains a research log which summarises my research experiences, the abstract to a group qualitative project, my Service Related Research Project (SRRP) and my Major Research Project (MRP).
SERVICE RELATED RESEARCH PROJECT

An evaluation of the views and experiences of staff in secondary mental health services regarding the involvement of people who use services and carers in the North West locality of a National Health Service Foundation Trust.

July 2011

Year 1
ABSTRACT

The aim of the study was to investigate staff views and experiences of the involvement of people who use secondary mental health services and their carers and to explore how positive and/or negative feedback has been received from them. A mixed methods design was employed via a questionnaire and Focus Group format to generate both quantitative data to generate a baseline of staff attitudes and qualitative data to explore the attitudes and experiences of staff in further detail. Participants were staff members employed in the North West (NW) locality of a National Health Service (NHS) Foundation Trust in the South East of England. The questionnaire yielded a response rate of 18.2% (n=20) and eight staff members participated in the focus group. Frequency data of the quantitative findings indicated that the involvement of people who use services was being implemented although specific areas need further development. Thematic analysis of the qualitative data produced from the questionnaire and Focus Group produced themes which included: 'communication and awareness', 'the impact on the person using the service', 'systemic issues' and 'process and content'. There was less agreement and awareness of the extent of the implementation of involvement of people who use services and carers. Issues regarding receiving feedback from people who use services were discussed. Specifically, participants recommended better communication; to people who use services, and within staff teams following receipt of feedback whether it be positive or negative.

Acknowledgements

Thank you to my university supervisor, Louise Deacon, to my field supervisor, Win Fleming and to all staff who participated in the study.
INTRODUCTION

Recent government policy, ‘No Health without Mental Health’ (HRMC, 2011), stated that people who use services\(^3\) and their carers should be listened to by staff and positioned to take control of their lives and treatment. The Royal College of Psychiatrists (2008) outlined the importance of the involvement of people who use services and carers to achieve equality in mental health services. Tait and Lester (2005) described the benefits of this, which included promoting greater social inclusion and May (2001) suggested that involvement in service provision may impact on the path to recovery.

Tait and Lester (2005) suggested that professional resistance may be a barrier to meaningful involvement of people who use services and carers. Staff members play an essential role in the involvement of people who use services and carers therefore it is important to consider their views and perspectives. Diamond et al. (2003) found modest to high levels of involvement of people who use services and carers related to staff recruitment, training and links with advocacy services. Soffe, Read and Frude (2004) conducted a UK based study and investigated 50 clinical psychologist’s views of the involvement of people who use services using a postal questionnaire adapted from the ‘Consumer Participation Questionnaire-CPQ’ (Kent & Read, 1998). Questionnaire items covered involvement of people who use services at all levels of service delivery (i.e. treatment, evaluation, planning and management). Kent and Read (1998) originally developed the CPQ and surveyed 72 mental health professionals in New Zealand. They found that involvement was regarded positively by staff but that it was more successfully implemented in individual treatment rather than service evaluation, planning and management which was echoed by Soffe et al.’s (2004) findings.

\(^3\) Personal communication received from involvement forums in the NW locality of the NHS Foundation Trust indicated that ‘people who use services’ was the preferred terminology therefore it was used in this study.
The NHS Foundation Trust, in collaboration with people who use services, carers and staff developed seven ‘standards for involving people’. People who use services have expressed dissatisfaction and raised various positive and negative issues in different forums in the NW locality of the NHS Foundation Trust (Personal communication, January, 2011\(^4\)). Some have voiced their concerns over a lack of action after they have given feedback\(^5\) to staff in secondary care services (Personal communication, January, 2011). Therefore, obtaining a better understanding of staff views of the involvement of people who use services and carers and how feedback from people who use services has been handled may help to identify ways in which this can be improved.

**Aims**

- To investigate the views and experiences of staff members in secondary mental health care services of the involvement of people who use services and carers.
- To further explore staff member’s experiences of receiving feedback from people who use services and carers and explore whether any changes to current practice could be made.

\(^4\) Communications from staff at the researcher’s current secondary mental health service and an involvement forum.

\(^5\) Feedback refers to verbal or written communication received by staff from people who use services and carers, pertaining to treatment, care, staff or service.
METHODS

Outline

The study was conducted using a mixed methods approach.

Two methods were employed:

1. An electronic questionnaire which generated quantitative and qualitative data.
2. A Focus Group which produced qualitative data.

The quantitative data from the questionnaire aimed to broadly represent staff views and experiences of the involvement of people who use services. The electronic questionnaire format allowed the researcher to efficiently access a large number of staff members over a period of one month.

The Focus Group method was useful for exploring participants experiences and knowledge to generate rich and detailed data. As recommended by Kreuger and Casey (2000), the Focus Group was facilitated by the researcher and eight participants were asked predetermined questions to stimulate discussion.

Using both methods allowed for comparison between the two formats and full exploration of the topic.

Questionnaire

Participants

Questionnaires were electronically distributed to 110 staff members in five secondary care mental health services in the North West locality of the NHS Foundation Trust which included four Community Mental Health Recovery Services and one Specialist Psychology Service. Job titles were requested to establish whether all professions were represented in the study.
All questionnaire respondents received an information sheet (Appendix A) which stated that by submitting the questionnaire, they had consented to participate in the study and they were informed that their responses would remain anonymous and confidential. Written approval was received from the NHS Foundation Trust’s Research and Development Department to conduct the study.

**Procedure**

The questionnaire employed in the study originated from the ‘Consumer Participation Questionnaire- CPQ’ (Kent & Read, 1998). This was adapted for use in the UK by Soffe et al. (2004) who commented that the reliability of this measure was unknown therefore results were to be considered tentatively. The original questionnaire included closed items and was adapted, with written permission from the original author, to include open-ended items probing staff views and experiences of feedback from people who use services (Appendix B). The questionnaire was created using a free online resource (http://www.esurveyspro.com/), piloted on a person who uses services and a Consultant Clinical Psychologist and distributed via an electronic link within an email (Appendix C) approximately eight weeks before the Focus Group took place.

**Analysis**

Frequency data was summarised from the survey according to percentages of ‘yes’, ‘no’, ‘don’t know’ and ‘other’ (free text option). Qualitative data derived from the ‘other’ open-ended items was analysed using thematic analysis according to the standardised principles outlined by Braun and Clarke (2006). Thematic analysis is a flexible method whereby trends are identified within the data according to a series of steps (Appendix D; Braun & Clarke, 2006). An ‘inductive’ approach and critical realist position was taken by the researcher in order to reflect the participant’s experiences, whilst taking into consideration the wider social and
political context. Themes were analysed at the semantic level due to an absence of theoretical assumptions underpinning the study (Braun & Clarke, 2006).

Focus group

Participants

An invitation to the Focus Group was sent via email (Appendix C) to 110 staff members. Eight participants comprising of one Consultant and one Senior Clinical Psychologist, three Trainee Clinical Psychologists, one Assistant Psychologist and two Student Mental Health Nurses took part in the Focus Group. Of the participants there were seven females and one male and ages were not requested. Participants gave their written consent to participate (Appendix E), agreed to be audio-taped and were informed that their responses would remain anonymous.

Procedure

The researcher visited three of the multi-disciplinary CMHRS team meetings to promote the Focus Group. The Focus Group was facilitated by the researcher who took written notes and audio-taped the session. Twelve semi-structured, open-ended and non-leading questions (Appendix F), which had been derived according to guidelines created by Kreuger and Casey (2000), were presented to the group for fifty minutes. Kreuger and Casey (2000) commented that Focus Groups can result in rich data and high external validity due to the presence of 'real-life' group dynamics.

Analysis

Thematic analysis, as described above, was employed to analyse the data from the Focus Group according to the method outlined by Braun and Clarke (2006).  

6 In order to allow the reader to see the coding process a section of the transcript and how it was coded is included in Appendix I.
RESULTS

Questionnaire

Of the 110 emails distributed, 20 responses were received resulting in an 18.2% response rate. All professional staff groups were represented in the questionnaire (appendix G). Demographic data was not requested from the respondents.

Frequency data

The data are presented according to the following five categories: treatment, evaluation, planning, management and feedback. A full summary of the data is shown in Appendix B but due to word limits the text below describes the most relevant findings.

Treatment

'Treatment' explored assessment procedures and goals. Nineteen of the 20 staff (95%) believed that people who use services should be involved in planning their treatment and 18 (89%) agreed that they should always or usually be involved in their diagnosis. No-one responded that clients should not be involved or that they did not know whether clients should be involved in their treatment planning or diagnosis. All 20 staff believed that people who use services should be at least partially responsible for setting their own treatment goals and 15 (75%) had discussed this with people who use services which goals were intended to be accomplished by treatment. Two (10%) respondents indicated that they had not discussed this and no-one responded that they did not know whether they had discussed this or not.
Evaluation

‘Evaluation’ encompassed complaints procedures and satisfaction surveys. Twelve (60%) staff reported that complaints procedures were simple to use, one (5%) respondent indicated that they were not simple to use and seven (35%) reported that they did not know whether they were simple to use or not. Twelve (60%) staff indicated that their service routinely conducted satisfaction surveys, five (25%) responded that their services did not do this and one (5%) did not know whether their service did this or not.

Planning

‘Planning’ related to the provision and planning of services. Nineteen (95%) staff had heard of the involvement of people who use services in the provision of services and no-one had had not heard or did not know whether this took place or not. Fourteen (70%) respondents indicated that their service had solicited input from people who use services for service planning, three (15%) responded that their services had not done this and one (5%) respondent did not know whether this had happened or not.

Management

‘Management’ explored hiring of staff and staff training. Ten (50%) respondents reported that their services involved people who use services in hiring decisions, three (15%) had not experienced this and one (5%) did not know whether this took place or not.

Five (25%) staff indicated that people who use services had been invited to participate in staff training events at their service, nine (45%) responded they had not been invited to their service and (15%) did not know whether they had been invited or not. Seven (35%) respondents reported that people who use services had been
invited to act as facilitators at staff training events at their service, six (30%) reported that they had not been invited to do this and six (30%) did not know whether they had been invited or not.

*Feedback*

Feedback’ involved issues of receipt of feedback from people who use services. All 20 staff had received positive feedback, 14 (70%) of them shared it with the team and two (10%) of them had kept it to themselves. Eighteen (90%) staff had been given negative feedback, nine (45%) had shared it with colleagues, four (25%) had informed their manager of the feedback and no-one had kept it to themselves.

*Thematic analysis*

Thematic analysis was used to analyse the qualitative responses to the questionnaire (see Appendix H for analysis).

*Communication*

Participants commented that they were often unsure of how frequently people who use services were involved in the hiring of staff and suggestions were made to improve communication.

'It is important that there is a transparent process, whereby it is communicated clearly to the ‘service user’ how their feedback has been received and addressed, what the outcome is and why.'

*Ambivalence*

Some respondents were apathetic about promoting involvement seemingly due to the current political and economic climate. One participant commented on how a focus on negative feedback received has resulted in low morale and expectations within their team.
'I think the current feeling of working in this service and the surrounding blame culture is that we need to prepare to defend ourselves at all times.'

The 'right' client
Participants commented that selecting the 'right' client in terms of their mental health, 'insight' and 'disability' might determine their level of involvement.
'I think people who use services should be involved...although I believe there are difficulties with this e.g. if the client lacks insight.'

Focus Group

Thematic analysis

The master themes generated from the data are described below (see Appendix J for analysis).

Systemic issues
Participants highlighted issues that had arisen in their own teams, the wider organisation and at government level. One participant detailed how complaints and compliments were discussed at a weekly team meeting which they found helpful. Conversely, it seemed that others emphasised a lack of knowledge and shared practice of communication about feedback within teams.

PI: 'I expect there's differences in the teams and professionals where some of us like to seek feedback regularly...other people and places might not'

Impact on the person using the service
Participants suggested that it might be empowering for some people who use services and carers to give feedback if they felt they had been listened to. They considered
that giving negative feedback may be anxiety-provoking for the person using the service.

P3: ‘I found...they really liked giving the feedback...it’s quite empowering for them’

P5: ‘there may be a lot of anxiety about saying things really if it weren’t positive feedback’

Process and content

There seemed to be uncertainty among the participants as to how to share feedback according to the type of feedback that was received. For example, the participants were unsure of what constituted a complaint or an airing of views. There seemed to be agreement about a team approach to resolve issues locally and communicate with the client.

P1: ‘It’s about being able to distinguish between somebody just wanting to air something they’re not happy with versus something they’re wanting to complain about’

P7: The way feedback can be communicated to clients...it’s important to have a team approach’

Communication and awareness

Participants agreed that generating a ‘feedback loop’ whereby staff actively acknowledged and responded to feedback given by people who use services was needed. Participants questioned how accessible existing routes were for people who use services to give feedback and suggested ideas to increase awareness and participation.

P4: ‘I think the ideas about how to communicate feedback back to the clients is one of the key things really’
DISCUSSION

The quantitative results of the questionnaire suggested that the involvement of people who use services was implemented to an extent at all levels of service delivery which mirrored the findings of Soffe et al. (2004). Specific areas for further development included satisfaction surveys, solicited involvement in the planning of services, hiring of staff, participation in training meetings and invitations to act as facilitators at staff training events. Most respondents were implementing or agreed that involvement should be implemented in terms of planning of treatment and goals, evaluation and diagnosis of presenting problem, complaints procedures and provision of services. As Kent and Read (1998) commented, positive views may be present in most staff but implementation at the planning and management level has yet to be fully established. The qualitative results from the thematic analysis emphasised the need for better communication, the difficulties of receiving negative feedback, improving involvement and choosing the ‘right client’ to be involved.

Themes from the qualitative results of the questionnaire such as ‘communication’ were expanded on in the Focus Group. The master themes of the thematic analysis highlighted systemic issues of team working, the impact on the person using the service, the difficulties of deciding how to share feedback from people who use services within the staff team and the importance of improving communication and awareness. For example, participants agreed that creating a ‘feedback loop’ whereby communicating with each party as part of a transparent process would be beneficial.

In terms of critical analysis, the online questionnaire may have increased the response rate given the time pressures on staff and was therefore seen as a strength of the study by the researcher. The researcher followed the guidelines of thematic analysis outlined by Braun and Clarke (2006) in a systematic manner allowing for
internal coherency of themes. Each master theme was considered to reflect the original data set which may have enhanced validity.

All staff roles were represented in the questionnaire responses, although a higher response rate from each staff role would have increased the reliability and external validity of the results. Some staff members may have been unable to access the questionnaire and the researcher also considered that the current political climate and related service re-designs may have raised the sensitivity of the topic of study which could have hindered participation. Participants in the Focus Group were mainly representative of the clinical psychology profession and staff involved in the initial feedback identified in the personal communication (Jan, 2011) did not attend. Therefore the results of the Focus Group could not be generalised to other mental health professions and the initial concerns raised may not have been fully explored in their original context.

In conclusion, further development of the involvement of people who use services is needed to place clients at the centre of their care in accordance with government agenda (HMRC, 2011). Future research might focus on further evaluation of the negative views and experiences reported in the questionnaire, potential attitude differences between groups of professionals and exploration of how the ‘right’ person for involvement is viewed.

**Recommendations**

- For respondents that reported lack of knowledge on certain areas of involvement, education and training might be a suitable intervention.
- Generation of a ‘feedback loop’ whereby staff members discuss the feedback given with the person using the service or carer and team and communicate to all parties involved.
- A published summary of feedback and responses to this, in an accessible format.
Generation of a leaflet for people who use services and carers outlining the process and benefits of giving feedback to staff.

Dissemination

The present study will be disseminated via presentation to all staff teams involved, senior management and to local forums involving people who use services in early September, 2011.
REFERENCES


Appendix A. Information sheet for online questionnaire

Information Sheet for participants

- This project has been designed to explore staff views on the involvement of people who use services.
- This will help to identify staff experiences and views of involving people who use services and how positive and negative feedback has been received from people who use services. The feedback from the survey will be disseminated to staff and recommendations may be made as a result of the survey results.
- As a participant, you will be invited to answer 27 questions as part of a questionnaire investigating staff views of the involvement of people who use services.
- The project will take place at a location convenient to the participant and travel will not be required.
- The questionnaire will take no longer than fifteen minutes.
- The questionnaire items are not considered to cause distress or affect physical health or wellbeing.
- If you feel that you have been affected by the project please contact the Samaritans on 08457 90 90 90.
- By submitting your questionnaire, it will be assumed by the researcher that you consent to participate in the project.
- You have the right to withdraw your consent to participate at any time whilst completing the questionnaire without having to give a reason.
- If you have submitted the questionnaire and would like to withdraw your consent please contact XXXXXXXXXXXX via email at XXXXXXXXXXXX.
- All identifiable information and data will be confidential.
- Any complaint or concerns about any aspects of the way you have been dealt with during the course of the study will be addressed; please contact XXXXXXXXXXXXXXX at XXXXXXXXXXXXXXXXXXXXXXXXX.
Appendix B. Questionnaire items and quantitative findings

<table>
<thead>
<tr>
<th>Questionnaire item</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Findings described</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your opinion, should people who use services be involved in the planning of their own treatment?</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(95%) (0%) (0%) (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your opinion, should people who use services be involved in the evaluation and diagnosis of their presenting issue(s)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>9</td>
<td></td>
<td></td>
<td>(47%)</td>
</tr>
<tr>
<td></td>
<td>(47%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(42%) (0%) (0%) (0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(0%) (5%) (33%) (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(0%) (10%) (5%) (20%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(11%) (0%) (0%) (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In most cases, where does the responsibility for deciding the goals of treatment usually lie?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entirely the service user</td>
<td>2</td>
<td></td>
<td></td>
<td>(10%)</td>
</tr>
<tr>
<td></td>
<td>(10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mostly the service user and the mental health worker a little</td>
<td>9</td>
<td></td>
<td></td>
<td>(45%)</td>
</tr>
<tr>
<td></td>
<td>(45%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Half the service user and half the mental health worker</td>
<td>9</td>
<td></td>
<td></td>
<td>(45%)</td>
</tr>
<tr>
<td></td>
<td>(45%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mostly the mental health worker and the service user a little</td>
<td>0</td>
<td></td>
<td></td>
<td>(0%)</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entirely the mental health worker</td>
<td>0</td>
<td></td>
<td></td>
<td>(0%)</td>
</tr>
<tr>
<td></td>
<td>(0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you tell people who use services what</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>(95%) (0%) (0%) (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
goals are intended to be accomplished by the treatment or provision of care?

**Findings not described**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are people who use services told they have a right to see their records?</td>
<td>13</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>(65%)</td>
<td>(10%)</td>
<td>(5%)</td>
<td>(20%)</td>
<td></td>
</tr>
<tr>
<td>Are people who use services informed of the facts about confidentiality and privacy regarding information contained in those records?</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>(95%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td>(5%)</td>
<td></td>
</tr>
<tr>
<td>Does your service sponsor events/forums that educate people who use services about their rights and entitlements?</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>(35%)</td>
<td>(25%)</td>
<td>(35%)</td>
<td>(5%)</td>
<td></td>
</tr>
<tr>
<td>In your opinion, should people who use services contribute to the writing of their notes and records?</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>(15%)</td>
<td>(50%)</td>
<td>(10%)</td>
<td>(25%)</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation**

**Findings described**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it simple to use- i.e. is it in plain language and are the steps or procedures user-friendly?</td>
<td>12</td>
<td>1</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>(60%)</td>
<td>(5%)</td>
<td>(35%)</td>
<td>(5%)</td>
<td></td>
</tr>
<tr>
<td>Does your service routinely conduct satisfaction surveys from people who use services on the services it offers?</td>
<td>12</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(60%)</td>
<td>(25%)</td>
<td>(5%)</td>
<td>(10%)</td>
<td></td>
</tr>
</tbody>
</table>

**Findings not described**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your service have a complaints procedure for people who use services?</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(100%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td></td>
</tr>
</tbody>
</table>

**Planning**

**Findings described**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you heard of or read anything about the involvement or participation of people who use services in the provision of mental health services?</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(95%)</td>
<td>(5%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td></td>
</tr>
<tr>
<td>Does your service solicit input from people who use services for the planning of mental health services?</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>(70%)</td>
<td>(15%)</td>
<td>(5%)</td>
<td>(10%)</td>
<td></td>
</tr>
</tbody>
</table>

**Findings not described**

90
How would mental health services change if people who use services were involved in the planning and/or delivery of those services?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve a lot</td>
<td>8</td>
<td>40%</td>
</tr>
<tr>
<td>Improve a little</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>No change</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Worsen a little</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Worsen a lot</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>20%</td>
</tr>
</tbody>
</table>

What do you see as possibilities if people who use services were involved in service planning and/or delivery? (Tick more than one if appropriate)

<table>
<thead>
<tr>
<th>Possibility</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upgrading of services and delivery</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>Less burnout and stress for the providers of those services</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>More chance that people who use services would benefit from these services the first time around</td>
<td>13</td>
<td>27%</td>
</tr>
<tr>
<td>Less chance of the 'revolving door' syndrome, where people who use services keep returning with the hope of finding help</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>Downgrading of services and delivery</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>More burnout and stress for the providers of those services</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>That people who use services would be regarded by professionals as 'tokenistic'</td>
<td>6</td>
<td>12%</td>
</tr>
<tr>
<td>That people who use services would not understand the terminology used, and</td>
<td>3</td>
<td>6%</td>
</tr>
</tbody>
</table>

91
therefore find it difficult to give any input.

Other 

5 (11%)

Management

Findings described

Are people who use services involved in the hiring decisions of your service's staff? 

10 3 1 6

(50%) (15%) (5%) (30%)

Are people who use services invited to participate in staff training meetings at your service? 

5 9 3 3

(25%) (45%) (15%) (15%)

Has your service ever asked people who use services to act as facilitators at staff training events? 

7 6 6 1

(35%) (30%) (30%) (5%)

Findings not described

How would mental health services change if people who use services were employed by that service? 

Improve a little 

4

(20%)

Improve a lot 

6

(30%)

No change 

4

(20%)

Worsen a little 

1

(5%)

Worsen a lot 

0 (0%)

Other 

5 (25%)

What do you see as the main reasons people who use services might not choose to be involved in mental health services? (Tick more than one if appropriate)

Too vulnerable 

5 (9%)
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacking in self-confidence</td>
<td>8</td>
<td>14%</td>
</tr>
<tr>
<td>Lacking in ability or knowledge</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Lacking in motivation</td>
<td>9</td>
<td>16%</td>
</tr>
<tr>
<td>Lack of trust in the ability of the services to provide help</td>
<td>7</td>
<td>12%</td>
</tr>
<tr>
<td>Not wanting to have any further contact after getting better</td>
<td>8</td>
<td>14%</td>
</tr>
<tr>
<td>Do not understand how to get involved</td>
<td>10</td>
<td>18%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>9%</td>
</tr>
</tbody>
</table>

### Feedback

#### Findings described

In your experience, if you have received positive feedback (such as comments in relation to the service, staff or their care) from people who use services what have you done with that feedback?

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I haven’t received any positive feedback</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>I kept it to myself</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>I informed the staff team and shared the feedback</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>20%</td>
</tr>
</tbody>
</table>

#### Findings not described

In your experience, if you have received negative feedback (such as comments in relation to the service, staff or their care) from people who use services, what have you done with that feedback?

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I haven’t received any negative feedback</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>I kept it to myself</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>I informed the staff team and shared the feedback</td>
<td>9</td>
<td>45%</td>
</tr>
<tr>
<td>I informed my manager</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>20%</td>
</tr>
</tbody>
</table>

93
<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am fully aware of these services and have not used them before with clients</td>
<td>11</td>
<td>55%</td>
</tr>
<tr>
<td>I am fully aware of these services and have used them before with clients</td>
<td>8</td>
<td>40%</td>
</tr>
<tr>
<td>I am not aware of these services</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>I am not aware of these services and would like more information about them</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>
Appendix C. Email invitation to participate in the study

Dear all,

As part of my training on the clinical psychology course, I am required to complete a piece of research that will be valuable to the service.

I am investigating, amongst CMHT staff in the North West xxxxx locality, their views of the involvement of people who use services and their experiences of receiving feedback.

I would be very grateful if you could spare a few minutes to complete the online questionnaire that I have put together. All details regarding the project are on the information sheet attached and I only request that you state your job role, all other details will remain anonymous.

I appreciate that you are all very busy and I have tried to keep it short so it should take less than 10 minutes to complete.

Please click on the link below to access the questionnaire:

http://www.eSurveysPro.com/Survey.aspx?id=f16a20e6-3dc9-4a64-821e-438c63fabb77

I will also be running a Focus Group on Thursday 26th May, 12:00 at xxxxxxxxx. If you would like to attend and express your views on this subject please let me know.

I will present the results to you when I have completed the project and bring some chocolates to say thank you!

Thank you in advance,

XXXXXXXXXXX

XXXXXXXXXXXXXXXX

Trainee Clinical Psychologist
Appendix D. Braun and Clarke’s (2006) standardised method of thematic analysis

<table>
<thead>
<tr>
<th>Steps</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.   Familiarisation with the data</td>
<td>Transcription of data and re-reading the data.</td>
</tr>
<tr>
<td>2.   Generating initial codes</td>
<td>Coding the data according to area of interest in a systematic way.</td>
</tr>
<tr>
<td>4.   Reviewing themes</td>
<td>Checking the themes relate to the original data set and initial codes.</td>
</tr>
<tr>
<td>5.   Defining and naming themes</td>
<td>Ensuring each code is placed under a theme and specifying the themes.</td>
</tr>
<tr>
<td>6.   Producing the report</td>
<td>Gathering concrete examples from the original data set that represent themes and relating back to the original research question.</td>
</tr>
</tbody>
</table>
Appendix E. Consent form for focus group

Consent Form

I, the undersigned, voluntarily agree to take part in the focus group on involving people who use services and carers.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS) ...............................................

Signed ........................................................................................................

Date ...............................................

Name of researcher (BLOCK CAPITALS) ...............................................

Signed ........................................................................................................

Date .............................................
Appendix F. Focus group introduction and questions

Introduction:

‘Thank you for attending the focus group today. The aim of the group is to explore your views and opinions about how you think feedback from people who use services and carers is handled in the services you work in and what changes, if any, you think could be made to improve this.

We will spend up to fifty minutes today exploring the topics. I have approximately 12 questions and I will be audio-taping your answers. The information sheet for the study is here and the consent form (read through consent form and ask to sign).’

Introductory question:

1. What is the first thing that comes to mind when you think of comments or feedback about services, staff or care) from people who use services or carers? (Introductory question)

Transition questions:

2. What is the first thing that comes to mind when you think of people who use services or carers commenting or offering feedback on services, staff or care?

3. What have learnt from your experiences of people who use services or carers commenting on or offering feedback on the service/ staff or care? (Transition question)

Key questions:

4. In your opinion, what changes, if any, do you think could be made in order to respond to comments or feedback more effectively? (Key question)

5. What would services look like if comments or feedback was dealt with in this way? (Key question)

6. What are your thoughts about advocacy services for assisting people who use services and carers with feedback? (Key question)

7. Are you aware of PALS?

8. What are your thoughts about PALS?

9. Are you aware of MATRIX?

10. What are your thoughts about MATRIX?

Summary question:
11. I’m going to give you one minute each to sum up what you think the most important aspects, if any, to change, as regards how the service responds to comments or feedback from people who use services and carers.

Ending question:

12. Have we missed anything? Is there anything you wanted us to ask but didn’t?

Closure of the focus group:

‘Thank you for attending the focus group, your participation is greatly appreciated and I will present the findings of the study to your services once the results have been analysed. If you would like to discuss anything we me that may have affected you from today’s discussion please speak with me shortly.’
### Appendix G. Job roles of respondents to the questionnaire

<table>
<thead>
<tr>
<th>Job title (as specified by respondents)</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>2</td>
</tr>
<tr>
<td>Consultant Clinical Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Trainee Clinical Psychologist</td>
<td>2</td>
</tr>
<tr>
<td>Assistant Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Support Worker</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Associate Specialist Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Medical Team</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Team Administrators</td>
<td>3</td>
</tr>
<tr>
<td>Support, Time and Recovery Worker</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
</tr>
<tr>
<td>Senior Approved Mental Health Practitioner</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix H. Thematic analysis of qualitative responses from questionnaire

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Initial codes</th>
<th>Concrete example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Lack of awareness and information</td>
<td>'Not clear on how they would go about making a complaint or where they would find this information so perhaps this could be more explicit'.</td>
</tr>
<tr>
<td></td>
<td>Making collaborative decisions</td>
<td>'We discuss this (rather than tell them)'</td>
</tr>
<tr>
<td></td>
<td>Uncertainty</td>
<td>'I know they have been in the past but not sure if it's happening now.'</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>Impact of current political and economic climate</td>
<td>'In the present climate I think there is little expectation that we can do much to remedy some of the situations which cause negative feedback'</td>
</tr>
<tr>
<td></td>
<td>Blame culture</td>
<td>'I think the current feeling of working in this service and the surrounding blame culture is that we need to prepare to defend ourselves at all times'</td>
</tr>
<tr>
<td></td>
<td>Threat to professional autonomy</td>
<td>'I think the clinician should be entitled to give their opinion without it being 'trashed' by the service user.'</td>
</tr>
<tr>
<td>The ‘right’</td>
<td>Mental health of the person using the</td>
<td>'Unless too unwell'</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>client</th>
<th>service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of who to involve</td>
<td><em>Clients would need to be chosen very carefully for there to be a positive outcome</em></td>
</tr>
<tr>
<td>Involving those who want to be involved</td>
<td><em>It would be important to get 'service users' involved who are interested in social inclusion</em></td>
</tr>
</tbody>
</table>
Appendix I. Section of focus group transcript

<table>
<thead>
<tr>
<th>Initial codes</th>
<th>Section of transcript</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication on feedback</td>
<td>FACILITATOR: ok so we’ve got about five minutes left and what I thought would be good to close the discussion would be to give you each a minute just to sum up what was the most important aspect of the discussion for you today? P1: I think the ideas about how to communicate uh feedback back to the clients is one of the key things really like even if its things which as you say we can’t sort of fulfil their hopes or expectations but being able to feed that back transparently that’s a big thing, saying about the loop you know and communication lines, putting it so some of the ideas that people here talking about that I think we have to be quite creative and um motivated to do things like that I guess. Me; Thank you P1: is that a minute? (laughter) P2: yeah I agree with what P1 is saying but I really liked what you were saying P7 about service user involvement informally but also at the organisational level as well and um so you can kind of get that feedback at both stages not just after they’ve received treatment but maybe you know how actually input before how the service may be run at the organisational level I thought that was quite interesting P3: I think something similar I think it’s just about this notion of the challenge of creating a culture where we use it because the more that were open to these informal</td>
<td>Communication and awareness</td>
</tr>
<tr>
<td>Empowering and engendering hope</td>
<td></td>
<td>Impact on the person using the service</td>
</tr>
<tr>
<td>Feedback on feedback</td>
<td></td>
<td>Communication and awareness</td>
</tr>
<tr>
<td>Creativity and motivation</td>
<td></td>
<td>Systemic issues</td>
</tr>
<tr>
<td>Feedback at organisational level</td>
<td></td>
<td>Systemic issues</td>
</tr>
<tr>
<td>Type of feedback</td>
<td></td>
<td>Process and content</td>
</tr>
<tr>
<td>Team culture</td>
<td></td>
<td>Systemic issues</td>
</tr>
<tr>
<td>Prevent complaints</td>
<td></td>
<td>Systemic issues</td>
</tr>
<tr>
<td>Foster open culture</td>
<td></td>
<td>Systemic issues</td>
</tr>
<tr>
<td>Feedback as reward to prevent complaints</td>
<td>comments I suppose we can really prevent complaints and nobody likes complaints you know so if we are able to somehow foster this more open culture with the informal comments maybe that would be a bit of a carrot to say well it’s going to stop all these horrible complaints so be more open at that level. Not quite sure how we do it maybe having it on the agenda or something for it to be meaningful.</td>
<td></td>
</tr>
<tr>
<td>Making feedback meaningful</td>
<td>P4: I’m similar to what everybody’s said I think it is quite important that the client knows they’ve been listened to and even though we may not have been immediately able to say oh yeah we’ll change that, get back to them and if they want to just so that they know they’ve been heard and we’re there for them you know</td>
<td></td>
</tr>
<tr>
<td>Important client feels listened to and feeling heard</td>
<td>P5: I agree with what P4 said about listening to them and then they will feel more motivated to participate in the future.</td>
<td></td>
</tr>
<tr>
<td>Listening result in future motivation to participate</td>
<td>P6: I agree with everything that’s said and I think that sometimes ‘service users’ don’t know how to give feedback and so it’s important to have that discussion in the team about letting people know what their routes of feedback are and what’s going to be done with it</td>
<td></td>
</tr>
<tr>
<td>Need for channels for feedback and raised awareness</td>
<td>P7: We’ve got themes haven’t we, which theme should I comment on? (laugh) empowering, empowering I know it’s a bit of a catchphrase empowering ‘service users’ but I think it’s important and the cultural shift that’s needed for us as professionals to not treat people as patients but to</td>
<td></td>
</tr>
</tbody>
</table>

| Impact on the person using the service |
| Impact on the person using the service |
| Impact on the person using the service |

| Communication and awareness |
| Impact on the person using the service |
| Systemic issues |

<p>| Impact on person using the service |
| Systemic issues |
| Communication and awareness |
| Systemic issues |</p>
<table>
<thead>
<tr>
<th>to clients</th>
<th>Team approach to gather feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>treat people as people and to actually think about how we do that cultural shift, where we are putting their experience at the centre of what we’re doing which involves this giving feedback on feedback and having it as a two way process rather than a one way process</td>
<td></td>
</tr>
<tr>
<td>P8: Yeah I agree I think it’s very much about the culture. I think also thinking about people thinking about the way in which it can be communicated to clients and the way the feedback is received as well, that’s important; different ideas about a team approach to sort of gather feedback</td>
<td></td>
</tr>
<tr>
<td>FACILITATOR: Thanks very much going round and doing this has given us a really good summary of what we’ve spoken about today and just finally is there anything that you think is really important that we’ve missed today or any final comments that you want to make?</td>
<td></td>
</tr>
<tr>
<td>P3: I was just wondering about a leaflet coming out of recommendations the findings and things just because it might keep kick-start people’s ideas</td>
<td></td>
</tr>
<tr>
<td>FACILITATOR: do you mean out of this research?</td>
<td></td>
</tr>
<tr>
<td>P3: Possibly, you could have it by a suggestion box or something</td>
<td></td>
</tr>
<tr>
<td>P7: A leaflet about what, what do you mean</td>
<td></td>
</tr>
<tr>
<td>P3: Well just about the importance of feedback and you might want to say we’ll learn from positive and negative things, you could invest??and always to talk to staff rather than suggestion box or a poster or something</td>
<td></td>
</tr>
<tr>
<td>P7: yeah that sounds like a good idea, about making the client aware they have a right or a want or that we are interested in listening to it, rather than think they are just complaining when giving feedback</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>P3: Yeah we’d like to hear from you and we’re trying to prevent things from happening and like you say it’s about empowering and have them on board and alongside.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix J. Detailed description of themes from the focus group

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Examples of initial codes</th>
<th>Concrete example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systemic issues</td>
<td>Lack of knowledge of shared practice</td>
<td>'It's not something we discuss at a team meeting about how many people are using advocacy services.'</td>
</tr>
<tr>
<td>Inpatient ward vs. community practice</td>
<td>Well I think you know it's more common on the ward but in the community I'm not sure how many people even know about it really.</td>
<td></td>
</tr>
<tr>
<td>Team culture</td>
<td></td>
<td>'How we do that cultural shift where we are putting their experience at the centre of what we're doing, which involves this giving feedback to feedback?'</td>
</tr>
<tr>
<td>Impact on the person</td>
<td>Empowerment using the service</td>
<td>'It's about empowering them and having them on board and alongside'</td>
</tr>
<tr>
<td>Threat</td>
<td></td>
<td>'Worried about their benefits and whether or not they may be referred to IAPT'</td>
</tr>
</tbody>
</table>
Positive experience  
'When they [people who use services] were asked about what they think about the service and their involvement they were really enthusiastic to contribute.'

Process and content  
Type of feedback  
'How do you know when something needs to be taken further or when is it someone just wanting to kind of air their feelings or views about something?'

Confusion over process to feedback  
'Well I do wonder you know, how do staff know what to do with feedback you know?'

Comparison with private sector  
'People have been moaning about various things in the health club and what this new manager’s done, she’s actually got a big board you know in the
Communication and Listening to feedback awareness

Feeding back on feedback

Improvements

reception area... "You told us this and we did this"

'The key here is to make sure that people feel they've been listened to and heard. Whether it's something emotive or not I think that makes a huge difference.'

'I think the ideas about how to communicate uh feedback back to the clients is one of the key things really like even if its things which as you say we can't sort of fulfil their hopes or expectations but being able to feed that back transparently that's a big thing.'

'I think the other thing that's interesting is to think about how we use systems like um websites more.'
Appendix K. Email containing evidence of feedback of SRRP results to the service.

This email is to confirm that xxxxxxxxxxx fed back xxx SRRP to the xxxxxxxxxxxxxxx multi-disciplinary team at the end of xxx first year adult placement in September 2011. xxx also attended the xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx 2011.

Best Wishes

Dr. xxxxxxxxxx
Chartered Senior xxxxxxxx Psychologist
<table>
<thead>
<tr>
<th></th>
<th>RESEARCH LOG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
APPENDICES TO THE RESEARCH DOSSIER:
Article submitted and accepted to Clinical Psychology Forum (Division of Clinical Psychology, British Psychological Society) pending publication: Feedback from people who use mental health services: what can be learned?

October 2012
Feedback from people who use mental health services: what can be learned?

Sophie Westwood & Win Fleming

In this article I discuss some of the issues and challenges concerned with receiving, processing and actioning feedback from people who use mental health services and their carers.

As a Trainee Clinical Psychologist in my second year of training, I have entered the profession at a time when I am surrounded by apprehension, uncertainty and an ever-changing National Health Service. The effects of the recession coupled with cuts to health and social services has opened the arena for the private and third sector organisations to bid for NHS contracts.

My second year brought with it a similar emphasis on the changing methods of delivering mental health services which aim to ‘fit’ people who use mental health services into categories which can be costed into ‘packages’. Secondary mental health care services are moving towards the Payment By Results (PbR) system which funds treatment according to the mental health cluster to which someone is assigned (Department of Health, 2012).

In the context of a more competitive market, how can NHS services adapt their method of service delivery to involve people who use services in a meaningful way and to improve quality of care?

Part of the service evaluation I conducted in my first year of clinical psychology training focused on ‘feedback’ received by staff in adult secondary mental health community teams from people who use services and their carers.

7 Personal communications received by local mental health services during my first year clinical placement indicated that the term ‘people who use services’ was preferred therefore I have chosen to use this term throughout this article as a way of implementing this feedback.
The Government's policy document, 'No Health without Mental Health' (HRMC, 2011), says that people who use services and their carers should be listened to by staff and to be allowed to take control of their lives and treatment. May (2001) suggests that involving people who use services and their carers in service provision may influence their recovery. Staff are encouraged to support 'recovery' by entering into mutual partnerships with people who use services as well as being open to learn from and be influenced by service users' wishes, preferences and priorities (Slade, 2009). Therefore, people who use services and the services themselves can benefit from having some input into that service, an opinion I also agree with.

Reflecting on my experiences of working in the NHS has led me to consider how Clinical Psychologists can influence these 'reorganisations' as the NHS moves into a more competitive environment. It also leads me to wonder how much 'customer service' is becoming a reality for NHS services and in the role of Clinical Psychologists.

Before training, one of my graduate posts involved working in a housing organisation where I completed an in-house management training programme whilst working as a mental health support worker. This was at the time when the recession first hit health and social services in 2009/2010 and staff morale in the housing organisation was low. A reorganisation in middle management resulted in job losses among staff who were highly valuable to the organisation, and a 'customer service' training programme was introduced. One of the results of this was the notion that a complaint is a valuable 'golden nugget' offering clues to improvement.

The term 'service-user' had changed to 'customer', supposedly to reflect values of empowerment and choice for people who used the housing organisation. I found it difficult to mould my style of engagement with the 'customers' of the housing organisation to the mechanistic, robotic and slightly patronising style advocated by that particular type of customer service training. I did, however, see the benefit of training all staff to treat vulnerable people as individuals with a voice who should be treated in a courteous and respectful way.
The idea for the service evaluation project I undertook stemmed from a comment received by my Clinical Supervisor that people who use services had voiced their concerns about being invited to give feedback to staff in secondary care services but not seeing any action taken as a result (Personal communication, January, 2011). The feedback referred to verbal or written comments given to staff by people who use services and their carers – comments which did not necessarily warrant a complaint. These perceptions by staff of the experience of receiving feedback from people who use services were evaluated. Staff views are important to explore: Tait and Lester (2005) suggest that resistance from professionals can be a barrier to meaningful involvement of people who use services and their carers.

The NHS Foundation Trust that I worked in during my first year of training developed standards for involving people, in collaboration with people who use services, carers and staff. The aim of my service evaluation was to obtain a better understanding of how feedback from people who use services had been handled and how this could be improved. I believe that a particular aspect of my project (as yet unpublished), namely how feedback from people who use services and their carers is received and handled by staff, is particularly pertinent to the Clinical Psychologist’s leadership role. On my training course there has been a particular emphasis on developing leadership skills as Clinical Psychologists are encouraged to step into management and leadership.

The service evaluation used thematic analysis (Braun and Clarke, 2006) to analyse the results from a questionnaire. A Focus Group was also held with staff from three local Community Mental Health Teams.

The resulting themes reflect important issues. Firstly, there was clearly a need for communicating with people who use services what happened to their feedback. This meant scrutinising how the feedback had been received by the staff, how it had been addressed and what the outcome was.

Secondly, the uncertainties within the current political and economic climate had left some staff feeling apathetic and defensive when given negative feedback (the Trust was in addition undergoing a major restructuring). This highlighted the importance
of a ‘team approach’ to resolving issues and the need for a culture where teams felt confident in their abilities, respected by their colleagues and open to new ideas about improving clinical practice or service delivery.

Good practice was shared when a staff member commented on how ‘complaints and compliments’ were shared at a weekly team meeting, saying that this had been a helpful experience. However, this staff member’s contribution was countered by others commenting that there was a lack of knowledge about what to do with feedback from people who use services. Some members of the Focus Group were unsure of what constituted ‘feedback’: was it a constructive complaint or merely an airing of views? This emphasised how difficult it was to know how to process the feedback. Thought was also given to who should be responsible for obtaining and dealing with feedback, as well as the impact on the person using the service of giving feedback to a service as it could be anxiety-provoking for some, especially those who want to offer negative comments.

Specific recommendations from the service evaluation included:

- Generation of a ‘feedback loop’ where staff members discuss the feedback given with the person using the service or carer and with the team and how to communicate with everyone involved.

- A published summary of feedback (a variety of media could be used to do this such as bulletin boards, newsletters and websites) and responses to this could be provided in accessible formats.

- A leaflet for people who use services and carers outlining the process of how to give feedback and the benefits for staff and people who use services and their carers.

Some GP practices already do this, and leisure centres often have boards displaying feedback and how it has been addressed. Of course, mental health services do not function as leisure centres and people who use services are not currently ‘paying
customers' in quite the same way. With the shift in mental health services to a PbR system, direct payments and personalisation budgets, people who use services are being given more choice about where to go for help with mental distress and what kind of organisations offer these services.

Recently, I have explored the impact that Clinical Psychologists can have on staff teams. In my current clinical placement, working with people with learning disabilities, I have attended a Cognitive Analytic Therapy (CAT) weekly supervision group. Here, a staff member has been learning about and using thinking from CAT to work with staff teams who are resistant to implementing guidelines recommended to them by this staff member.

I've seen how effective this approach has been in enhancing reflection and communication among team members. I also considered the relevance of reflective practice groups (Thorndycroft & McCabe, 2008) and cognitive-behavioural models of team consultation (Lake, 2008). There is already a wealth of expertise and good practice within Clinical Psychology staff teams. Are we in a position to help and encourage staff teams to explore the issues about receiving feedback from people who use services? How can we work together to uncover the best ways of acquiring ideas from staff teams about how to obtain feedback – and what we do with that feedback?

I attend the Service User & Carer Advisory Group which is attached to the University of Surrey's PsychD clinical psychology programme. This helps to inform my understanding of the impact of involving people who use services and carers on matters relating to the training course. Their feedback is encouraged, listened to and addressed: any reasons, ideas or suggestions that cannot be actioned are addressed openly. Indeed, a great deal of time is given to this process and it is managed in a respectful and sensitive way. The result is the meaningful involvement of people who use services. I can’t honestly say that I have experienced this process to the same extent during my various clinical placements so far. Could addressing the issue of creating a ‘feedback loop’ so that comments from people who use services are listened to, addressed and fed back to the person who offered the comments improve
the situation? It would require little in the way of funding, but would make a vast
difference to the service and to the people who use its services.

Mental health services don’t need a roll out of ‘customer service’ training. Instead, I
believe we need training for all staff so that they can recognise when someone is
merely ‘axe grinding’ or providing genuine and constructive feedback as well as
solutions to the issue.

One way forward might be to ask clients at the end of each session what was helpful
or unhelpful about the clinical session. I believe this could be another step to
improving professional practice and improving the service offered. I’m aware that
clients won’t always feel comfortable giving feedback to me at the end of the session
(especially if it’s not so positive!), but I do try to follow-up their comments and ideas
in a sensitive manner. And I continue to learn from my colleagues and supervisors
how to develop my skills in asking for and acting on this feedback.

While a process for a ‘feedback loop’ would be helpful, allowances for people’s
individual styles of engaging with others are essential to the success of this.

Using a ‘team approach’ to process feedback could help with managing the care of
people who use services, particularly for one group – those who have been given the
diagnosis of borderline personality disorder (BPD). Often, feedback offered by
people with BPD can result in ‘splitting’ a staff team. The term ‘splitting’ relates to
the psychoanalytic concept of ‘splitting off’ or dissociating between different
emotional states (Klein, 1946) resulting in others being perceived as either ‘bad’ or
‘good’. As a result, staff can develop antagonistic views towards each other
depending on which side of the ‘split’ they are on (Gunderson & Links, 2008).
Opening up dialogue and addressing the constructive elements of feedback or
reflecting on the relational dynamics of the person using the service can help to
reduce anxiety and tension amongst staff and improve the quality of care for people
who live with BPD.
Of course, I’m aware that many mental health services are already doing this and I’ve been impressed by the expertise that colleagues in my clinical placements have demonstrated since I began my clinical training – they are valuable teachers. I hope that as a result of this article, best practice can be shared and innovative, simple and cost-effective ways of creating ‘feedback-loops’ can be explored.

Disclaimer
The views expressed in this article are solely those of the authors and not the organisations they are employed by.

Acknowledgements
Thank you to all staff who participated in the service evaluation project and my supervisors, Win Fleming and Louise Deacon. I am very grateful to Barbara Riddell for her contributions and editing of the manuscript.

Affiliations
Sophie Westwood, Trainee Clinical Psychologist, University of Surrey.

Address
Sophie Westwood, Trainee Clinical Psychologist, Department of Clinical Psychology, AD Building, University of Surrey, Guildford, Surrey GU2 7XH; s.westwood@surrey.ac.uk.

References


QUALITATIVE RESEARCH PROJECT (ABSTRACT):

Perceptions of Facebook

May 2011

Year 1
This study aimed to investigate the perceptions of the social networking site 'Facebook' amongst its users. Quantitative research on this topic has tended to focus on campus-based student samples, and a qualitative approach and a non-student sample was selected here in order to generate richer data for analysis within a wider group of Facebook users. Semi-structured interviews were carried out with four participants, and data was analysed using a Thematic Analysis approach. Four major themes emerged from the data: 'communication', 'knowledge of others', 'change in use over time', and 'the 'dark side' of Facebook'. Participants noted the utility of Facebook in enhancing communication and increasing knowledge of others, both close and distant friends. A general trend for fluctuating use of Facebook over time was reported. Concerns were raised over the possible addictive and psychologically or socially damaging impact of using Facebook. Differences also emerged between the constructions of how Facebook could be used, and the ways in which participants actually felt they used the site. Implications for the role of Facebook in both individual and wider social contexts are discussed, and directions for further research are suggested.
Investigating the job demands and support available to Improving Access to Psychological Therapies workers

By

Sophie Westwood

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

School of Psychology
Faculty of Arts and Human Sciences
University of Surrey
July 2013
©Sophie Westwood 2013
Acknowledgements

I would like to thank my research supervisors Dr Nan Holmes, Dr Linda Morison and Dr Jackie Allt for their help, support, encouragement and expertise. I am grateful for the technical support provided by Andrew Barnes.

Thank you to all of the IAPT service managers who granted approval for the project to be undertaken in their IAPT services. I am sincerely grateful to each IAPT worker who participated in the project and particularly those who took the time to contact me directly in order to participate in the project.

On a more personal note, thank you to my partner Paul for his continued love, support and skill at making me laugh whilst contending with the academic and emotional challenges of clinical training. My fellow trainees, Emma, Lucy, Katie, and Nicki, and friends have provided support, fun and laughter throughout my experience of clinical training and I would have struggled without it. Finally, thank you to my parents, Dave and Helen, for a lifetime of support, encouragement, love and belief.
CONTENTS

ABSTRACT 131

1.0 INTRODUCTION 133

1.1 Overview 133
1.2 Burnout 134
1.3 Burnout and stress 135
1.4 Burnout and depression 136
1.5 Theoretical basis of burnout 136
   1.5.1 Early research 136
   1.5.2 The Multidimensional Model of Burnout (MMB) 137
   1.5.3 Critique of the MMB 137
   1.5.4 The Job Demands-Resources Model of burnout 138
   1.5.5 Exhaustion 139
   1.5.6 Disengagement 140
   1.5.7 Evidence for the JD-RM 141
   1.5.8 A critique of the JD-RM 142
1.6 Measures of burnout 143
1.7 The prevalence of burnout in mental health workers 144
   1.7.1 Age 145
   1.7.2 Years of experience 145
   1.7.3 Gender 146
   1.7.4 Job characteristics 146
   1.7.5 Critique of the burnout research in mental health workers 147
1.8 IAPT 148
1.9 The present study 149
1.10 Research hypotheses 150
2.0 METHODS

2.1 Study design

2.2 Participants

  2.2.1 Inclusion and exclusion criteria

  2.2.2 Sample size calculation

2.3 Procedure

  2.3.1 Study recruitment

    2.3.1a IAPT Services

    2.3.1b ‘CBT Today publication’

    2.3.1c BABCP Forum website

2.4 Ethical considerations

2.5 Measures

  2.5.1 Oldenburg Burnout Inventory

  2.5.2 Mental Health Professional’s Stress Scale

  2.5.3 Non-standard questionnaire

  2.5.4 Demographic questionnaire

2.6 Pilot

2.7 Statistical analyses

  2.7.1 Examining the distribution of the data

  2.7.2 Parametric or non-parametric tests

2.8 Application of statistical analysis to hypotheses

  2.8.1 Preparation of data

  2.8.2 Hypothesis 1a: There will be a substantial prevalence of
burnout in PWPs, HI therapists and Counsellors

  2.8.3 Hypothesis 1b: Burnout in IAPT workers will be related to
job role, age, gender, years of experience and length of time
worked in the IAPT service.

  2.8.4 Hypothesis 2a: Greater job demands will be associated with
greater levels of exhaustion

  2.8.5 Hypothesis 2b: Job demands will be associated with
exhaustion but not disengagement
2.8.6 Hypothesis 3a: A lack of job resources will be associated with greater levels of disengagement

2.8.7 Hypothesis 3b: Job resources will be associated with disengagement but not exhaustion

2.9 Qualitative analysis

2.9.1 Hypothesis 2b and 3b
3.0 RESULTS

3.1 Missing data

3.2 Description of the sample
   3.2.1 Gender
   3.2.2 Age
   3.2.3 Years of Mental Health work experience
   3.2.4 Length of time worked in IAPT service
   3.2.5 Ethnicity

3.3 Preliminary data analysis

3.4 Results relating to study hypotheses
   3.4.1 Hypothesis 1a: There will be a substantial prevalence of burnout in PWPs, HI therapists and Counsellors
   3.4.2 Hypothesis 1b: Burnout in IAPT workers will be related to job role, age, gender, years of experience and length of time worked in the IAPT service
   3.4.3 Hypothesis 2a: Greater job demands will be associated with greater levels of exhaustion
   3.4.4 Moderating effects of time worked in the service
   3.4.5 Qualitative analysis
      3.4.5a Content analysis of job demands
   3.4.6 Hypothesis 2b: Job demands will be associated with exhaustion but not disengagement
   3.4.7 Moderating effects of time worked in the service
   3.4.8 Hypothesis 3a: A lack of job resources will be associated with greater levels of disengagement.
   3.4.9 Moderating effects of time worked in the service
   3.4.10 Qualitative analysis
      3.4.10a Content analysis of job resources
3.4.11 Hypothesis 3b: Job resources will be associated with disengagement but not exhaustion

3.4.12 Moderating effects of time worked in the service

3.5 Further analyses

3.5.1 Predicting burnout
4.0 DISCUSSION

4.1 Summary of the findings

4.1.1 Hypothesis 1a: There will be a substantial prevalence of Burnout in PWPs, HI Therapists and Counsellors

4.1.2 Hypothesis 1b: Burnout in IAPT workers will be related to job role, age, gender, years of experience and length of time worked in the IAPT service

4.1.3 Hypothesis 2a: Greater job demands will be associated with greater levels of exhaustion

4.1.4 Hypothesis 2b: Job demands will be associated with exhaustion but not disengagement

4.1.5 Hypothesis 3a: A lack of job resources will be associated with greater levels of disengagement.

4.1.6 Hypothesis 3b: Job resources will be associated with disengagement but not exhaustion

4.1.7 Further analyses

4.2 Interpretation of results

4.2.1 The JD-RM

4.2.2 Burnout in IAPT workers

4.3 Critique

4.3.1 Triangulation

4.3.2 Design

4.3.3 Measures

4.3.4 Data collection

4.4 Implications for clinical practice

4.5 Future research

4.6 Conclusions

4.7 REFERENCES

APPENDIX
ABSTRACT

Objective
The aim of this study was to establish whether burnout was prevalent in Improving Access to Psychological Therapies (IAPT) workers or not and if so, which job characteristics were related to this. The Job Demands-Resources Model (Demerouti, Bakker, Nachreiner & Schaufeli, 2001; JD-RM) was tested to investigate whether the two psychological processes underpinning burnout, exhaustion and disengagement, related to job demands and job resources respectively.

Design
A cross-sectional quantitative survey design was employed utilising the Oldenburg Burnout Inventory (Demerouti et al., 2001), the Mental Health Professionals Stress Scale (Cushway, Tyler & Nolan, 1996) and a non-standard questionnaire concerning IAPT job characteristics.

Participants
The sample included 202 IAPT workers recruited either from IAPT services or via a magazine and website affiliated to the British Association for Behavioural and Cognitive Psychotherapists (BABCP).

Results
Nearly two thirds of the IAPT workers experienced burnout. Psychological Wellbeing Practitioners (PWPs) were one and a half times more likely to experience burnout than High Intensity (HI) Therapists and length of time worked in the IAPT service predicted burnout in the total sample. Working for two years or more in the IAPT service and overtime hours were the overall predictors of burnout in PWPs. There were no significant predictors of burnout in HI Therapists. The results of the present study did not support the JD-RM.

Discussion
Possible reasons for the failure to find support for the JD-RM are discussed. The prevalence of burnout in IAPT workers is explored in relation to the existing research.
and the study is critically evaluated. The clinical implications of the results and future research are discussed.

Conclusions
The prevalence of burnout in IAPT workers is high. Attempts to prevent burnout through consideration of certain job characteristics will be imperative if IAPT services want to avoid the well documented economic costs of burnout.
1.0 INTRODUCTION

1.1 Overview

Work-stress has been defined as "the adverse reaction people have to excessive pressures or other types of demand placed on them at work" by the Health and Safety Executive (2007, p.7; HSE). It has been noted in a variety of mental health professionals including: occupational therapists, psychiatrists, social workers, clinical psychologists and case managers (Carson & Fagin, 1996). Demerouti, Bakker, Nachreiner and Ebbinghaus (2002) stated that when 'work-stress' is experienced over a prolonged period of time in the same job, it can develop into 'burnout' which is a chronic, long-term (mental) health impairment. This was first described in 'human service workers' (Freudenberger, 1974; Maslach, 1976). Burnout can be costly for individuals and organisations due to increases in turnover, absenteeism and reduced productivity (Cordes & Dougherty, 1993; Jackson & Maslach, 1982; Leiter & Maslach, 1988; Shirom, 1989). Patients are less satisfied with the care they receive when physical and mental health care workers experience burnout (Vahey, Aiken, Sloane, Clarke & Vargas, 2004; Garman, Corrigan & Morris, 2002; Halbesleben & Rathert, 2008; Anagnostopoulos et al., 2012). No research into burnout has yet been conducted on 'Psychological Wellbeing Practitioners' (PWP's), High Intensity (HI) therapists and Counsellors who are responsible for delivering the government's Improving Access to Psychological Therapies' (IAPT) programme. IAPT services deliver evidence-based treatment approved by the National Institute for Clinical Health and Excellence (NICE) primarily for depression and anxiety disorders. The government committed to funding the programme and training thousands of therapists. Given the impact that burnout can have on mental health workers' performance, levels of absenteeism and turnover, and patient satisfaction, it is essential that this is investigated in IAPT workers to ensure that the IAPT investment is secure.

This introduction will provide a definition of burnout, a description of its theoretical basis, the prevalence of it amongst mental health workers and the different factors
that relate to this. Finally there will be a description of IAPT services, the role of PWP s and HI therapists and why they may be at risk of burnout. The quality and adequacy of research included in this review was assessed according to its recency, relevance to the research question, utilisation of validated measures of burnout and/or work-stress, and sample size. Additionally, the quality of the methods and robustness of the analyses were assessed in consideration of the overall credibility of the studies.

1.2 Burnout

The phenomenon of burnout was first introduced into the academic arena in the United States of America (USA) by Freudenberger (1974) and Maslach (1976). Simultaneously, the use of the term 'burnout' grew increasingly in the USA among human service workers in the 1970s (Maslach et al., 2001). Burnout is conceptualised as "a syndrome of emotional exhaustion (EE), depersonalisation (DP), and reduced personal accomplishment (PA) that can occur among individuals who do people work of some kind" (Maslach, 1982, p.3). This is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviour at work. It results from a misfit between the intentions outcomes for the role and the reality of the job and develops gradually as a response to chronic and interpersonal stressors in the work environment, over a period of approximately two years (Schaufeli & Enzmann, 1998). It may remain unnoticed for a long time and the result is a chronic, long term mental health impairment (Demerouti et al., 2002; Maslach, Schaufeli & Leiter, 2001). Often burnout is self-perpetuating because of inadequate coping strategies that are associated with the syndrome (Schaufeli and Enzmann, 1998). Some of the physical symptoms of burnout include sleep difficulties, headaches and vulnerability to illness (Kwee, 1990). Emotional exhaustion, depression, anxiety, low self-esteem and substance misuse are some of the associated psychological symptoms (Maslach et al., 2001). Behavioural effects such as reduced work performance and absenteeism have been identified (Kwee, 1990). Burnout in nurses working in hospitals in the USA
Major Research Project
Introduction

(Vahey et al., 2004) and physicians in Greece (Anagnostopoulou et al., 2012), emotional exhaustion in staff working in a psychosocial rehabilitation programme for people with mental health difficulties (Garman et al., 2002), and depersonalization in physicians (Halbesleben & Rathert, 2009) has been found to relate to lower levels of patient satisfaction. Therefore burnout has negative consequences for patients.

1.3 Burnout and stress

Burnout has been distinguished from stress. Stress develops when external factors disrupt the equilibrium of the cognitive, emotional and environmental system (Lazarus & Folkman, 1984; McGrath, 1976). Work-stress has generally been defined as a negative psychological state or reaction to perceived or actual overwhelming work-related pressures that workers do not feel able to cope with or have the abilities/resources to manage (Cox, 1978, 1985, 1990; Lazarus & Folkman, 1984; HSE, 2007). Demerouti et al. (2002) conceptualised it as a temporary state involving cognitive, affective and fatiguing symptoms which could be reversed under conditions such as a change in tasks or adequate recuperation. Schaufeli and Buunk (1996) proposed that burnout was a consequence of a build-up of work-stress related to the imbalance of job demands and resources over a prolonged period of time. Cherniss (1980) found that two years of experience of working in the same job under these conditions resulted in burnout.

Maslach (1993) commented that unlike burnout, work-stress does not seem to involve the development of negative attitudes and behaviours towards the recipients of care, the job and the organisation. Therefore the concept of burnout also differs to that of work-stress in that it is multidimensional (Schaufeli & Enzmann, 1998). The discriminant validity between burnout and work-stress has been demonstrated (Cox, Kuk & Leiter, 1993; Schaufeli & Van Dierendonck, 1993). Schaufeli and Enzmann (1998) suggested that work-stress and burnout can only be discriminated retrospectively as burnout can be mediated by the expectations of the worker. As such, workers with low initial motivation or commitment to the job are prone to
work-stress whereas workers with high initial motivation and commitment to the job are prone to burnout (Brill, 1984; Pines, 1993).

1.4 Burnout and depression

Kaschka, Korczak and Broich (2011) commented on the ‘fuzzy’ boundaries between burnout and mental health difficulties such as depression. The symptoms of depression include fatigue, social withdrawal, low mood and feelings of failure (Beck, 1970; Beck, Steer & Garbin, 1988). These are thought to overlap with the three core dimensions of burnout according to the Multidimensional Model of Burnout (MMB; Maslach, 1982, 1998; Leiter & Durrup, 1994), especially the ‘emotional exhaustion’ dimension (Schaufeli & Enzmann, 1998). Studies have shown that depression and burnout are consistently correlated with one another (e.g. Maslach & Jackson, 1986). However, Leiter and Durup (1994) studied 307 hospital workers in Eastern Canada using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986). They found that burnout and depression were strongly related but distinct concepts and supported the construct validity for both. Burnout was conceptualised as a work-specific problem and depression as a difficulty that affects every domain of life (Leiter & Durup, 1994). Glass and McKnight (1996) reviewed 18 studies of burnout (as measured by the MBI) and depression and supported these findings. They suggested that burnout may be an antecedent to depression.

1.5 Theoretical basis of burnout

1.5.1 Early research

Maslach (1982) and Schaufeli, Maslach and Marek (1993) commented on the lack of empirical theory present in early research into burnout. Research into burnout was initially placed into the ‘pop psychology’ category amongst non-scholarly research
(Maslach et al., 2001). Unlike other theoretically-driven research, theories of burnout developed from a bottom-up approach based on people’s experiences at work (Maslach, 1976). A definition of burnout was developed from several years of exploratory research and qualitative interviews in a wide range of professions such as health care, social services, mental health and the criminal justice system. Maslach (1982, 1998) developed the Multidimensional Model of Burnout (MMB) which has been the predominant theory in the field and applies to a wide range of industries.

1.5.2 The MMB

The MMB consists of three core dimensions. The first, ‘emotional exhaustion’, describes feelings of being emotionally strained and physically and emotionally exhausted by work. This is the basic stress dimension of the MMB and the most widely reported (Maslach et al., 2001). It occurs from the overwhelming demands of providing care at work (from job characteristics such as caseload and scarcity of resources) and as a result, workers try to cope by distancing themselves from their work. The worker begins to view the recipient of their care as an impersonal object who lacks uniqueness and ‘depersonalization’ develops. This dimension relates to the interpersonal context of employment and refers to negative or detached responses to other people, usually the recipient of the worker’s care or specific aspects of their job. Maslach et al. (2001) supported claims that emotional exhaustion tended to develop into depersonalization sequentially. The third core domain, reduced ‘personal accomplishment’, describes low feelings of competence and decreased achievement and reduced self-efficacy and productivity in work. It relates to the self-evaluation component of employment arising from emotional exhaustion and/or depersonalisation.

1.5.3 Critique of the MMB

There is debate regarding the dimensionality and scope of burnout (see Schaufeli et al., 2008). Shirom (2003) conducted a review of burnout research and argued that the
MMB lacked theoretical underpinnings. He stated that it did not explain how the three core dimensions of burnout formed a single theoretical construct. Shirom (1989) and Kristensen, Borritz, Villadsen and Christensen (2005) argued that burnout refers only to the ‘emotional exhaustion’ dimension of the MMB. It has been shown to be the most internally consistent and stable dimension of burnout relative to depersonalisation and personal accomplishment (Schaufeli & Enzmann, 1998). Green, Walkey and Taylor (2001) found that emotional exhaustion and depersonalisation were generally considered to be the core dimensions of the MMB. Personal achievement has been shown to be the weakest dimension of the MMB in terms of its significant relationships with other variables related to the varying demands and resources of the job (Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998). Therefore, Demerouti et al. (2001) concluded that the third dimension, ‘reduced personal achievement’ was not necessary in the conceptualisation of burnout.

1.5.4 The Job Demands-Resources Model of burnout (JD-RM)

The JD-RM was developed by Demerouti et al., (2001). They conceptualised burnout as a dichotomous trait whereby people were either experiencing burnout or not. Maslach’s model indicated that burnout was a continuous trait whereby people could experience high, medium or low levels of it (Maslach & Jackson, 1986). The JD-RM proposed that burnout develops irrespective of the type of occupation when job demands are high and job resources are limited. This is due to energy depletion which undermines an employee’s motivation in negative working conditions. The JD-RM is an overarching model that aims to reduce work-stress and prevent burnout (Demerouti et al., 2001). Employers could assess the adequacy of any job design in a particular occupational context in terms of job demands and resources instead of trying to change worker’s perceptions of their working environment (Demerouti et al., 2001). The JD-RM allows for specific, practical and possible low-cost recommendations to be made in order to prevent burnout by reducing job demands and augmenting resources.
The JD-RM incorporates two of the core dimensions from the MMB: ‘exhaustion’ ('emotional exhaustion') which is linked to job demands and ‘disengagement’ from work ('depersonalization') which is related to job resources.

1.5.5 Exhaustion

This dimension refers to intensive physical, affective and cognitive strain in response to overwhelming demands at work. Demerouti et al. (2001) argued that the JD-RM incorporates the physical, cognitive and emotional aspects of exhaustion. It specifically relates to ‘job demands’ which are the physical, social or organisational aspects of the job that require sustained physical or mental effort. Even when job demands are positive, they may turn into stressors (external factors that have the potential to cause a negative influence), when they require more effort than is achievable (Meijman & Mulder, 1998). Hockey (1993) proposed that workers engage in a ‘performance-protection strategy’ when they are required to cope with stressors or ‘job demands’ such as workload. To achieve this, Demerouti et al. (2001) stated that a worker must activate their autonomic and endocrine systems and/or use increased subjective effort (Hockey, 1993). Therefore the greater the activation or effort, the greater the physiological costs to the individual. Demerouti et al. (2001) outlined the compensatory strategies that workers may employ to deal with these physiological demands such as strategy adjustments (narrowing of attention, redefinition of task requirements) and fatigue after-effects (risky choices, high subjective fatigue). The long-term effect of using these strategies results in exhaustion and the individual is drained of energy. Consequently, with the contribution of Hockey’s (1993) ideas, Demerouti et al. (2001) theorised that the development of fatigue explains the relationship between job demands and exhaustion.
1.5.6 Disengagement

This dimension refers to distancing oneself from one’s work and experiencing negative attitudes towards the work object, work content or the work in general. It specifically relates to ‘job resources’ which are defined as physical, social, psychological or organisational aspects of the job that achieve certain functions. These include work goals, reducing job demands, and stimulating personal growth and development. Job resources may be located at the organisational, interpersonal or task level. Demerouti et al. (2001) proposed that the relationship between job resources and disengagement may be explained by the process of health protecting factors such as job resources keeping people healthy. Demerouti et al. (2001) chose to focus on external resources, such as organisational and social factors, rather than internal resources, such as cognitions and actions, (Richter & Hacker, 1998). They claimed that internal resources could be stable or situational dependent on the context of a particular job design. When job resources are low, individuals cannot cope with the negative influences or environmental demands (such as high workload) and they cannot obtain their goals (Demerouti et al., 2001). As such, a lack of motivation ensues and withdrawal from the job can act as protection from the frustration of future failure to achieve work goals. This conceptually linked to Hobfoll’s (1989) Conservation of Resources theory. A prime human motivation is directed towards the accumulation and maintenance of resources in order to protect against negative outcome. Stress is caused when the protection of these valued resources is threatened and there is the potential for them to be lost.

Schaufeli et al., (2008) commented that the JD-RM contributed to knowledge of the different psychological processes underlying burnout. High job demands relate to an energy-driven or conversely, health impairment process, leading to exhaustion (Bakker & Demerouti, 2006). Job resources relate to motivational processes at work and if this is lacking, withdrawal behaviour ensues resulting in disengagement (Bakker & Demerouti, 2008; Schaufeli, Bakker & Van Rhenen, 2009).
1.5.7 Evidence for the JD-RM

Demerouti et al. (2001) initially tested this model with 374 German employees from the human services, industrial and transport sectors. They hypothesised that job demands would primarily and positively relate to exhaustion and job resources would primarily and negatively relate to disengagement. To determine the specific job demands and resources of each type of work, two independent observers attended the workplace to observe employees during their work and interview their supervisors. They utilised the Oldenburg Burnout Inventory (Demerouti et al., 2002) and included their own measure of job demands and resources with five statements relating to job demands and six to job resources. Participants were asked to rate the extent to which they agreed with each statement. The results confirmed the hypotheses. Demerouti et al. (2001) concluded that workers in jobs with high job demands and low job resources were at greater risk of experiencing exhaustion and disengagement which over time, could result in burnout. They claimed that this applied to any occupation and that there was strong and consistent validity for the JD-RM.

Further support was provided for the JD-RM by Peterson, Demerouti, Bergström, Samuelsson, Åsberg and Nygren (2008). They investigated 3719 employees in a Swedish County Council and found that workers who were experiencing burnout reported high job demands and poor access to job resources. Bakker, Demerouti and Schaufeli (2003) provided further evidence for this ‘dual process’ by studying 477 participants from a call centre in Holland. Their findings supported the JD-RM’s predictive validity for self-reported absenteeism and turnover intentions and the results largely supported the dual processes of the JD-RM. Findings to support the JD-RM have been replicated frequently in samples of 214 nutrition production employees (Bakker, Demerouti, DeBoer & Schaufeli, 2003; 1919 Finnish teachers (Hakenen, Bakker & Demerouti, 2005); 146 workers of varying occupations (Bakker, Demerouti & Verbeke, 2004), and 3092 workers in home care organisations (Bakker, Demerouti, Taris, Schaufeli & Schruers, 2003) in the Netherlands. Schaufeli and Bakker (2004) identified a need for longitudinal research into the temporal and dynamic nature of burnout using the JD-RM. They wanted to test whether the JD-RM could predict burnout and other factors over time. Schaufeli et
al. (2009) investigated 201 telecom managers in the Netherlands and conducted a two-wave longitudinal study over a period of one year. They found that an increase in job demands and a decrease in job resources predicted greater future burnout scores even when initial burnout scores were controlled for.

1.5.8 A critique of the JD-RM

Demerouti et al. (2001) proposed that the JD-RM was a parsimonious model with only four basic components: job demands, resources, exhaustion and disengagement. There is much evidence to support the JD-RM. Schaufeli et al. (2009) claimed that job demands and job resources could be empirically distinguished and that they were weakly to moderately negatively correlated (e.g. Bakker, Demerouti, DeBoer & Schaufeli, 2003; Bakker, Demerouti, Taris, Schaufeli & Schruers, 2003; Demerouti et al., 2001). It expands on previous models, such as the Job Demands-Control Model (Karasek, 1979; Van Veldhoven, Taris, De Jonge & Broersen, 2005; Lewig & Dollard, 2003) and the Effort-Reward Imbalance Model (Siegrist, 1996; Lewig & Dollard, 2003; see Bakker & Demerouti (2006) for a review of these models), can be applied to a wide range of occupations and is cross-culturally valid (Bakker & Demerouti, 2006; Schaufeli et al., 2009)

There are some weaknesses in the evidence supporting the JD-RM. Firstly it was mainly conducted by the proponents of the model which could indicate researcher bias. However, other researchers (e.g. Peterson et al., 2008) across Europe and the USA have applied the JD-RM to varying occupations and found support for the model. Secondly, there was an over-representation of cross-sectional research meaning that causal statements of the relationships between variables could not be made. A longitudinal study was conducted (Schaufeli et al., 2009) but with a relatively small sample size which limited the statistical power and external validity of the findings. Thirdly, the use of self-report measures alone is a weakness of some of the evidence. Worker’s perceptions of their jobs may not necessarily reflect reality. Using self-report measures can cause common methods variance problems (Bakker, van Veldhoven & Xanthopoulou, 2010) although some studies did employ
objective measures of burnout, such as absenteeism (e.g. Bakker, Demerouti, DeBoer & Schaufeli, 2003; Bakker, Demerouti & Schaufeli 2003), which helped to avoid this (Llorens, Bakker, Salanova, & Schaufeli, 2006; Bakker et al., 2010). Finally, sample sizes varied from 146 to 3719 amongst the existing research. Findings from larger and heterogeneous samples have external validity and can be generalised across occupations (Cook & Campbell, 1979). In their study of the JD-RM, Demerouti et al. (2001) commented that they had an adequate sample size but there was a lack of randomly selected samples from a wide range of occupations which reduced the generalizability of the results.

1.6 Measures of burnout

The MBI (Maslach & Jackson, 1986; Maslach, Jackson & Leiter, 1996) was developed in the 1980s to measure burnout and it is the most popular measure of burnout (Schaufeli et al., 2008). It assesses the three dimensions of burnout: emotional exhaustion, depersonalization and reduced personal accomplishment. Its internal consistencies are usually well above 0.7 for Cronbach's alpha coefficients (Schaufeli et al., 2001) and the validity of the three-factor structure has been confirmed many times (e.g. Gold, Bachelor & Michael, 1989; Lee & Ashforth, 1990).

Critically, the popularity of the MBI represents a weakness of it. In a systematic review of 36 studies between 2004 and 2009, Kaschka et al. (2011) concluded that the cut-offs on the MBI used to diagnose burnout were varied or not stated. In their review of 18 studies investigating burnout, Leiter and Harvie (1996) arrived at a similar conclusion and stated that there were differences in the scoring and analysis of the MBI. Demerouti et al. (2001), Demerouti and Nachreiner (1996) and Lee and Ashforth (1990) criticised the MBI claiming that all of the items were phrased positively on the emotional exhaustion and depersonalisation dimensions and negatively on the personal accomplishment dimension. From a psychometric point of view, Demerouti et al. (2001) argued that one-sided scales were inferior to scales that
included both positively and negatively worded items. Participants may acquiesce which can lead to artificial factor solutions when positively and negatively worded items cluster together (Doty & Glick, 1998).

As a result of this, an alternative measure of burnout that dealt with the shortcomings of the MBI, the Oldenburg Burnout Inventory (OLBI), was constructed and validated among different occupational groups (Demerouti et al., 2001). Both scales of the OLBI, exhaustion and disengagement, had positively and negatively worded items and therefore dealt with the shortcomings of the MBI. Demerouti et al. (2001) and Halbesleben and Demerouti (2005) stated that the OLBI captures a broader conceptualisation of burnout than the MBI, takes into account the cognitive and physical elements of exhaustion and measures a wider range of burnout experiences. It has been applied in some studies to test the JD-RM (e.g. Peterson et al., 2008). Halbesleben and Demerouti (2005) studied 2599 USA workers and found evidence of acceptable reliability (similar test-retest reliability compared to the MBI and internal consistencies ranged from .74-.87), factorial validity, and construct validity for the English-translation of the OLBI.

1.7 The prevalence of burnout in mental health workers

Burnout in mental health workers has been widely studied (e.g. Maslach et al. 2001; Salyers and Bond 2001; Schaufeli & Buunk, 2003; Shirom 2003). Morse, Salyers, Rollins, Monroe-De Vita and Pfahler (2012) found that the prevalence of burnout in mental health workers in the USA and the UK was between 21% and 67%. In any occupation burnout is costly in terms of increases in turnover, absenteeism, reduced productivity, and human considerations (Cordes & Dougherty, 1993; Jackson & Maslach, 1982; Leiter & Maslach, 1988; Shirom, 1989). Retaining engaged and motivated staff in mental health services is important to reduce these costs and, for example, provide continuity in the quality of care for patients and secure the financial investment made by organisations through training and professional development (Maslach & Jackson, 1986). The literature has shown that a variety of
factors related to the individual (e.g. age, gender) and the external work environment are associated with burnout in mental health workers.

1.7.1 Age

In their review of the burnout research, Maslach et al. (2001) claimed that age was the only individual characteristic that has been frequently related to burnout with employees under 30 years old experiencing higher levels of burnout. In psychologists, age was shown to negatively correlate with measures of emotional exhaustion and depersonalization on the MBI (Ackerley, Burnell, Holder & Kurdek, 1988). Kwee (1990) investigated burnout in 98 Dutch psychotherapists using the MBI and found the younger the participant, the more prone to burnout they were. Lloyd and King (2004) found that younger Australian mental health social workers and occupational therapists were vulnerable to depersonalization than older practitioners. Vredenburgh, Carlozzi and Stein (1999) also found that age was negatively correlated with burnout in Counselling Psychologists in the USA. Conversely, Leiter and Harvie (1996) failed to find any significant relationship between age and burnout in a review of 18 studies.

1.7.2 Years of experience

Schaufeli and Buunk (1996) proposed that prolonged work-stress develops into burnout. Increased work experience has been shown to reduce work-related stress (Hellman, Morrison & Abramowitz, 1987). Leiter and Harvie (1996) found in their review of burnout research that several studies reported negative correlations between years of experience and the two core dimensions of emotional exhaustion and depersonalization on the MBI (Ackerley et al., 1988; Carney, Donovan, Yurdin, Starr, Pernell-Arnold & Mallach-Bornberg, 1993; Tamura, Guy, Brady & Grace, 1994). Farber (1985) found that this relationship held once age was partialled out. Other studies have also supported the negative correlation between years of experience and burnout in a variety of mental health professionals (Guthrie, Tattan,
Lasalvia et al. (2009) however found that having 12 or more years of mental health work experience predicted burnout in a sample of 2000 Italian mental health workers.

### 1.7.3 Gender

Leiter and Harvie (1996) failed to find any differences between burnout and gender. No relationship was found between gender and any of the three subscales of the MBI (Ackerley et al., 1988). In a more recent study investigating work-stress, Cushway (2011) found that of 287 clinical psychological trainees, females had higher scores of general distress on the General Health Questionnaire-28 (GHQ-28; Goldberg & Hillier, 1979) than men. In addition to this, Priebe, Fakhoury, Hoffmann and Powell (2005) studied 189 mental health professionals working in community mental health teams in London and Berlin and found that male gender predicted lower burnout and higher team identity.

### 1.7.4 Job characteristics

Lasalvia et al. (2009) investigated whether job characteristics such as workload, changes in the organisation and management issues predicted burnout or not. They found that involvement in face-to-face contact with patients was a predictor of burnout in Italian mental health staff. They claimed that certain perceived organisational factors such as low workload were important to protecting against the risk of developing burnout. In their systematic review of 52 studies addressing stress in mental health workers, Coyle, Edwards, Hannigan, Fothergill and Burnard (2005) commented on the association between workload and burnout (Barber, 1996). Maslach et al. (2001) claimed that factors such as time pressure, workload and severity of clients' problems all correlated moderately or highly with burnout. Additionally, lack of feedback, lack of participation in decision making and lack of
autonomy also related to burnout. With regards to overtime, Peterson et al. (2008) found that the non-burnout group reported less overtime than the burnout group.

Cushway and Tyler (1994) found that being responsible for supervising trainees accounted for the greatest variance in stress ratings in senior psychologists. Supervisory responsibilities may contribute to burnout as work-stress is a precursor to this (Schaufeli & Buunk, 1996). Cushway, Tyler and Nolan (1996) developed the ‘Mental Health Professionals Stress Scale’ (Cushway, Tyler & Nolan, 1996; MHPSS) which measured the impact of different sources of stress at work. The MHPSS consists of seven subscales measuring the perceived sources of stress of workload, client-related difficulties, home-work conflict, professional self-doubt, relationships and conflicts with other professionals and organisational and structural processes. These could be categorised according to the demands or resources of the job. Cushway et al. (1996) recruited 154 Clinical psychologists and 111 mental health nurses and found that ‘workload’ related to a stress measure in mental health nurses and ‘organisation and structural processes’ related to the same measure in clinical psychologists. For both groups ‘home-work conflict’ was most strongly and consistently associated with higher scores on the GHQ measuring mental health outcome.

1.7.5 Critique of the burnout research in mental health workers

The research cited has been undertaken in Europe (e.g. Kwee, 1990), North America (e.g. Vrendenburgh et al., 1999) and Australia (e.g. Lloyd & King, 2004). This demonstrates that burnout in mental health workers is cross-culturally valid at least among developed Western cultures reflecting the globalisation of burnout (Schaufeli, Leiter and Maslach, 2008). A variety of measures were used to assess burnout. This means that generalising results across studies was difficult. Additionally, the cross-sectional study design of much of the literature and the use of self-reports limits the ability to establish cause and effect (Shirom, 2003). Longitudinal studies of burnout would be preferable in order to compensate for this.
1.8 IAPT

In 2004, NICE conducted a review of evidence-based treatment and strongly supported the use of psychological treatment for anxiety disorders and depression (Clark, 2011). In 2005, the government committed to investing millions of pounds into the ‘Improving Access to Psychological Therapies’ (IAPT) programme (Care Services Improvement Partnership, 2007). Many new IAPT services were developed to ensure, amongst other things, provision of a suitably trained and accredited workforce. As of August 2012, the workforce included 1683 Psychological Wellbeing Practitioners (PWPs), 2960 High-intensity (HI) therapists and 1110 Counsellors (IAPT, 2013). There are distinct aspects of IAPT worker job roles that differentiate them from other mental health workers. These are described below.

When the IAPT programme was introduced, Cognitive-Behavioural Therapy (CBT) was the predominant treatment choice for depression and anxiety disorders. This was delivered at two levels of ‘dosage’ (Richards & Suckling, 2009). The first, a ‘low intensity’ (LI) level involved assessment and interventions delivered by service-trained PWPs. The second involved a ‘high-intensity’ (HI) level delivered by trainees or accredited CBT therapists. PWPs offer high volume, LI interventions following a written recovery programme accompanied by widely available resources. Most clinical PWP contact is made over the telephone following a first face-to-face assessment session. They work using different media including web-based support. Bespoke IT systems are utilised alongside a call-centre approach meaning data can be inputted onto IT systems whilst talking with patients. Case managers and supervisors review cases every four weeks which aids clinical decision-making and there is a risk management protocol to follow. Weekly client outcome measures also help to facilitate clinical decision making. Patients are required to complete these either on a self-report basis or with a PWP or HI therapist. Computerised CBT, group work and counselling are also available as other treatment options. Face-to-face and HI interventions are conducted in the community in sites such as GP practices.

---

8 People who use IAPT services will be referred to as ‘patients’ throughout the present study in accordance with language in IAPT literature (IAPT National Programme Team, 2011).
The model of ‘stepped care’ was employed to ensure that as patients enter the IAPT service, they are treated with the least intensive intervention. Patients can then be ‘stepped up’ through decisions made on the basis of weekly outcome measures and case management supervision. This approach, alongside other elements of IAPT service delivery such as the ‘dosage’ of treatment, a high volume and differing types of patient contact, and a focus on performance and targets represent the unique challenges that IAPT workers face in their job roles.

1.9 The present study

Given the vast literature on burnout and the documented effects this can have, for example, on a worker’s mental and physical health, their performance at work and levels of absenteeism (e.g. Cordes & Dougherty, 1993; Jackson & Maslach, 1982; Leiter & Maslach, 1988; Shirom, 1989), it is vital that the factors contributing to this are investigated in order to prevent it.

My personal experience of training as a PWP highlighted several key aspects of the job role that affected my wellbeing at work. These areas included telephone working; a high volume caseload; lacking the reflective time to absorb the emotional content of my patient work, and the central display of ‘recovery rate’ performance targets in reference to national IAPT league tables in the central hot-desk room. I was interested to investigate whether IAPT workers were experiencing burnout and if so, whether and how these organisational factors, unique to IAPT services, related to this.

The present study aims to explore burnout in IAPT workers due to the absence of any previous research with this particular group of workers. They are part of a new and unique wave of nationwide psychological services in which the government have invested heavily, but who as mental health workers may be at risk of burnout. The JD-RM (Demerouti et al., 2001) has been chosen as the theoretical basis of this study.
for several reasons. Firstly, it can be applied to a wide range of occupational groups and allows for the specific and unique identification of job demands or resources relating to that occupation. Secondly, it allows for any valid measure to test the job demands and characteristics relevant to a particular job. Thirdly, it focuses specifically on external (or situational) job demands and resources meaning that low-cost and pragmatic solutions may be suggested to prevent burnout. This is important in the context of the National Health Service (NHS), a public health system with limited resources.

1.10 Research Hypotheses

1.

a. There will be a substantial prevalence of burnout in PWPs, HI therapists and Counsellors in IAPT services (as defined by high scores on the exhaustion and disengagement scales of the OLBI).

b. Burnout in IAPT workers will be related to job role, age, gender, years of mental health work experience and length of time worked in the IAPT service.

2. To test the fit of the Job Demands-Resource Model (Demerouti et al., 2001) of burnout:

a. Greater job demands will be associated with greater levels of exhaustion. Higher mean scores of exhaustion will be associated with a higher:

- Number of patients on caseload.
- Mean score on the MHPSS Workload subscale.
- Number of hours worked as overtime.
- Mean score on the MHPSS Home-work conflict subscale.
- Number of hours of total patient contact per week.
- Number of hours of telephone contact with patients per week.
- Number of group contact with patients per week.
- Number of face-to-face contact hours per week.
- Number of hours supervising other staff.
- Number of patients with severe difficulties.
- Mean score on the MHPSS Client-related difficulties subscale.
- Awareness of IAPT targets.
- Number of hours spent fulfilling administration duties.

b. Job demands will be associated with exhaustion but not disengagement.

3.

a. A lack of job resources will be associated with greater levels of disengagement. Higher mean scores of disengagement will be associated with:

- Lower number of hours of clinical supervision received.
- Lower number of hours of case management supervision (for PWPs only).
- Higher mean scores on the MHPSS Organisational issues subscale.
- Higher mean scores on the MHPSS Relationships and conflicts subscale.
- Higher mean scores on the MHPSS Self-doubt subscale.
- Higher mean score on the MHPSS Lack of resources subscale.
- Higher number of difficulties accessing a desk per week.
- Higher number of difficulties with accessing clinical space to see patients.

b. Job resources will be associated with disengagement and not exhaustion.
2.0 METHODS

2.1 Study Design

A quantitative approach was employed because quantitative methods, through precise description, formal measurement, manipulation and control of numeric variables, allow evidence to be gathered to inform theory (Field, 2013). Theories from existing research can be tested using specific mathematical models and inferential statistics. This implies a hypothetico-deductive approach whereby the researcher is impartial and objective (Barker, Pistrang, & Elliot, 2002). There are established theories of reliability and validity to assess measurement errors in quantitative research which enable researchers to have confidence in their measures (Barker et al., 2002). Sampling theory can be used to estimate how well quantitative findings generalise to the wider population and comparisons can be made with other research findings (Barker et al., 2002).

A cross-sectional design was utilised meaning that each participant was approached at one point in time (Barker et al., 2002). Cross-sectional surveys are relatively quick, easy and cost-effective to administer although they fail to establish cause and effect (Mann, 2003). This design allowed for the collection of data from a large number of participants within a given time period. Employing a design that was simple and anonymous was crucial for recruiting from a busy work setting and gaining potentially sensitive information such as job demands and work-stress.
2.2 Participants

2.2.1 Inclusion and exclusion criteria

The inclusion criteria required current employment in an IAPT service as a:

- Psychological Wellbeing Practitioner (PWP) or Trainee PWP.
- High Intensity (HI) Therapist (other qualifications could be held alongside this) or Trainee HI Therapist.
- Counsellor

Exclusion criteria:

- Employment Support Advisors and Administration staff in IAPT services.9

Complete data was gained from 262 participants. Due to the anonymous data collection aimed at increasing response rate, no analyses were conducted to assess for any differences based on the source of the data. However, the researcher was able to ascertain approximately how many participants were recruited via each recruitment method (Appendix A). An approximate response rate of participants from IAPT services was calculated at 30%. Participants who worked less than 34 hours per week (part-time employment) were removed from the sample due to the expected presence of confounding variables (e.g. other employment during the week). Insufficient data was provided by 39 participants and removed. This may have represented participant’s withdrawal of consent. The final sample included 202 participants.

---

9 This was due to their non-clinical roles and their exposure to different demands of the job i.e. absence of a patient caseload.
2.2.2 Sample size calculation

A range of statistical tests were used to examine the hypotheses in the present study. G-Power 3.1 software (Faul, Erdfelder, Lang & Buchner, 2007) was employed to conduct sample size estimates. Three parameters were specified to complete the a-priori power calculation: the standard level for alpha level which was 0.05; power of 0.8 (Cohen, 1992); and medium effect size. This method resulted in a minimum sample of 82 participants for the Pearson’s correlation coefficients calculations and 64 participants in each group for an independent samples t-test. There a total sample size of 128 was required. To calculate the prevalence of burnout, exact 95% confidence intervals were obtained using an on-line calculator. The exact method of calculating the confidence interval uses the fact that the data follow a binary distribution rather than assuming that the proportions follow an approximately normal distribution. If 100 participants were sampled and there was a 50% prevalence of burnout, the confidence interval was calculated to be between 39.8 % and 60.1 %. This was considered to adequate precision.

2.3 Procedure

2.3.1 Study recruitment

2.3.1a IAPT Services

The researcher and the researcher’s academic supervisor made contact with potential IAPT services in the south central, south east coast and London regions of England (IAPT, 2013; Retrieved from http://www.iapt.nhs.uk/regions/) via telephone, email or in person approximately six to nine months before data collection began. The researcher’s field supervisor was also employed in a senior management position with an IAPT service in the selected recruitment regions. In total, 15 of the 35 IAPT services contacted agreed to participate in the project. Three IAPT services declined
to participate because they were already participating in research; one IAPT service stated there were too many demands on the service at the present time; ten IAPT services did not respond to the researcher’s initial queries relating to the project after three months, and six IAPT services (or the NHS R&D or organisation’s senior management) refused as the project was not in line with its research priorities. It was expected that at least 100 participants would be available to recruit across the participating IAPT services.

Once contact had been made with an IAPT service, the researcher or academic supervisor discussed the study with the service manager. A formal letter of invitation (Appendix B) to participate in the study was emailed to the service manager along with a Participant Information Sheet (PIS; Appendix C) and the questionnaire designed for the study (Appendix D). When permission had been granted by the service manager/s, the researcher applied for the relevant NHS R&D approval to conduct the study within a particular NHS Trust. One organisation was a non-NHS provider and did not require this.

The researcher completed 11 applications to separate NHS Research and Development (R&D) departments in differing NHS Trusts for approval to conduct the present study in NHS IAPT services. Eight of these applications were made through the ‘Integrated Research Application System’ (IRAS) and three were made through local application systems relevant to the particular NHS R&D departments. One of these applications was rejected due to differing research priorities within that particular NHS Trust. Therefore eight of the 11 applications were approved through the IRAS system and two were accepted through local NHS R&D departments (Appendix E). This resulted in 15 IAPT services participating (some were located within the same NHS Trust).

After NHS R&D approval (or agreement from the service manager in non-NHS service providers) had been gained, the researcher emailed each service manager with a standard email to distribute to their staff. This email contained a message addressed to all PWP, HI Therapists and Counsellors in the IAPT service with the electronic link to the questionnaire (Appendix F) and the PIS attached. Five paper
copies of the questionnaire (which included the PIS and a second class stamp addressed envelope), accompanying leaflets (Appendix G) to advertise the questionnaire and three posters (Appendix H) advertising the project were also sent to the service manager. The researcher requested that the service manager introduce the study at a team meeting in order to encourage participation. Where this was not possible, the researcher attended the team meeting and introduced the study to the IAPT staff team.

Two reminder emails were sent aimed at increasing the response rate (Dillman, Smyth, & Christian, 2009). These contained the original standard email with the electronic email link to the questionnaire. They were sent to IAPT service managers to distribute to their teams at intervals of approximately four to six weeks in a two to three month period after the original email had been sent. The reminders were entitled ‘REMINDER: For the attention of all PWPs, HI Therapists and Counsellors’ and then ‘FINAL REMINDER: For the attention of all PWPs, HI Therapists and Counsellors’. The researcher also offered to send any further paper copies of the questionnaire at the IAPT service manager’s request.

Monetary incentives help to increase response rate (Edwards et al., 2002). Entry into a prize draw for the opportunity for one participant to win £75 of ‘Amazon’ vouchers was offered upon completion of the questionnaire. If participants wanted to enter the prize draw they were asked to provide an email address for the researcher to contact them should they win. They were informed that their email addresses would be stored securely and separately from their questionnaire data to protect participant anonymity and destroyed once the prize draw had been completed.

2.3.1b ‘CBT Today’ publication

The researcher contacted the editors of the British Association for Behavioural and Cognitive Psychotherapists (BABCP) ‘CBT Today’ publication via email and wrote a 250 word article (Appendix I) to advertise the study. This was published in the October 2012 edition free of charge. The researcher stated that participants interested
in completing the study should contact her via her university email address to request either the paper or electronic version of the questionnaire. A standard email message (Appendix J), including the link to the questionnaire and PIS or a paper copy of the questionnaire accompanied by the leaflet and PIS were sent to participants who contacted her. Information was included about the prize draw.

2.3.1c BABCP Forum website

A recommendation was made by the CBT Today editor to advertise the project on the BABCP ‘CBT Café’ discussion forum website free of charge. The researcher posted a short piece of text (Appendix K) which detailed the same procedure of recruitment as outlined for the ‘CBT Today’ publication.

2.4 Ethical considerations

Prior to application for NHS R&D approval, the University of Surrey Faculty of Arts and Human Sciences Ethics Committee granted ethical approval for the study (Appendix L). Two amendments were made regarding the additions to the recruitment strategy and approval was granted for both of these requests. The researcher conducted the study in line with the British Psychological Society’s (BPS) Code of Ethics and Conduct (BPS, 2009) and Code of Human Research (BPS, 2010).

If participants consented to participate in this study it was anticipated that there was the potential minimal risk of emotional distress from considering and answering questions related to exhaustion, disengagement and burnout. These concepts were not explicitly stated in the questionnaire in order to reduce sampling bias. Information was provided on the PIS about sources of support with contact details for relevant organisations and a clinical psychologist (independent of this study) who had agreed to offer support. There were no adverse effects anticipated for
researchers. Regular supervision with the research supervisors ensured that any issues arising were dealt with in a timely and effective manner.

Participant risks were assessed in relation to the potential benefits of the study. If the findings of the study demonstrated that exhaustion, disengagement or burnout were present in IAPT workers, practical and low-cost recommendations could be made to services to potentially adapt job demands or increase job resources. This would serve to enhance employee wellbeing and the productivity of the IAPT service and prevent burnout. Participants would be contributing to knowledge about how to improve the support available to them within IAPT services. It was considered that the benefits of participating in this study outweighed the risks.

Participants gave their informed consent, having been required to read the PIS, at the beginning of the questionnaire by indicating ‘yes’ or ‘no’ to a consent question. They were given the opportunity to withdraw from the study at any time and without reason up until the researcher’s doctoral submission date. The researcher guaranteed the participant’s confidentiality and anonymity in the handling and analysis of all data. Their data would not be shared with their employers to ensure that their employment status was not at risk and individual IAPT services were not named.

2.5 Measures

Participants were required to complete a questionnaire comprising a non-standard questionnaire, the OLBI (Demerouti et al., 2001), the MHPSS (Cushway et al., 1996) and a demographic questionnaire. Standard instructions for the OLBI and MHPSS were provided (see Appendix D for copy of questionnaire). A description of each measure is described below (see Appendix M for further detail of variables).
2.5.1 Oldenburg Burnout Inventory (Demerouti et al., 2001; OLBI)

The OLBI measures burnout on two of the core dimensions of the MMB. The OLBI includes eight items measuring ‘exhaustion’ and eight items measuring ‘disengagement’ (Appendix D). Demerouti and Nachreiner (1999; as cited in Demerouti et al., 2001) confirmed the two-dimensional structure using factor analysis and convergent validity was confirmed. Participants answer each item according to a four-point scale of strongly agree (1) to strongly disagree (4). Each of the two subscales results in a score between 8 and 32. Mean scores for each subscale are calculated. Demerouti et al. (2001) found that the Cronbach’s alpha of the exhaustion and disengagement scales were .82 and .83 respectively and the correlation between both subscales was .39 (p<.001). In the present study, the Cronbach’s alpha coefficient was .86 for exhaustion and .83 for disengagement.

Halbesleben and Demerouti (2005) confirmed good test–retest reliability which was comparable to the test-retest reliability of the MBI (Taris, Le Blanc, Schaufeli & Schreurs, 2005). The factorial validity of the OLBI has been confirmed in the United States (Halbesleben & Demerouti, 2005) and Greece (Demerouti, Bakker, Vardakou, & Kantas, 2003). Halbesleben and Demerouti (2005) were the first to provide evidence for the reliability, factorial validity, and construct validity of the English-translation of the OLBI. Four groups (‘Burnout’, ‘Exhaustion’, ‘Disengagement’ and ‘Below cut-off’) were created using data from the OLBI in the present study. This is described in section 2.8.2.

2.5.2 Mental Health Professionals Stress Scale (Cushway et al., 1996; MHPSS).

The MHPSS was selected as a measure of job demands and resources relevant to the work of mental health professionals and corresponds with the JD-RM of burnout. It

---

10 In return for use of the OLBI free of charge the author of the inventory requested data to further validate the measure. This will solely be participants’ age, gender, occupation and score on the inventory. No identifying data will be shared with the author. This information was stated in the PIS.
was developed by Cushway et al. (1996) and originally tested with a sample of 154 clinical psychologists and 111 mental health nurses. It consists of 42 items which are grouped into seven subscales (Appendix D). Each subscale was identified as either a job demand or resource for the purpose of the present study (abbreviations for certain subscales are provided and will be referred to throughout the text):

Job demand variables:
- Workload
- Home-work conflict
- Client-related difficulties

Job resource variables:
- Organisational structure and processes (Organisational issues)
- Relationships and conflicts with other professionals (Relationships and conflicts)
- Lack of Resources
- Professional Self-doubt (Self-doubt)

Each item is answered on a four-point scale. A score of 0 represents ‘does not apply to me’ and 3 represents ‘does apply to me’. It is a self-administered measure. The MHPSS demonstrated good discriminant validity, concurrent validity and internal consistency (Cronbach’s alpha was .94 for mental health nurses and .87 for clinical psychologists; Cushway et al., 1996). In the present study, Cronbach’s alpha coefficient was .94.

The author of the scale gave permission for the measure to be used. She was contacted again to clarify the language related to the four-point scale as it was deemed unclear during the pilot phase of the questionnaire. Based on her advice the statements describing severity were amended to the following: ‘does not apply to me at all’ (1); ‘applies to me a little’ (2); ‘applies to me’ (3), ‘applies to me strongly’ (4). Therefore total scores range from 6 to 24 for each of the seven subscales and mean scale scores are calculated. Higher mean scores reflect a greater source of stress. The MHPSS is headed ‘Sources of pressure at work’. The word stress was omitted from
the questionnaire because of potential confounding difficulties associated with people’s differing interpretations of stress (Cushway et al., 1996).

To assess whether there was any overlap between the subscales of the MHPSS and OLBI, the individual mean scores on the items of each scale from the data collected in the present study were correlated with one another using Pearson’s correlation coefficients. The language of the items from the MHPSS that were statistically significantly correlated with the OLBI with an effect size of 0.9 or more was assessed to examine whether the items were measuring a similar construct. Three items (Appendix M) originating in the Workload and Home-work conflict subscales were thought to overlap with two of the items in the exhaustion subscale of the OLBI. This was taken into account in the interpretation of the MHPSS subscales following statistical analyses.

2.5.3 Non-standard questionnaire: ‘Information about your job as an IAPT worker’.

This questionnaire, comprising 23 questions, was developed by the researcher and her supervisors to gather information pertaining to the job demands and resources of an IAPT worker’s job role in accordance with the JD-RM (Demerouti et al., 2001). IAPT research reports (IAPT Programme Review, 2011; Department of Health, 2011), the researcher’s past experience as an IAPT worker, the field supervisor’s experience as an IAPT service manager and the academic supervisor’s experience of training IAPT workers assisted in the creation of a list of job demands and resources. These questions were piloted as described below and amended accordingly in relation to the feedback. Of the 23 questions in the questionnaire, 20 were quantitative and measured on an interval scale with a range of single or multiple choice answers. The questions were used to develop the following variables: (abbreviations are noted after certain variables and will be referred to throughout the text):

- Job role
- Number of contracted hours per week
- Years of mental health work experience (MH work experience)
- Years worked in the IAPT service

Job demand variables:
- Hours spent providing case management supervision
- Hours spent providing clinical supervision
- Number of patients on caseload (Caseload)
- Percentage of patients experiencing mild-moderate difficulties\(^{11}\) (Mild-moderate difficulties)
- Percentage of patients experiencing moderate-severe difficulties (Moderate-severe difficulties).
- Hours of total patient contact per week (Total contact)
- Hours of telephone patient contact per week (Telephone contact)
- Hours of face-to-face patient contact per week (Face-to-face contact).
- Hours of group patient contact per week (Group contact)
- Hours spent inputting data per week (Inputting data)
- Hours of overtime per week (Overtime)
- Awareness of IAPT targets (Awareness of targets)

Job resource variables:
- Number of difficulties accessing a desk to work from per week (Desk difficulties)
- Number of difficulties accessing clinical space per week (Clinical space difficulties)
- Hours of case management supervision received per week
- Hours of clinical supervision received per week

The Awareness of targets variable was measured using a Likert scale (ranging from one to five and with numbers increasing in awareness: not aware, a little aware, \(^{11}\) Participants were given exact cut-offs from the PHQ-9 (Kroenke, Spitzer & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) in which to classify patients into either mild-moderate difficulties or moderate-severe difficulties. This was in accordance with the terms used for patient severity in the IAPT literature (IAPT National Programme Team, 2011).
moderately aware, very aware and very much aware). The final three of the 23 items were qualitative and open-ended (text was limited to approximately 200 characters to reduce length of answer). The aim of these items was to gather information regarding any job demands or resources of an IAPT worker’s role that the researcher had neglected to include in the questionnaire.

2.5.4 Demographic questionnaire: ‘Information about you’

A non-standard questionnaire was devised comprising three items: gender, age and ethnic group\textsuperscript{12}. This was to gather information relating to the research hypotheses and monitor the representativeness of the sample.

2.6 Pilot

The whole questionnaire measure was piloted by colleagues of the researcher, namely three trainee clinical psychologists, one clinical psychologist and one IAPT worker. Feedback was gained in relation to presentation, ease of understanding and relevance to the job demands and resources in an IAPT service. The questionnaire was revised and amended accordingly. To increase participation, the researcher offered both paper and electronic versions of the questionnaire. The latter was created using technical support from a technician at the University of Surrey. This contained an informed consent process with identical content to that of the paper version of the questionnaire.

Based on reading speeds specified by Ziefle (1998) it was calculated that it would take approximately 8.5 minutes and 9.5 minutes to complete the paper and electronic versions of the questionnaire respectively. Therefore based on reports of average reading speed and additional time for hesitation, re-reading or contemplation of

\textsuperscript{12} Ethnic groups were specified in accordance with the ethnic group options given in the 2011 Census ‘Household Survey’ (Office of National Statistics, 2011).
questions, the estimated completion time of the questionnaire, in both paper and electronic format, was 15-20 minutes.

2.7 Statistical analyses

2.7.1 Examining the distribution of the data.

The Statistical Package for Social Sciences (SPSS, Version 17.0) was used to analyse the data. As is conventional two-tailed tests were performed and alpha was set at .05. The data were checked for outliers, missing information and errors in entry. Each variable was assessed for normality using visual histograms (Altman, 1991; Appendix N). To examine normality of data Tabachnik and Fidell (2007) recommend inspecting the shape of a distribution as other statistical tests such as Kolmogorov-Smirnov can be too sensitive with large samples. Normal Q-Q Plots were also generated (Field, 2013) to assess whether the observed values for each score were plotted on a reasonably straight line against the expected value from the normal distribution (Pallant, 2010). This would indicate a normal distribution. These methods identified that two variables did not follow a normal distribution ('awareness of IAPT targets' and 'burnout'). Exhaustion and disengagement were normally distributed which was necessary for the Pearson’s correlation coefficients in accordance with Altman’s (1991) recommendation that at least one variable should be normally distributed.

2.7.2 Parametric or non-parametric tests

Parametric tests produce a statistic from the sample that estimates the population parameter (Wilcox, 2001). They are generally regarded as robust and powerful with the ability to attempt to efficiently detect real differences and effects if they genuinely exist (Field, 2013; Freidlin & Gastwirth, 2000). They often hold several assumptions which need to be met in order for the research to be valid. The
population from which the sample is drawn is required to be normally distributed, the
variances of the populations should be approximately equal (homogeneity of variance) and there should be an absence of outliers.

Non-parametric tests adopt a procedure of testing a hypothesis by applying a ranking procedure to the data and calculating the analysis using these ranks (Field, 2013). They often have less statistical power than parametric tests. In relation to the 'awareness of IAPT targets' variable, a Mann-Whitney U test was calculated as an alternative to its parametric equivalent, an independent samples t-test. A Spearman’s Rho correlation coefficient was calculated as an alternative to its parametric equivalent, Pearson’s correlation coefficient.

2.8 Application of statistical analysis to hypotheses

2.8.1 Preparation of data

Means and standard deviations were calculated for the interval study variables and modal ranges were identified for the categorical variables. Analysing data according to the different IAPT job roles (i.e. PWPs vs. HI Therapists) increased the utility of the research in making practical recommendations for preventing burnout.

In order to aid comparison between PWPs and HI Therapists, independent sample t-tests were performed using SPSS to investigate whether any statistically significant differences between the mean scores of each variable existed. The modal range of the awareness of IAPT targets variable was examined and a Mann-Whitney U test was calculated to test for any statistically significant differences between PWPs and HI Therapists.

The ‘hours providing clinical supervision’ and ‘hours providing case management supervision’ variables were collapsed into one variable measuring the total hours spent supervising staff per week (‘supervising staff’). The ‘hours of clinical
supervision received’ and ‘hours of case management supervision received’ were collapsed into one variable measuring the total number of supervision hours received per week (‘supervision received’). The resulting variables were more meaningful and appropriate for statistical analysis.

2.8.2 Hypothesis 1a: There will be a substantial prevalence of burnout in PWPs, HI therapists and Counsellors.

The data was prepared using SPSS to reverse the appropriate items on the OLBI. The mean scores of the OLBI subscales were calculated and categorised into one of four groups as specified by Peterson, Demerouti, et al. (2008):

- Burnout (disengagement cut-off scores ≥2.10, exhaustion cut-off scores ≥2.25).
- Disengagement (disengagement cut-off scores ≥2.10, exhaustion cut-off scores <2.25).
- Exhaustion (disengagement cut-off scores <2.10, exhaustion cut-off scores ≥2.25).
- Below cut-off (disengagement cut-off scores of <2.10, exhaustion cut-off scores <2.25).

A binary variable which indicated whether the participant had experienced burnout or not by collapsing the Disengagement, Exhaustion and Below cut-off groups was created. This procedure was applied to the total sample, PWPs and HI Therapists to enable the prevalence of burnout to be estimated. A Pearson’s Chi-squared calculation was performed to assess for statistically significant differences between the proportions of each group in the total sample, PWPs and HI Therapists.
2.8.3 Hypothesis 1b: Burnout in IAPT workers will be related to job role, age, gender, years of experience and length of time worked in the IAPT service.

The 'burnout' category created for hypothesis 1a was a binary dependent variable. Therefore to model the probability of burnout logistic regression models were fitted with the independent predictor variables: job role, age, gender, years worked for IAPT service and MH work experience. This analysis was performed for the total sample, PWPs and HI Therapists.

2.8.4 Hypothesis 2a: Greater job demands will be associated with greater levels of exhaustion.

Scatterplots illustrated the relationship between the job demands variables and exhaustion. Each was examined for the influence of outliers and whether or not there was a linear relationship between the two variables. Pearson’s correlation coefficient were calculated and appropriate hypothesis tests conducted to analyse whether any statistically significant relationships were present between the 14 job demand variables and mean scores of exhaustion. Spearman’s Rho correlation coefficients were calculated for the ‘awareness of targets’ variable that contained ordinal data and violated the assumptions of a parametric test (Howitt & Cramer, 2011). The analysis was conducted on the total sample, PWPs and HI Therapists. For theoretical reasons and due to the statistically significant effect of years worked in the IAPT service on PWPs, further analysis was conducted using General Linear Modelling to examine whether years worked in the IAPT service moderated the relationship between each job demand variable and exhaustion (i.e. did the associations between job demands and exhaustion become stronger as time in the service increased).
2.8.5 Hypothesis 2b: Job demands will be associated with exhaustion but not disengagement.

The statistical analyses outlined for hypotheses 2a were applied with disengagement as the dependent variable.

2.8.6 Hypothesis 3a: A lack of job resources will be associated with greater levels of disengagement.

An identical statistical method to that of Hypothesis 2a was applied with the seven job resource independent variables and disengagement as the dependent variable.

2.8.7 Hypothesis 3b: Job resources will be associated with disengagement but not exhaustion.

An identical statistical method to that of Hypothesis 2b was applied with the seven job resource independent variables and exhaustion as the dependent variable.

2.9 Qualitative Analysis

2.9.1 Hypothesis 2b and 3b

Data derived from the three open-ended items of the questionnaire was analysed to verify that the quantitative measures used in the present study adequately captured the job demands and resources. Participants were allowed a maximum response of 200 characters to each item. Thus, a qualitative approach with a ‘small q’ was adopted in the present study without intending to conduct a full and in-depth qualitative analysis or change the nature of the research from deductive to inductive (Kidder & Fine, 1987).
Content analysis (Berelson, 1984) can be applied to qualitative or quantitative data, often links these approaches (Breakwell, Smith & Wright, 2012) and is used alongside or to supplement the quantitative data. The data in the present study was classified into codes which led to the construction of master themes. A quantitative approach was applied to comment on the frequency of the themes according to guidelines described by Marks and Yardley (2004) and Breakwell et al. (2012). A credibility check was performed by an independent researcher of approximately 10% of the data and certain codes were amended accordingly.
3.0 RESULTS

3.1 Data screening

3.1.1 Missing data

As indicated in section 2.2.1, the final sample included 202 participants. One Counsellor remained in the total sample. Due to issues with anonymity, this participant was added to the HI Therapist sample. There were 20 missing data values for the desk difficulties variable resulting in a sample size of 182 for this variable and one missing data value for the clinical space difficulties variable resulting in a sample size of 201 for this variable.
### 3.2 Description of the sample

#### Table 1

*Summary of participant demographics*

<table>
<thead>
<tr>
<th>Demographic category</th>
<th>Total sample (%)</th>
<th>PWPs (% of PWP sample)</th>
<th>HI Therapists (% of HI Therapist sample)</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>202 (100)</td>
<td>105 (100)</td>
<td>97 (100)</td>
<td></td>
</tr>
</tbody>
</table>

**Gender**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>165 (82)</td>
<td>90 (86)</td>
<td>75 (77)</td>
<td>.123</td>
</tr>
<tr>
<td>Male</td>
<td>37 (18)</td>
<td>15 (14)</td>
<td>22 (23)</td>
<td></td>
</tr>
</tbody>
</table>

**Age group**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>79 (39)</td>
<td>65 (62)</td>
<td>14 (14)</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>54 (27)</td>
<td>20 (19)</td>
<td>34 (35)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>40-49</td>
<td>44 (22)</td>
<td>14 (13)</td>
<td>30 (31)</td>
<td></td>
</tr>
<tr>
<td>50+</td>
<td>25 (12)</td>
<td>6 (6)</td>
<td>19 (20)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

**Years of MH Work experience**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>152 (75)</td>
<td>93 (89)</td>
<td>59 (61)</td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td>35 (17)</td>
<td>11 (10)</td>
<td>24 (25)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>20+</td>
<td>15 (7)</td>
<td>1 (1)</td>
<td>14 (14)</td>
<td></td>
</tr>
</tbody>
</table>

**Length of time worked in IAPT service.**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD)</td>
<td>2.1 (1.1)</td>
<td>1.8 (1.1)</td>
<td>2.5 (1.0)</td>
<td></td>
</tr>
<tr>
<td>&lt; 2 years</td>
<td>66 (33)</td>
<td>49 (47)</td>
<td>17 (18)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>≥ 2 years</td>
<td>136 (67)</td>
<td>56 (53)</td>
<td>80 (82)</td>
<td></td>
</tr>
</tbody>
</table>

**Ethnicity**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
<th>P-value$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>153 (76)</td>
<td>80 (76)</td>
<td>73 (75)</td>
<td>.877</td>
</tr>
<tr>
<td>Other</td>
<td>49 (24)</td>
<td>25 (24)</td>
<td>24 (25)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: SD= Standard Deviation

$^a$ Pearson's Chi-square test of independence to test for statistically significant differences between PWP and HI Therapist samples.
As shown in Table 1, PWPs and HI Therapists each represented approximately half of the sample.

3.2.1 Gender

The majority of participants were female and there was no statistically significant difference between the gender proportions of PWPs and HI Therapists ($\chi^2 (1) = 2.4, p=0.123$).

3.2.2 Age

Age was displayed according to groups of ten years in order to protect participant anonymity (this was identified as a particular issue in participant emails addressed to the researcher during data collection). The modal age range was 20-29 years for PWPs and 30-39 years for HI Therapists. A statistically significant association was found between job role and the proportions of different age ranges of participants ($\chi^2 (3) = 48.9, p<0.001$). Over 60% of PWPs were in the 20-29 age group compared to only 14% of HI Therapists. Over a third of HI Therapists were in the 30-39 age group compared to only 19% of PWPs. There were 31% of HI Therapists in the 40-49 age group compared to 13% of PWPs and 20% of HI Therapists in the 50 years or more age group compared to 6% of PWPs.

3.2.3 Years of MH work experience

The modal range for years of mental health experience was 0-9 years for the total sample including the PWP and HI Therapist samples. A statistically significant association was found between job role and the participant’s MH work experience ($\chi^2 (2) = 23.4, p<0.001$). Nearly 90% of PWPs were in the 0-9 years of MH Work experience group compared to 61% of HI Therapists. There were 25% of HI Therapists in the 10-19 years of MH Work experience group compared to 10% of
PWPs and 14% of HI Therapists in the 20 years or more MH Work experience group compared to 1% of PWPs.

3.2.4 Length of time worked in the IAPT service

The majority of the total sample had worked in the IAPT service for two or more years. A statistically significant association was found between job role and whether or not participants had worked for the IAPT service less than two years or two or more years $\chi^2 (1) = 19.5$, $p<.001$. Nearly 50% of PWPs had worked in the IAPT service for less than two years compared to 18% of HI Therapists. Over 80% of HI Therapists had worked in the IAPT service for two years or more compared to 53% of PWPs.

3.2.5 Ethnicity

The majority of participants were of White British ethnic origin across the total sample and within the PWP and HI Therapist sample. There was no statistically significant difference between the proportions of PWPs or HI Therapists of White British or Other ethnic origins ($\chi^2 (1) = 0.24$, $p=.877$).

3.3 Preliminary data analysis

During preparation of the variables for statistical analyses, four variables were collapsed into two variables. Table 2 displays descriptive statistics for the exhaustion, disengagement, job demands and job resources variables (apart from the awareness of targets variables which is described below).
Table 2

Descriptive statistics of study variables for the total sample, PWPs and HI Therapists

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total sample (n=202)</th>
<th>PWP (n=105)</th>
<th>HI Therapist (n=97)</th>
<th>P-value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Exhaustion&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.6</td>
<td>0.6</td>
<td>2.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Disengagement</td>
<td>2.3</td>
<td>0.5</td>
<td>2.4</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Job demands</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseload (no. of patients)</td>
<td>31.9</td>
<td>18.1</td>
<td>41.4</td>
<td>19.6</td>
</tr>
<tr>
<td>MHPSS Workload&lt;sup&gt;c&lt;/sup&gt;</td>
<td>2.4</td>
<td>0.8</td>
<td>2.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Overtime (hours)</td>
<td>2.4</td>
<td>2.5</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>MHPSS Home-work conflict</td>
<td>1.7</td>
<td>0.6</td>
<td>1.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Patient contact (hours)</td>
<td>20.6</td>
<td>7.4</td>
<td>22.2</td>
<td>8.4</td>
</tr>
<tr>
<td>Telephone contact (hours)</td>
<td>5.8</td>
<td>7.6</td>
<td>10.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Face-to-face contact (hours)</td>
<td>13.9</td>
<td>7.6</td>
<td>10.7</td>
<td>8.2</td>
</tr>
<tr>
<td>Group contact (hours)</td>
<td>1.4</td>
<td>2.7</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Supervising staff (hours)</td>
<td>1.0</td>
<td>1.9</td>
<td>0.63</td>
<td>1.7</td>
</tr>
<tr>
<td>Mild-moderate difficulties (% of patients)</td>
<td>49.6</td>
<td>24.6</td>
<td>57.5</td>
<td>22.8</td>
</tr>
<tr>
<td>Moderate-severe difficulties (% of patients)</td>
<td>45.9</td>
<td>25.1</td>
<td>37.3</td>
<td>22.0</td>
</tr>
<tr>
<td>MHPSS Client-related difficulties</td>
<td>1.8</td>
<td>0.5</td>
<td>1.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Inputting data (hours)</td>
<td>9.9</td>
<td>4.6</td>
<td>9.8</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Job resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHPSS Organisational issues</td>
<td>2.0</td>
<td>0.8</td>
<td>2.1</td>
<td>0.8</td>
</tr>
<tr>
<td>MHPSS Relationship &amp; conflicts</td>
<td>1.5</td>
<td>0.5</td>
<td>1.6</td>
<td>0.5</td>
</tr>
<tr>
<td>MHPSS Professional self-doubt</td>
<td>2.0</td>
<td>0.6</td>
<td>2.1</td>
<td>0.7</td>
</tr>
<tr>
<td>MHPSS Lack of resources</td>
<td>2.0</td>
<td>0.7</td>
<td>2.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Clinical space difficulties&lt;sup&gt;d&lt;/sup&gt; (per week)</td>
<td>1.3</td>
<td>2.2</td>
<td>1.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Desk difficulties&lt;sup&gt;e&lt;/sup&gt; (per week)</td>
<td>0.9</td>
<td>2.1</td>
<td>0.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Supervision received (hours)</td>
<td>1.5</td>
<td>2.2</td>
<td>1.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

<sup>a</sup>p-values of independent samples t-tests to assess for statistically significant differences between PWPs and HI Therapists, <sup>b</sup> range of mean scores for the OLBI exhaustion and disengagement scales = 1-4, <sup>c</sup> range of mean scores for each MHPSS subscale = 1-4, <sup>d</sup>n=201 for total sample, n=105 for PWPs, n=96 for HI Therapists, <sup>e</sup>n=182 for total sample, n=92 for PWPs, n=90 for HI Therapists
Table 2 allows for comparison between the mean of each variable for the total sample, PWPs and HI Therapists. PWPs showed statistically significantly higher mean scores than HI Therapists on seven variables. These included the OLBI disengagement scale; number of patients on caseload; patient contact and telephone patient contact hours; percentage of patients with mild-moderate difficulties; number of difficulties accessing clinical space per week and hours of supervision received. HI Therapists showed statistically significantly higher mean scores than PWPs on three variables. These included face-to-face contact hours, supervising staff hours, and a higher percentage of patients with moderate-severe difficulties. One ordinal data variable, the Awareness of targets, was measured using a Likert scale ranging from 1 to 5. For the total sample and PWPs the median was 3 (moderately aware) and for HI Therapists the median was 4 (very aware). A Mann-Whitney U test was performed to assess for a statistically significant difference between PWP and HI Therapist awareness of IAPT targets and a statistically significant difference was found between the two groups (p=.034).

3.4 Results relating to study hypotheses

3.4.1 Hypothesis 1a: There will be a substantial prevalence of burnout in PWPs and HI therapists in IAPT services.

Table 3 displays the number of participants and percentage of the total, PWP and HI Therapists samples assigned to the categories of Below cut-off, Disengagement, Exhaustion and Burnout.
Table 3

Frequency of burnout groups in Peterson, Demerouti, et al. (2008) and the present study

<table>
<thead>
<tr>
<th>Sample (%)</th>
<th>n</th>
<th>BC</th>
<th>D</th>
<th>E</th>
<th>B</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterson et al.⁵</td>
<td>3719</td>
<td>1302 (35.0)</td>
<td>469 (12.6)</td>
<td>697 (18.7)</td>
<td>1251 (33.6)</td>
<td>32.1, 35.2</td>
</tr>
<tr>
<td>Present study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total sample</td>
<td>202</td>
<td>36   (17.8)</td>
<td>20 (9.9)</td>
<td>25 (12.5)</td>
<td>121 (59.9)</td>
<td>52.8, 66.7</td>
</tr>
<tr>
<td>PWP</td>
<td>105</td>
<td>18   (17.1)</td>
<td>7 (6.7)</td>
<td>8 (7.6)</td>
<td>72 (68.6)</td>
<td>58.8, 77.3</td>
</tr>
<tr>
<td>HI Therapist</td>
<td>97</td>
<td>18   (18.6)</td>
<td>13 (13.4)</td>
<td>17 (17.5)</td>
<td>49 (50.5)</td>
<td>40.2, 60.8</td>
</tr>
<tr>
<td>P-value⁶</td>
<td>.793</td>
<td>.109</td>
<td>.033</td>
<td>.009</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: BC= Below Cut-off, D= Disengagement, E=Exhaustion, B=Burnout, CI=Confidence Interval for percentage experiencing burnout.

⁵ Peterson, Demerouti, et al. (2008), ⁶ Pearson’s chi-square test of independence of difference between PWP and HI Therapist groups.

Over half of the total sample was assigned to the burnout group with 95% confidence intervals for the true prevalence of burnout being between 53% and 67%. There was a statistically significant difference between the proportions of PWP (approximately two thirds) and HI Therapists (approximately half) located in the Burnout group ($\chi^2 (1) = 6.84$, $p=.009$). In comparison to the Peterson, Demerouti, et al. (2008) study, the percentage of participants in the Burnout group from the total sample in the present study was almost double.
Figure 1. Scatterplot of exhaustion and disengagement mean scores with intercept lines representing the mean cut-off scores for determining each of the four groups: Below cut-off, Exhaustion, Disengagement and Burnout.

Figure 1 displays the relationship between the mean scores of exhaustion and disengagement and visually illustrates their spread across the four groups. A positive linear relationship can be seen between the exhaustion and disengagement scores suggesting that they are associated with each other rather than independent.

A Pearson’s correlation coefficient calculation was calculated. Exhaustion and disengagement were statistically significantly and positively correlated with a large effect size for the total sample ($r=.69$, $p<.001$), PWP's ($r=.68$, $p<.001$) and HI therapists ($r=.68$, $p<.001$).
3.4.2 Hypothesis 1b: Burnout in IAPT workers will be related to job role, age, gender, years of experience and length of time worked in the IAPT service

Logistic regression models were fitted to assess the relationship between age, gender, years worked for IAPT service and years of MH work experience as predictor variables and burnout as the binary dependent variable (generated from hypothesis 1a). Assumptions for multicollinearity were checked by assessing the tolerance and VIF values and there was no evidence of multicollinearity. Two sets of models were fitted. One examined the relationship between each variable separately and burnout (unadjusted analysis) and the other examined the effect of each of the predictors adjusting for the effect of the other predictors (adjusted analysis).

For the total sample, Table 4 shows similar percentages of burnout (around 60-65%) in all age groups apart from the 40-49 year age group where the percentage was lower (40%). Results from the unadjusted logistic regression modelling showed that the odds of burnout in the 40-49 year age group were significantly lower relative to the other age groups. However when the other predictors were adjusted for, this was no longer statistically significant. Tables 5 and 6 show a similar pattern across age groups in both PWP and HI therapists but the differences were not statistically significant.

Table 4 shows that job role was a significant predictor of burnout in the adjusted and unadjusted analyses. PWP were almost two and a half times more likely to experience burnout than HI Therapists. Length of time worked in the IAPT service was a statistically significant predictor of burnout when the other predictors were adjusted for. The percentage of participants with burnout was around eight per cent higher in those who had worked in IAPT services for two or more years. Participants who had worked in the IAPT service for two or more years were twice as likely to experience burnout than those who had worked for less than two years. The full model containing all predictors for the total sample was statistically significant ($\chi^2 (8, n=202) = 19.42, p=.013$), explained between 9.2% (Cox & Snell R squared) and 12.4% (Nagelkerke R squared) of the variance in burnout, and correctly classified 65.8% of cases. Tables 5 and 6 show that this pattern was much more pronounced for
PWPs where the odds of burnout after two or more years was 2.75 relative to those who had worked in IAPT for less than two years. After adjusting for the other predictors this increased to 3.86. For PWPs, the full model containing all predictors was statically significant ($\chi^2 (6, n=105) = 13.22, p=.040$), explained between 11.8% (Cox & Snell R square) and 16.6% of the variance in burnout, and correctly classified 70.5% of cases. For HI therapists there were no predictors of burnout ($\chi^2 (7, n=97) = 4.69, p=.698$).
Table 4

*Unadjusted and adjusted logistic regression analyses of five predictor variables on the likelihood of burnout in the total sample (n=202).*

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis</th>
<th>Adjusted analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Job role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HI Therapist</td>
<td>52/79 (65.8)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PWP</td>
<td>2.45</td>
<td>1.20, 4.98</td>
<td>.014</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>52/79 (65.8)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>35/54 (64.8)</td>
<td>0.96</td>
<td>0.46, 2.00</td>
</tr>
<tr>
<td>40-49</td>
<td>19/44 (43.2)</td>
<td>0.40</td>
<td>0.19, 0.84</td>
</tr>
<tr>
<td>50+</td>
<td>15/25 (60)</td>
<td>0.78</td>
<td>0.31, 2.00</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>103/165 (62.4)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>18/37 (48.6)</td>
<td>0.57</td>
<td>0.28, 1.17</td>
</tr>
<tr>
<td>Years of MH work Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>95/152 (62.5)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td>19/35 (54.3)</td>
<td>0.71</td>
<td>0.34, 1.50</td>
</tr>
<tr>
<td>20+</td>
<td>7/15 (46.7)</td>
<td>0.53</td>
<td>0.18, 1.53</td>
</tr>
<tr>
<td>Years worked in IAPT service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2 years</td>
<td>36/66 (54.5)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>≥2 years</td>
<td>85/136 (62.5)</td>
<td>1.39</td>
<td>0.77, 2.52</td>
</tr>
</tbody>
</table>

*Note: CI= Confidence Interval*
Table 5

Unadjusted and adjusted logistic regression analyses of four predictor variables on the likelihood of burnout in PWP (n=105).

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis</th>
<th>Adjusted analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio 95% CI</td>
<td>P value</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>44/65 (67.7)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>15/20 (75.0)</td>
<td>1.43 0.46, 4.47 .536</td>
<td>.056</td>
</tr>
<tr>
<td>40-49</td>
<td>8/14 (57.1)</td>
<td>0.64 0.20, 2.07 .453</td>
<td>.056</td>
</tr>
<tr>
<td>50+</td>
<td>5/6 (83.3)</td>
<td>2.39 0.26, 21.73 .440</td>
<td>.056</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>64/90 (71.1)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>8/15 (53.3)</td>
<td>0.46 0.15, 1.41 .176</td>
<td>.056</td>
</tr>
<tr>
<td>Years of MH work experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>65/93 (69.9)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10+</td>
<td>7/12 (58.3)</td>
<td>0.60 0.18, 2.06 .420</td>
<td>.056</td>
</tr>
<tr>
<td>Years worked in IAPT service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 2 years</td>
<td>28/49 (57.1)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>≥ 2 years</td>
<td>44/56 (78.6)</td>
<td>2.75 1.17, 6.45 .020</td>
<td>.056</td>
</tr>
</tbody>
</table>

Note: CI= Confidence Interval
<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis</th>
<th>Adjusted analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>18/14 (57.1)</td>
<td>0.30, 3.78</td>
<td>.915</td>
</tr>
<tr>
<td>30-39</td>
<td>20/34 (58.8)</td>
<td>1.07</td>
<td>0.93</td>
</tr>
<tr>
<td>40-49</td>
<td>11/30 (36.7)</td>
<td>0.43</td>
<td>0.37</td>
</tr>
<tr>
<td>50+</td>
<td>10/19 (52.6)</td>
<td>0.83</td>
<td>0.70</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>39/75 (52.0)</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>10/22 (45.5)</td>
<td>0.30, 2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years of MH work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience</td>
<td>0-9</td>
<td>13/24 (54.2)</td>
<td>1.14</td>
</tr>
<tr>
<td></td>
<td>10-19</td>
<td>6/14 (42.9)</td>
<td>0.73</td>
</tr>
<tr>
<td></td>
<td>20+</td>
<td>8/17 (47.1)</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>&lt;2 years</td>
<td>4/180 (51.2)</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>&gt;=2 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CI = Confidence Interval
3.4.3 Hypothesis 2a: Greater job demands will be associated with greater levels of exhaustion

Correlation coefficients were calculated for the range of variables measuring job demands against exhaustion and are shown in Table 7. Cohen (1988) suggests cut-offs for a small effect size of .1 to .29; a medium effect size of .3 to .49, and a large effect size of .5 to 1.0.

Table 7

*Pearson’s correlation coefficient of associations between job demand variables and exhaustion and disengagement*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total sample</th>
<th>PWP</th>
<th>HI Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>n</td>
<td>202</td>
<td>202</td>
<td>105</td>
</tr>
<tr>
<td>Caseload</td>
<td>.16***</td>
<td>.25*</td>
<td>.10</td>
</tr>
<tr>
<td>Workload</td>
<td>.70*</td>
<td>.58*</td>
<td>.72*</td>
</tr>
<tr>
<td>Overtime</td>
<td>.27*</td>
<td>.17***</td>
<td>.41*</td>
</tr>
<tr>
<td>Home-work conflict</td>
<td>.64*</td>
<td>.49*</td>
<td>.65*</td>
</tr>
<tr>
<td>Patient contact</td>
<td>.33*</td>
<td>.33*</td>
<td>.33**</td>
</tr>
<tr>
<td>Telephone contact</td>
<td>.22**</td>
<td>.21**</td>
<td>.19***</td>
</tr>
<tr>
<td>Face-to-face contact</td>
<td>.07</td>
<td>.08</td>
<td>.09</td>
</tr>
<tr>
<td>Group contact</td>
<td>.12</td>
<td>.14***</td>
<td>-.01</td>
</tr>
<tr>
<td>Supervising staff</td>
<td>-.07</td>
<td>-.12</td>
<td>.00</td>
</tr>
<tr>
<td>Mild-mod difficulties</td>
<td>-.01</td>
<td>-.03</td>
<td>-.05</td>
</tr>
<tr>
<td>Mod-severe difficulties</td>
<td>.11</td>
<td>.06</td>
<td>.19***</td>
</tr>
<tr>
<td>Client-related difficulties</td>
<td>.46*</td>
<td>.44*</td>
<td>.48*</td>
</tr>
<tr>
<td>Inputting data</td>
<td>.19**</td>
<td>.11</td>
<td>.28**</td>
</tr>
<tr>
<td>Awareness of targetsa</td>
<td>-.17***</td>
<td>-.13</td>
<td>-.17</td>
</tr>
</tbody>
</table>

*Note: E= Exhaustion, D= Disengagement

*a* Spearman’s Rho Correlation Coefficient was calculated.

* p<.001, **p<.01, ***p≤.05
As shown in Table 7, for the total sample, nine of the job demand measures were statistically significantly and positively correlated with exhaustion. Workload and home-work conflict showed a large effect size; client-related difficulties and patient contact showed a medium effect size, and overtime, telephone contact, inputting data and caseload showed a small effect size. Awareness of targets was statistically significantly and negatively correlated with exhaustion with a small effect size. Due to the overlap between certain items of the MHPSS and OLBI (see Section 2.5.2), the results from the correlations between the workload and home-work conflict and exhaustion might have been inflated due to the measurement of similar constructs.

### 3.4.4 Moderating effects of time worked in the service

The results of the logistic regression modelling shown in Table 5 suggest that the length of time worked in an IAPT service was a statistically significant predictor of burnout in PWPs. In addition, the literature suggests that the negative impact of job demands are more likely to manifest after some time. Therefore Pearson’s correlation coefficients stratified by time worked in the service were calculated to assess the relationship between the job demands variables and exhaustion. A general linear model was fitted to assess whether the length of time a PWP had worked in the IAPT service moderated the relationship between job demands variables and exhaustion.
Table 8

Pearson’s correlation coefficients of the relationships between job demands and exhaustion and disengagement and a test of the moderating effects of length of time PWPs had worked in the IAPT service on these relationships

<table>
<thead>
<tr>
<th>Variable</th>
<th>&lt;2 Years (n=49)</th>
<th>≥2 Years (n=56)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>Caseload</td>
<td>.22</td>
<td>.25</td>
<td>-.03</td>
</tr>
<tr>
<td>Workload</td>
<td>.69*</td>
<td>.56*</td>
<td>.76*</td>
</tr>
<tr>
<td>Overtime</td>
<td>.31***</td>
<td>.10</td>
<td>.44**</td>
</tr>
<tr>
<td>Home-work conflict</td>
<td>.56*</td>
<td>.39**</td>
<td>.71*</td>
</tr>
<tr>
<td>Patient contact</td>
<td>.30***</td>
<td>.18</td>
<td>.33***</td>
</tr>
<tr>
<td>Telephone contact</td>
<td>.14</td>
<td>-.03</td>
<td>.27***</td>
</tr>
<tr>
<td>Face-to-face contact</td>
<td>.13</td>
<td>.26</td>
<td>.03</td>
</tr>
<tr>
<td>Group contact</td>
<td>-.09</td>
<td>-.22</td>
<td>.03</td>
</tr>
<tr>
<td>Supervising staff</td>
<td>.29***</td>
<td>.12</td>
<td>-.18</td>
</tr>
<tr>
<td>Mild-mod difficulties</td>
<td>.08</td>
<td>.04</td>
<td>-.17</td>
</tr>
<tr>
<td>Mod-severe difficulties</td>
<td>.21</td>
<td>.06</td>
<td>.17</td>
</tr>
<tr>
<td>Client-related difficulties</td>
<td>.39**</td>
<td>.30***</td>
<td>.51*</td>
</tr>
<tr>
<td>Inputting data</td>
<td>.30***</td>
<td>.19</td>
<td>.26***</td>
</tr>
<tr>
<td>Awareness of targets^</td>
<td>-.18</td>
<td>-.04</td>
<td>-.17</td>
</tr>
</tbody>
</table>

Note: E= Exhaustion, D= Disengagement

^ Spearman’s Rho Correlation Coefficient was calculated, b, c p-value for moderating effect of length of time worked in IAPT service on the association between the job demands variable and exhaustion/disengagement.

* p<.001, **p<.01, ***p<.05

Table 8 shows that the association between workload and exhaustion increased and the association between supervising staff and exhaustion decreased the longer a PWP worked in the IAPT service.
3.4.5 Qualitative Analysis

3.4.5a Content Analysis of Job Demands

There were 202 responses to the question asking participants to identify aspects of their roles as IAPT workers that they perceived as demanding and impacted on their wellbeing. Having read through the data, 22 codes were generated that led to the development of four master themes (see Appendix O for an example of the data and the rules of all codes and master themes). Quotes to support each master theme and their frequencies are described below

Management/structural pressures

Any responses related to the management style, pressure exerted from management and service protocols, design and delivery of service were coded as 'management/structural pressures'.

Participant (P)1: ‘Juggling targets, administration and general duties.’

This theme was coded 172 times and represented 67.2% of the total 256 coded themes.

Training and development

All responses that were associated with work-based training or continuing personal and professional development were coded within this theme.

P2: ‘Being constricted to using only certain models and not being supported in expanding psychological skills in working with clients.’

The training and development theme was coded 21 times and represented 8.2% of the total content.
Emotional impact

This theme related to any statements participants made about the personal impact of their work on their wellbeing.

P3: ‘Feeling robotic in that clients are seen back to back without time to debrief or unwind from one client to the next.’

The emotional impact theme was coded 32 times and represented 12.5% of the content.

Patient issues

Responses that were related to the patient or the patient work were coded in this theme.

P4: ‘Seeing many clients who do not seem to fit IAPT disorders and who do not seem appropriate for therapy.’

The patient issues theme was coded 31 times and represented 12.1% of the content.

3.4.6 Hypothesis 2b: Job demands will be associated with exhaustion but not disengagement

The same process as hypothesis 2a was applied to correlating the job demands variables with disengagement and Table 7 displays the results. For the total sample, eight of the job demand measures were statistically significantly and positively correlated with disengagement. Workload showed a large effect size; patient contact, client-related difficulties and home-work conflict showed a medium effect size, and group contact, overtime, telephone contact and caseload showed a small effect size.
3.4.7 Moderating effects of time worked in the service

The longer a PWP had worked in the service, the larger the association of homework conflict and telephone contact with disengagement.

3.4.8 Hypothesis 3a: A lack of job resources will be associated with greater levels of disengagement

Table 9 displays the Pearson’s correlation coefficients for the seven job resources variables. There was one missing data entry for the clinical space difficulties variable.

Table 9

Pearson’s correlation coefficient of associations between job resources variables and disengagement and exhaustion

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total sample</th>
<th>PWPs</th>
<th>HI Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E D</td>
<td>E</td>
<td>D</td>
</tr>
<tr>
<td>n</td>
<td>202 202</td>
<td>105 105</td>
<td>97 97</td>
</tr>
<tr>
<td>Organisational issues</td>
<td>.55* .49*</td>
<td>.58* .52*</td>
<td>.53* .45*</td>
</tr>
<tr>
<td>Relationships and conflicts</td>
<td>.36* .36*</td>
<td>.40* .40*</td>
<td>.32** .31**</td>
</tr>
<tr>
<td>Self-doubt</td>
<td>.50* .53*</td>
<td>.42* .53*</td>
<td>.57* .51*</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>.44* .46*</td>
<td>.45* .51*</td>
<td>.41* .38*</td>
</tr>
<tr>
<td>Clinical space difficulties</td>
<td>.20** .25*</td>
<td>.19  .23***</td>
<td>.17  .25***</td>
</tr>
<tr>
<td>Desk difficulties(^a)</td>
<td>.13 .04</td>
<td>.08  .07</td>
<td>.19  .04</td>
</tr>
<tr>
<td>Supervision received</td>
<td>-.03 -.01</td>
<td>-.17 -.12</td>
<td>-.04 -.01</td>
</tr>
</tbody>
</table>

Note: E= Exhaustion, D=Disengagement.

\(^a\) n=201 for total sample, n= 96 for HI Therapists, \(^b\) n=182 for total sample, n=92 for PWP sample, n=90 for HI Therapist sample.

* p<.001, **p<.01, ***p≤.05
Table 9 shows the Pearson’s correlation coefficients for the total sample, PWPs and HI Therapists. For the total sample, five of the job resource variables were statistically significantly and positively correlated with disengagement. Self-doubt showed a large effect size; organisational issues, lack of resources and relationships and conflicts showed a medium effect size, and clinical space difficulties showed a small effect size.

**3.4.9 Moderating effects of time worked in the service**

As in hypothesis 2a, Table 10 displays the Pearson’s correlation coefficients performed to assess the relationship between the job resources variables and disengagement and to investigate the moderating effect of length of time worked in the IAPT service on this relationship.

Table 10

<table>
<thead>
<tr>
<th>Variable</th>
<th>&lt; 2 Years (n=49)</th>
<th>≥ 2 Years (n=56)</th>
<th>P-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>Organisational issues</td>
<td>.50*</td>
<td>.47**</td>
<td>.51*</td>
</tr>
<tr>
<td>Relationships &amp; conflicts</td>
<td>.23</td>
<td>.12</td>
<td>.45*</td>
</tr>
<tr>
<td>Self-doubt</td>
<td>.57*</td>
<td>.22</td>
<td>.49*</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>.56*</td>
<td>.31***</td>
<td>.46*</td>
</tr>
<tr>
<td>Clinical space difficulties</td>
<td>.49*</td>
<td>.27</td>
<td>.04</td>
</tr>
<tr>
<td>Desk difficulties^a</td>
<td>-.09</td>
<td>-.19</td>
<td>.20</td>
</tr>
<tr>
<td>Supervision received</td>
<td>-.15</td>
<td>-.24</td>
<td>-.09</td>
</tr>
</tbody>
</table>

*Note: E= Exhaustion, D= Disengagement*

^a n=42 for PWPs worked less than two years, n=50 for PWPs worked two years or more; ^b, ^c p-value for moderating effect of length of time worked in IAPT service on the association between the job resources variable and exhaustion/disengagement.

* p<.001, **p<.01, ***p≤.05
Table 10 shows that two job resource variables were statistically significantly associated with disengagement with a medium effect size for PWPs who had worked in the service for less than two years. For PWPs who had worked in the IAPT service for two years or more four job resource variables were statistically significantly associated with disengagement. Organisation issues showed a large effect size and relationships and conflicts, self-doubt and lack of resources showed a medium effect size.

The longer a PWP had worked in the service, the larger the association between the desk difficulties and disengagement.

3.4.10 Qualitative analysis

3.4.10a Content analysis of job resources

There were 202 responses to the open-ended item questioning which aspects of their job roles participants thought alleviated stress at work. Having read through the data, 14 codes were generated that led to the development of four master themes (see Appendix P for an example of the data and the rules of codes and master themes). Quotes to support each master theme and their frequencies are described below

Peer support

Any reference made to support from colleagues, either individually or as a team, was coded in this theme.

P5: ‘Good relationships with colleagues/good support.’

Peer support was coded 119 times out of 273 codes and represented 43.6% of the content.
Service-related Resources

Any responses that related to positive aspects of the job role that had been provided by the service to alleviate stress were coded in this theme.

P6: ‘I enjoy having additional duties in addition to the treatment and assessment of clients; e.g. supervising others, having supervision, being involved in community engagement projects’.

This theme was coded 127 times and represented 46.5% of the content.

Helping people

Any comments that related to patient work and the satisfaction or positive feedback gained from this was coded in this theme.

P7: ‘Satisfaction of working with people and being able to see them progress.’

This theme was coded 13 times and represented 4.8% of the content.

Absence of aspects relieving stress

Comments associated with a lack of any aspects of participant’s job role that alleviated stress were coded in this theme.

P8: ‘None, you need to de-stress in your own time’.

This theme was coded 14 times and represented 5.1% of the content.
3.4.11 Hypothesis 3b: Job resources will be associated with disengagement and not exhaustion

The same process as hypothesis 3a was applied to correlating the seven job resources variables with exhaustion and Table 9 displays the results. For the total sample, organisational issues and self-doubt showed a large effect size; lack of resources and relationships and conflicts showed a medium effect size, and clinical space difficulties showed a small effect size.

3.4.12 Moderating effects of time worked in the service

The association between clinical space difficulties and exhaustion decreased the longer a PWP worked in the IAPT service.

Overall, the results of hypotheses 2 and 3 did not support the dual processes of the JD-RM, namely that job demands relate to exhaustion and job resources relate to disengagement. The Pearson’s correlation coefficients calculated for Hypothesis 2b show that of the 14 job demand variables, seven of them were statically significantly related to exhaustion and disengagement. Equally, the Pearson’s correlation coefficients calculated for Hypothesis 3b show that five of the seven job resource variables were statistically significantly correlated with exhaustion and disengagement. The present study failed to find evidence to support the JD-RM.
3.5 Further analyses

3.5.1 Predicting burnout based on job characteristics, age, gender, years of MH work experience and length of time worked in the IAPT service.

The results of hypothesis 2b and 3b did not support the 'dual processes' of exhaustion and disengagement as proposed by the JD-RM. Therefore specific variables (not including the MHPSS subscales) representing the more objective job characteristics (both the job demand and resources variables measured from the 'Information about your job as an IAPT worker' section of the questionnaire) were selected from the results of hypothesis 2a and 3a according to whether they were statistically significantly related to exhaustion and/or disengagement for either the total sample, PWPs or HI Therapists. They were added to the logistic regression model fitted to examine hypothesis 1b. Models were fitted for the total sample, PWPs and HI Therapists. The caseload, face-to-face contact, telephone contact and group contact variables were not added to the adjusted analyses due to collinearity with the patient contact variable. The results are presented in Tables 11, 12 and 13.
Table 11
Unadjusted and adjusted logistic regression analyses for job characteristic variables to predict the likelihood of burnout in the total sample (n=202)

<table>
<thead>
<tr>
<th>Total sample Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis (n=202)</th>
<th>Adjusted analysis (n=201)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio 95% CI P-value</td>
<td>Odds Ratio 95% CI P-value</td>
</tr>
<tr>
<td>Job role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HI Therapist</td>
<td>52/79 (65.8)</td>
<td>1</td>
<td>1.05, 6.20 .039</td>
</tr>
<tr>
<td>PWP</td>
<td></td>
<td>2.55</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>35/54 (64.8)</td>
<td>.96 0.46, 2.00 .904</td>
<td>0.51, 3.28 .589</td>
</tr>
<tr>
<td>30-39</td>
<td>19/44 (43.2)</td>
<td>.40 0.19, 0.84 .016</td>
<td>0.17, 1.32 .150</td>
</tr>
<tr>
<td>40-49</td>
<td>15/25 (60)</td>
<td>.78 0.31, 2.00 .597</td>
<td>0.23, 3.15 .817</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>103/165 (62.4)</td>
<td>1</td>
<td>1.03, 1.03 .043</td>
</tr>
<tr>
<td>Male</td>
<td>18/37 (48.6)</td>
<td>.57 0.28, 1.17 .125</td>
<td>0.30, 1.61 .392</td>
</tr>
<tr>
<td>Years of MH work experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>95/152 (62.5)</td>
<td>1</td>
<td>1.00, 1.04 .039</td>
</tr>
<tr>
<td>10-19</td>
<td>19/35 (54.3)</td>
<td>.71 0.34, 1.50 .370</td>
<td>0.25, 1.64 .353</td>
</tr>
<tr>
<td>20+</td>
<td>7/15 (46.7)</td>
<td>.53 0.18, 1.53 .236</td>
<td>0.12, 2.17 .362</td>
</tr>
<tr>
<td>Years worked in IAPT service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 2 years</td>
<td>36/66 (54.5)</td>
<td>1</td>
<td>1.03, 1.03 .043</td>
</tr>
<tr>
<td>≥ 2 years</td>
<td>85/136 (62.5)</td>
<td>1.39 0.77, 2.52 .280</td>
<td>1.03, 4.66 .043</td>
</tr>
<tr>
<td>Job characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseload</td>
<td>1.02 1.00, 1.04 .039</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overtime hours</td>
<td>1.12 1.00, 1.27 .067</td>
<td>1.12 0.98, 1.29 .109</td>
<td></td>
</tr>
<tr>
<td>Patient contact hours</td>
<td>1.07 1.03, 1.12 .001</td>
<td>1.05 1.00, 1.10 .073</td>
<td></td>
</tr>
<tr>
<td>Face-to-face contact hours</td>
<td>1.01 0.98, 1.05 .583</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone contact hours</td>
<td>1.05 1.01, 1.20 .028</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group contact hours</td>
<td>1.02 0.92, 1.14 .704</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate-severe difficulties</td>
<td>1.01 1.00, 1.02 .298</td>
<td>1.01 1.00, 1.03 .101</td>
<td></td>
</tr>
<tr>
<td>Inputting data hours</td>
<td>1.03 0.97, 1.20 .299</td>
<td>1.02 0.95, 1.10 .600</td>
<td></td>
</tr>
<tr>
<td>Clinical space difficulties*</td>
<td>1.22 1.03, 1.44 .022</td>
<td>1.13 0.95, 1.35 .163</td>
<td></td>
</tr>
</tbody>
</table>

Note: CI = Confidence Interval
*n=201 due to one missing data entry.
Table 12
Unadjusted and adjusted logistic regression analyses for job characteristic variables to predict the likelihood of burnout in PWPs (n=105)

<table>
<thead>
<tr>
<th>PWP Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis (n=105)</th>
<th>Adjusted analysis (n=105)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>44/65 (67.7)</td>
<td>1</td>
<td>0.46, 4.47</td>
</tr>
<tr>
<td>30-39</td>
<td>15/20 (75.0)</td>
<td>1.43</td>
<td>0.20, 2.07</td>
</tr>
<tr>
<td>40-49</td>
<td>8/14 (57.1)</td>
<td>.64</td>
<td>0.26, 2.173</td>
</tr>
<tr>
<td>50+</td>
<td>5/6 (83.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>64/90 (71.1)</td>
<td>1</td>
<td>0.15, 1.41</td>
</tr>
<tr>
<td>Male</td>
<td>8/15 (53.3)</td>
<td>.46</td>
<td></td>
</tr>
<tr>
<td>Years of MH work experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-9</td>
<td>65/93 (69.9)</td>
<td>1</td>
<td>0.18, 2.06</td>
</tr>
<tr>
<td>10-19</td>
<td>7/12 (58.3)</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>Years worked in IAPT service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2 years</td>
<td>28/49 (57.1)</td>
<td>1</td>
<td>1.17, 6.45</td>
</tr>
<tr>
<td>≥2 years</td>
<td>44/56 (78.6)</td>
<td>2.75</td>
<td></td>
</tr>
<tr>
<td>Job characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseload</td>
<td>1.01</td>
<td>0.10, 1.03</td>
<td></td>
</tr>
<tr>
<td>Overtime hours</td>
<td>1.60</td>
<td>1.20, 2.12</td>
<td></td>
</tr>
<tr>
<td>Patient contact hours</td>
<td>1.08</td>
<td>1.02, 1.14</td>
<td></td>
</tr>
<tr>
<td>Face-to-face contact hours</td>
<td>1.06</td>
<td>1.00, 1.12</td>
<td></td>
</tr>
<tr>
<td>Telephone contact hours</td>
<td>1.02</td>
<td>0.97, 1.07</td>
<td></td>
</tr>
<tr>
<td>Group contact hours</td>
<td>0.91</td>
<td>0.70, 1.18</td>
<td></td>
</tr>
<tr>
<td>Moderate-severe difficulties</td>
<td>1.03</td>
<td>1.00, 1.05</td>
<td></td>
</tr>
<tr>
<td>Inputting data hours</td>
<td>1.22</td>
<td>1.01, 1.24</td>
<td></td>
</tr>
<tr>
<td>Clinical space difficulties</td>
<td>1.16</td>
<td>0.94, 1.43</td>
<td></td>
</tr>
</tbody>
</table>

Note: CI= Confidence Interval
Table 13
Unadjusted and adjusted logistic regression analyses for job characteristic variables to predict the likelihood of burnout in HI Therapists (n=97)

<table>
<thead>
<tr>
<th>HI Therapist Predictor variable</th>
<th>Prevalence of Burnout (%)</th>
<th>Unadjusted analysis (n=97)</th>
<th>Adjusted analysis (n=96)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Age 20-29</td>
<td>8/14 (57.1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20/34 (58.8)</td>
<td>1.07</td>
<td>0.30, 3.78</td>
</tr>
<tr>
<td></td>
<td>11/30 (36.7)</td>
<td>.43</td>
<td>0.12, 1.58</td>
</tr>
<tr>
<td></td>
<td>10/19 (52.6)</td>
<td>.83</td>
<td>0.21, 3.35</td>
</tr>
<tr>
<td>Gender Female</td>
<td>39/75 (52.0)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10/22 (45.5)</td>
<td>.77</td>
<td>0.30, 2.00</td>
</tr>
<tr>
<td>Years of Mental Health Experience 0-9</td>
<td>30/59 (50.8)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13/24 (54.2)</td>
<td>1.14</td>
<td>0.44, 2.96</td>
</tr>
<tr>
<td></td>
<td>6/14 (42.9)</td>
<td>.73</td>
<td>0.22, 2.35</td>
</tr>
<tr>
<td>Years worked in IAPT service &lt; 2 years</td>
<td>8/17 (47.1)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>41/80 (51.2)</td>
<td>1.18</td>
<td>0.42, 3.37</td>
</tr>
<tr>
<td>Job characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseload</td>
<td>1.00</td>
<td>0.95, 1.06</td>
<td>.879</td>
</tr>
<tr>
<td>Overtime hours</td>
<td>1.01</td>
<td>0.88, 1.16</td>
<td>.904</td>
</tr>
<tr>
<td>Patient contact hours</td>
<td>1.04</td>
<td>0.96, 1.11</td>
<td>.344</td>
</tr>
<tr>
<td>Face-to-face contact hours</td>
<td>1.03</td>
<td>0.94, 1.11</td>
<td>.550</td>
</tr>
<tr>
<td>Telephone contact hours</td>
<td>1.23</td>
<td>0.91, 1.65</td>
<td>.177</td>
</tr>
<tr>
<td>Group contact hours</td>
<td>1.02</td>
<td>0.91, 1.14</td>
<td>.736</td>
</tr>
<tr>
<td>Moderate-severe difficulties</td>
<td>1.01</td>
<td>0.99, 1.02</td>
<td>.458</td>
</tr>
<tr>
<td>Inputting data hours</td>
<td>0.97</td>
<td>0.89, 1.06</td>
<td>.516</td>
</tr>
<tr>
<td>Clinical space difficulties</td>
<td>1.25</td>
<td>0.95, 1.62</td>
<td>.106</td>
</tr>
</tbody>
</table>

Note: CI = Confidence Interval
* n=96 due to one missing data entry.
Table 11 shows that for the total sample, number of patients on caseload, patient contact hours, telephone contact hours and number of clinical space difficulties were all statistically significant individual predictors of burnout. However when adjusting for the other predictors in the model, only job role (being a PWP) and working for two or more years in the IAPT service remained a statistically significant predictor of burnout. The model containing all predictors was statistically significant ($\chi^2 (13, n=201) = 36.63, p<.001$), explained between 16.7% (Cox & Snell R squared) and 22.5% (Nagelkerke R squared) of the variance in burnout, and correctly classified 66.2% of cases.

For PWPs, working for two years or more in the IAPT service, overtime hours, patient contact hours, moderate-severe patient difficulties and inputting data hours were statistically significant predictors of burnout. However when the other predictors were adjusted for, only working for two years or more in the IAPT service and overtime hours remained statistically significant predictors of burnout. The model containing all predictors was statistically significant ($\chi^2 (11, n=105) = 32.90, p<.001$), explained between 26.9% (Cox & Snell R squared) and 37.8% (Nagelkerke R squared) of the variance in burnout, and correctly classified 80.0% of cases.

There were no statistically significant predictors of burnout for HI Therapists ($\chi^2 (12, n=96) = 8.51, p=.744$).
4.0 DISCUSSION

4.1 Summary of the findings

4.1.1 Hypothesis 1a: There will be a substantial prevalence of burnout in PWPs and HI therapists in IAPT services.

This hypothesis was supported by the results of the present study. Nearly two thirds of participants experienced burnout according to the definition provided by Peterson, Demerouti, et al. (2008). PWPs were more likely to experience burnout than HI Therapists.

4.1.2 Hypothesis 1b: Burnout in IAPT workers will be related to job role, age, gender, years of experience and length of time worked in the IAPT service.

There was partial support for this hypothesis. For the total sample, job role (being a PWP) and length of time worked in the IAPT service (two years or more) was a statistically significant predictor of burnout. An adjusted logistic regression analysis confirmed that PWPs who had worked in the IAPT service for two or more years were two to three times more likely to experience burnout than those who had worked in the IAPT service for less than two years. There were no significant predictors of burnout in HI Therapists. Overall, gender, age and years of MH work experience did not predict burnout in the present study.

4.1.3 Hypothesis 2a: Greater job demands will be associated with greater levels of exhaustion.

The results supported hypothesis 2a in that several variables indicating increased job demands (workload, home-work conflict, client-related difficulties, patient contact
hours, overtime, telephone contact, inputting data and caseload) were associated with
greater levels of exhaustion for the total sample. The awareness of targets variable
showed a statistically significantly negative correlation with exhaustion. However,
not all variables indicating job demands were associated with exhaustion (face-to-
face contact, group contact, supervising staff, mild-mod difficulties and mod-severe
difficulties).

4.1.4 Hypothesis 2b: Job demands will be associated with exhaustion but not
disengagement.

This hypothesis was not supported by the results of the present study. For the total
sample, of the 14 variables indicating increased job demands, eight of them
caseload, workload, overtime, home-work conflict, patient contact, telephone
contact, group contact and client-related difficulties) were associated with greater
levels of disengagement.

4.1.5 Hypothesis 3a: A lack of job resources will be associated with greater levels
of disengagement.

The results supported hypothesis 3a in that several variables indicating decreased job
resources (organisational issues, relationships and conflicts, self-doubt, lack of
resources and clinical space difficulties) were associated with greater levels of
disengagement for the total sample. However, not all variables indicating job
resources (supervision received) were associated with disengagement.

4.1.6 Hypothesis 3b: Job resources will be associated with disengagement and not
exhaustion.

This hypothesis was not supported by results of the present study. Of the seven job
resource variables, five of them (organisational issues, relationships and conflicts,
self-doubt, lack of resources and clinical space difficulties) were statistically significantly correlated with exhaustion for the total sample.

4.1.7 Further analyses: Predicting burnout based on job characteristics, age, gender, years of MH work experience and length of time worked in the IAPT service

For the total sample, job role (being a PWP) and working for two years or more in the IAPT service remained a predictor of burnout. Participants who had worked in the IAPT service for two years or more were just over twice as likely to experience burnout than those who had worked in the IAPT service for less than two years. PWPs were more likely to experience burnout than HI Therapists. For PWPs, an adjusted logistic regression analysis showed that working for two years or more in the IAPT service and overtime hours were predictors of burnout. There were no significant predictors of burnout in HI Therapists.

4.2 Interpretation of results

4.2.1 The JD-RM

Whilst certain job demands correlated with exhaustion and specific job resources were associated with disengagement, the reverse was also true with job demands correlating with exhaustion and job resources with disengagement. This finding indicated that job demands and job resources did not map onto the separate constructs of exhaustion and disengagement exclusively. Demerouti et al. (2001) found that exhaustion and disengagement were correlated with each other with a medium effect size but in the present study a large effect size was found for this relationship. The categories of Burnout, Exhaustion, Disengagement and Below cut-off were clustered closely together. This demonstrated that the categories were not as independent from one another as Demerouti et al. (2001) proposed.
Several reasons could account for the lack of support for the JD-RM in the present study. In their original test of the JD-RM, Demerouti et al. (2001) objectively measured job demands and resources using two observer ratings. In the present study, only one IAPT service manager consulted on the suitability of the job demands and resources self-reported measures due to time constraints. Another objective measure could have been to include behavioural measures such as absenteeism and work performance as indicators of exhaustion and disengagement (Llorens et al., 2006). Schaufeli and Bakker (2004) emphasised the need for more research to use objective measures of exhaustion such as psychophysiological measures. However, in the present study there was an effort to use some more objective measures such as number of difficulties per week accessing clinical space. According to the author of the OLBI (E. Demerouti, personal communication, 28 September, 2011) any measure of job demands and resources should be applicable to the JD-RM and therefore provide evidence to support it. This was not the case in the present study.

Some of the previous studies that support the JD-RM applied Structural equation modelling (SEM) in the form of Confirmatory Factor Analysis (e.g. Bakker, Demerouti & Schaufeli, 2003; Demerouti et al., 2001). Whilst this is a popular and powerful method (for review see Tomarken & Waller, 2005), it is different to the statistical analysis of the present study. Demerouti et al. (2001) claimed that the JD-RM was a parsimonious model that could be applied to any work context. Given this, it should be testable under a variety of statistical analyses, particularly correlational analysis which is a simple and robust method.

Job demands and resources may be less independent of one another in their relationships with exhaustion and disengagement and more conceptually linked than the JD-RM proposed. Schaufeli and Bakker (2004) found that job demands and resources were not entirely independent where lacking resources might also increase demands. Maslach (1976) also highlighted that the relationships between staff, recipients of care and managers could act as either the demands or resources of the
job. Therefore the same job characteristic could apply to both job demand and resources.

Existing research has shown that job demands related to disengagement and job resources with exhaustion. Bakker et al. (2004) found a direct and negative relationship between job resources and exhaustion in workers from varying occupations (although the strength of this relationship was weaker than that of job demands and exhaustion). Job demands such as workload were shown to relate to disengagement (Bakker, Demerouti & Schaufeli, 2005) and this relationship increased over time (Mauno, Kinnunen, & Ruokolainen, 2007). Van den Broeck, De Cuyper, De Witte and Vansteenkiste (2010) also commented on the unanticipated relationships found between some job demands and disengagement. They contended that job demands comprised job hindrances, health impairing demands, and job challenges which require further energy but are stimulating. Although the 600 participants in their study were not mental health workers, they argued that the category of job demands was not as homogenous as outlined by Demerouti et al. (2001). Van den Broeck et al. (2010) stated that job demands tend to negatively relate to engagement (the reverse of disengagement theoretically) which they concluded helped to explain the health impairing process of job demands. This was illustrated with the findings of the present study however further research would be needed to validate this claim.

Taking into account the lack of support for the JD-RM, other theoretical models of burnout could have been applied to the present study. Carson and Kuipers (1998) developed a model that took into account the personal factors relating to work-stress. However, it would be unlikely that only the 17.8% of IAPT workers in the present study that were not experiencing Burnout, Exhaustion or Disengagement possessed the personal resources to manage work-stress and those that were experiencing Burnout, Exhaustion or Disengagement did not. It would be more probable that organisational factors were influencing IAPT workers experience of burnout. Likewise, Demerouti et al. (2001) stated that internal resources can often fluctuate depending on job design and Cox and Griffiths (2010) noted how measurement of personal factors that contribute to the construct of work-stress can be challenging.
Maslach (2006) stated that while personal and organisational factors may both contribute to burnout, the latter has a greater influence. Leiter and Maslach (2005) developed a ‘mediation model’ whereby burnout mediated the relationship between organisational stressors and stress outcomes such as deteriorating health and absenteeism. They hypothesised that a greater mismatch between the fit of a person and key aspects of their job resulted in higher levels of burnout. They developed the Areas of Worklife Survey (Leiter & Maslach, 2006; AWS) as a companion measure to the MBI which assesses six areas of the perceived work-life environment (workload, control reward, fairness, community and values) that could contribute to burnout. Maslach (2006) claimed that this model could act as a diagnostic tool for tailoring solutions to prevent burnout.

4.2.2 Burnout in IAPT workers

To date, no research investigating burnout in IAPT workers has been conducted. The results of this study show that nearly two thirds of the total sample of IAPT workers experienced burnout. A similar prevalence of burnout in mental health care workers was reported in the existing literature (Morse et al., 2012). This was almost double the size of the prevalence of burnout found by Peterson, Demerouti, et al. (2008) who had employed a much larger sample which recruited health care workers, some of whom were psychologists. It could be that the nature of the IAPT worker’s job role influenced the higher prevalence of burnout in the present study.

The existing literature suggested that younger therapists were more susceptible to burnout (Ackerley et al., 1988; Kwee, 1990). Age was not a predictor of burnout in the present study when other variables were adjusted for. However, age groups of IAPT workers younger than 40 years and older than 50 years did predict burnout when the other variables were not adjusted for. There might have been pressures outside of work, such as either caring for young children or older parents, which influenced their vulnerability to burnout. Lasalvia et al. (2009) found burnout in older mental health workers with longer careers and suggested this could be due to the chronic nature of burnout. Indeed, ‘ageist’ practice was an issue identified in the
content analysis concerning aspects of the job role that affected staff wellbeing. It might be that IAPT workers over 50 years of age feel in a minority age group. In 2008-2009, IAPT workers aged 50 and over represented 17% of the national IAPT workforce compared to 74% of IAPT workers aged 49 years or less (NHS England, personal communication, June 17th, 2013). This age group might have lacked the peer support that was frequently referred to as a job characteristic that helped to alleviate work-stress. Further research is needed to clarify this.

Gender was not a significant predictor of burnout as claimed by Maslach (2001). Male participants only represented a small percentage of participants in the present study however this was similar to the percentage of male IAPT workers (19%) reported between 2008-2009 (NHS England, personal communication, June 17th, 2013).

More MH work experience was associated with lower levels of exhaustion and disengagement in previous research (e.g. Tamura et al., 1994). This variable did not predict burnout in the present study. However working for two or more years in the IAPT service was a significant predictor of burnout for PWPs. This links to Cherniss’ (1980) finding and Schaufeli and Enzmann’s (1998) proposal that burnout develops gradually over two years. PWPs may have been more likely than HI Therapists to experience a lack of career progression and thus notice their lack of status compared to HI Therapists. A longitudinal study of PWPs would be necessary to establish this claim.

In terms of job characteristics, overtime was the only job characteristic that held as a predictor of burnout in PWPs when all of the other predictors were accounted for. Higher levels of overtime have been shown to relate to a component of burnout (Peterson, Demerouti, et al., 2008). A similar amount of overtime hours was shown for PWPs and HI Therapists. There may have been aspects of the PWP role, such as an increased caseload with less ability to emotionally or meaningfully invest in the patient work that raised their sensitivity to the effects of overtime hours on burnout. Further investigation would be needed to support this.
There were other job characteristics that predicted burnout in the unadjusted analyses for either the total sample (caseload, patient contact, telephone contact and clinical space difficulties) or PWPs (overtime, patient contact, mod-severe difficulties and inputting data) which suggests there might be some association between these job characteristics and burnout. A larger caseload (which might also reflect greater amounts of patient contact hours) was related to an increase in work-stress and burnout in previous research (Barber, 1996; Coyle et al., 2005; Hellman et al., 1987; Maslach et al., 2001). Telephone contact could have related to burnout due to interference with the therapeutic relationship (Richards et al., 2006) meaning that the work is less rewarding. This may merit further exploration. Maslach et al. (2001) highlighted the positive relationship between severity of client-difficulties and burnout. PWPs are not trained to work with patients with moderate-severe difficulties. The correlation between the MHPSS client-related difficulties subscale (which measures difficult/demanding patients and no change/slowness of change in the patient) and exhaustion and disengagement in PWPs might have reflected this. Inputting data hours links to the ‘admin time’ code identified in the content analysis and clinical space difficulties might have related to the ‘physical working environment’ code. The association between clinical space difficulties and exhaustion was also significantly decreased the longer a PWP worked in the IAPT service. Perhaps as PWPs familiarise themselves with accessing clinical space this becomes less of a stressor. No research has demonstrated this relationship before.

Although the MHPSS variables were not included as predictors of burnout, they were all associated with exhaustion and/or disengagement for the total sample and identified as sources of work-stress in the content analysis. For example, a major theme from the content analysis regarding aspects of work that affected wellbeing was ‘management/structural pressures’. Organisational issues measured sources of stress such as poor management and supervision and the Lack of resources subscale included items referring to poor physical working conditions which were also codes of this theme. Maslach et al. (2001) claimed that factors such as time pressure (a code of ‘management/structural pressures) correlated moderately or highly with burnout and the workload subscale measured a lack of time to complete tasks satisfactorily as a source of stress. Maslach et al. (2001) commented on the negative
effects on workers when there is a mismatch between a worker’s input of effort and the expected receipt of job opportunities. A code of the ‘training and development’ theme of the content analysis was ‘lack of career prospects’ which was reflected in the self-doubt subscale which explored a lack of appropriate training and support. ‘Peer support’ was frequently referred to in the content analysis and the relationships and conflicts subscale made reference to a lack of emotional support from and conflict with colleagues. Therefore given the importance of ‘peer support’ to participants, perhaps a lack of it resulted in it becoming a source of stress.

There were certain job characteristics that were not predictors of burnout. For example, group contact hours did not predict burnout. This might have been because groups are often facilitated by two colleagues who can support each other. Given the frequent reference to ‘peer support’ in the content analysis, group work may be more enjoyable and less stressful because of this. Supervising staff did not predict burnout although its positive relationship with exhaustion was significantly decreased the longer a PWP had worked in the IAPT service. Cushway and Tyler (1994) found that providing supervision was a stressor for ‘higher grade’ psychologists.

There were no significant predictors of burnout for HI Therapists. Considering half of HI Therapists experienced burnout this suggests that the job characteristics in the present study may not have been specific or sensitive enough to assess this relationship adequately. For example, receiving supervision was cited in the content analysis as a demanding aspect of the job role that affected the wellbeing of participants at work. Gathering quantitative data on the number of hours of supervision received may not have been adequate in determining which aspects of supervision, such as the quality of the supervisory alliance or the experience of the supervisor, might have prevented burnout. Face-to-face contact did show a medium effect size when associated with disengagement for HI Therapists alone. HI Therapists conducted significantly more face-to-face contact hours than PWPs which might have accounted for this relationship. Additionally, they spent more time supervising staff and working with a higher percentage of patients with moderate-severe difficulties and received less supervision than PWPs. Further investigation
into these job characteristics might help to reveal specific predictors of burnout in HI therapists.

4.3 Critique

4.3.1 Triangulation

Triangulating the data by including open-ended items allowed for verification of the quantitative measures of job demands and job resources. Kidder and Fine (1987) described this as ‘triangulation of measurement’ and this was seen as a strength of the present study. Most of the job demands identified by participants in the content analysis were measured quantitatively: however two codes emerged, ‘travel’ and ‘flexible working hours’ that had not been measured quantitatively.

4.3.2 Design

The cross-sectional design of the present study means that the observed relationships should be interpreted with caution and no causal inferences should be made. Schaufeli and Bakker (2004) highlighted the issue of negative affect as a possible ‘third’ confounding variable influencing the relationship between job demands, or health impairment, and burnout. They commented that generally, negative affect did not influence the relationship between self-report measures of stressors and strains (e.g. De Jonge, Dollard, Dormann, Le Blanc, & Houtman, 2001). The questionnaire needed to be completed quickly in a busy work environment therefore it was not possible to account for negative affect in the present study. Future longitudinal research or a cross-sectional study design including a measure of affect could account for this.
4.3.3 Measures

Self-report measurement was used to assess exhaustion and disengagement and it is possible that the correlational results might have been slightly inflated by 'common methods variance' (especially given the strength of relationship between exhaustion and disengagement). However, Spector (2006) stated that common methods variance is often overestimated and that most methods contain some level of bias. To reduce bias, as mentioned previously, more objective measures such as ratings from several IAPT service manager ratings of job demands and resources could have been employed (Demerouti et al., 2001). Although measures of job characteristics such as number of patients on caseload were employed in the present study these were self-reported and may have been inflated by participants. A more objective way of gaining this information could have been to obtain actual patient data from IAPT service databases. Time constraints did not allow for this.

The cut-offs for the Burnout, Exhaustion, Disengagement and Below cut-off groups, as measured by the OLBI, were taken from one previous study (Peterson, Demerouti, et al., 2008). The calculations of the conversion from the MBI score to the OLBI could not be obtained which meant that it was not possible to comment on the robustness or validity of the statistical conversion of MBI scores to the OLBI. Given this, the OLBI may not have been adequate in assessing burnout. Nevertheless, in the present study the majority of participants scored highly on exhaustion and disengagement, components of burnout, which unequivocally emphasises the stressful nature of an IAPT worker’s job role.

4.3.4 Data collection

Participants were mostly young White British females. Between 2008-2009, females represented 80% and workers aged between 20-29 years of age represented 27% of the national IAPT workforce (NHS England, Personal communication, June 17th, 2013). This was similar to the proportions of age and gender reported in the present study. Counsellors were under-represented within the sample and due to time
limitations, it was not possible to follow-up with IAPT service managers whether they had been recruiting Counsellors or not. Counsellors represent a smaller proportion of the IAPT workforce (one fifth) than PWP (they represent one quarter) and HI Therapists (just over one third) and are more likely to work part-time (IAPT, 2013). The 50:50 proportions of the PWP and HI Therapist samples were reflective of the proportions in most IAPT services up to August 2012 (IAPT, 2013).

In terms of bias, the present study may have attracted the attention of participants who were unhappy with or wanted to express negative aspects of their experiences as an IAPT worker. For example, workers in newly developed IAPT services with difficulties accessing desks, clinical space and IT resources (as highlighted by feedback from IAPT service managers) might have been more likely to complete the study than those that did not. Furthermore, demand characteristics, whereby some participants may have guessed the nature of the research or been emotionally affected by the items as they were completing them, may have been sources of bias in the present study. For example, IAPT service managers were told the specific aims of the study (for ethical reasons) and this may have influenced how they described the study to their staff.

There was an estimated 30% IAPT service response rate. Participation might have been enhanced by stating explicitly on the PIS form that Trainee PWP and HI Therapists could participate in the study (which they could). Baruch and Holtom (2008) commented that respondents at work can be inundated with questionnaires and some IAPT services were involved in other research projects. Breakwell et al. (2012) however stated that a lower response rate does not necessarily indicate that the estimate of the sample would be biased. Increasing a sample size does not necessarily lead to more accurate results (Jones & Lang, 1980). Hawley, Cook and Jensen-Doss (2009) investigated response rates from mental health providers by conducting a study using a cross-sectional survey design. They found a 39.8% response rate from clinicians in mental health care services and commented that they were typically poor responders. Baruch and Holtom (2008) found that an average response rate of 35 per cent was common for organisational studies published in
2005. Therefore the approximate response rate in the present study may be considered adequate and representative of IAPT workers.

**4.4 Implications for clinical practice**

The majority of IAPT workers in the present study experienced burnout. It will be important for IAPT service managers to be mindful of the prevalence of burnout in their services.

For PWPs, those that have worked in the service for two years or longer are at an increased risk of burnout. Reducing overtime, patient contact, the number of patients with moderate-severe difficulties that they work with and time spent inputting data might help to prevent burnout. Supporting PWPs with accessing clinical space and supervising staff within their first two years of employment could help to prevent exhaustion. Likewise for HI Therapists, greater face-to-face contact with patients could be a job characteristic that contributes to disengagement.

Due to the busy and target-focussed environment of IAPT services reducing these job characteristics may not be possible. Aspects such as support from colleagues, having enough time to complete administrative duties and opportunities provided to enhance professional development were cited frequently by participants as job characteristic that help to alleviate stress at work. It could be that identifying the pattern of contact hours and implementing regular breaks, lunch hours and/or a check-in with a ‘daily supervisor’ might help to reduce the impact of the job characteristics that relate to burnout. Protected time could be scheduled following each patient contact to complete the administrative recording and duties.

Lone working was cited in the content analysis as a job characteristic that affected participant’s wellbeing at work. Bhatara, Fuller, O’Connor-Davis and Misra (1996) implemented interdisciplinary educational programs over a period of three years aimed at reducing professional isolation and lack of training opportunities. They hoped to increase job satisfaction and possibly job retention by doing this. Bhatara et
al. (1996) found improvements on measures of professional isolation. Training sessions could be offered by IAPT workers with specialist interests during a team meeting as part of a timetable suited to that particular IAPT service. Peterson, Bergstrom, Samuelsson, Asberg and Nygren (2008) piloted a peer-support working group for health-care workers, which included psychologists, with the aim of alleviating work-stress and burnout. The intervention ran for ten weekly two hour sessions and was claimed to be relatively low cost. The findings of the randomised controlled study showed that the intervention increased perceived general health and reduced perceived work demands. Although time intensive, an intervention such as this could be adjusted and implemented with IAPT workers. The efficacy of these suggested interventions could be tested by asking IAPT workers to complete wellbeing or work-stress measures before and after these changes have been made.

4.5 Future research

To improve on the present study, future research could involve more recruitment participants from varying ethnic backgrounds. ‘Travel difficulties’ and ‘flexible working hours’ could be added as job characteristics and certain codes from the content analysis such as ‘constraints of one therapeutic model’, that are specific to the IAPT service model could be investigated further. Participants could be asked what they think could realistically be improved to alleviate work-stress. Where possible, objective measures of job characteristics, such as gaining actual sizes of caseloads from electronic databases in IAPT services, could be used. If the results of the present study were replicable, exploring why certain job characteristics, such as data input, were not predictors of burnout could be an avenue for further research. Investigation into why variables such as telephone contact, clinical space difficulties and awareness of targets, were not related to exhaustion and/or disengagement or only significantly related but with a small effect size could also be conducted. It may be that more in-depth exploration and qualitative investigation of these job characteristics is needed. This could also help to provide greater detail of the specific predictors of burnout in HI Therapists.
In terms of theoretical models of burnout, the JD-RM could be applied to future research into burnout in IAPT workers with more careful differentiation of job demands and resources. Job resources that are more distal from job demands such as career perspective could be measured (Schaufeli & Bakker, 2004) and job demands could be differentiated into job hindrances and challenges (Van den Broeck et al., 2010). The relationship between these qualitative constructs of job demands and exhaustion and/or disengagement could be investigated. Alternatively, as mentioned in section 4.2.1, the mediation model of burnout (Leiter & Maslach, 2005) could be applied to future research into burnout in IAPT workers. Lasalvia et al. (2009) studied 2000 Italian mental health workers, utilising a cross-sectional survey design and measured the relationship between the impact of key aspects of mental health worker’s job roles, namely the areas measured by the AWS (Leiter & Maslach, 2006), and other factors such as organisational change and management issues, and burnout (as measured by the MBI). ‘Stress outcomes’ such as performance, absenteeism and mental health (as measured by the GHQ) could be a way of accounting for the economic, emotional and physical costs of burnout in IAPT workers. Additionally, investigation into the patient experience of receiving treatment from IAPT workers experiencing burnout would enhance our understanding of the impact of burnout on patient outcomes. Specific interventions to reduce work-stress in six different key areas of an IAPT workers job role such as creating a team culture that fosters fairness and reward could be implemented and assessed (Lasalvia et al., 2009). Edwards et al. (2002) commented on the lack of evidence relating to stress management interventions for mental health workers and future research is needed to establish their efficacy.

Some studies have begun to investigate the temporal development and dynamic nature of burnout. Which core dimensions develop first and at what point in time does for example, work-stress develop into exhaustion and how might this interact with disengagement processes? Demerouti et al. (2001) claimed that exhaustion might develop faster than disengagement because individuals seem to be more sensitive to job demands (Hobfoll, 1989). How do job characteristics impact on these dimensions at different time points? Schaufeli et al. (2009) began investigations into
the dynamic nature of burnout and they commented that a three-wave longitudinal study is necessary to fully investigate the relationship between variables such as high job demands, burnout and sickness absenteeism (Cole & Maxwell, 2003). Maslach and Leiter (2008) conducted the first longitudinal study of the mediation model of burnout and this could be applied to measure burnout and the opposite end of the construct, engagement, over time. Further longitudinal research with adequate sample size would help to validate the results of the present study and contribute to knowledge about the causality of burnout and its development over time.

4.6 Conclusions

The aim of the research was to establish whether IAPT workers experienced burnout and investigate which demographic factors and job characteristics might relate to this based on the Job Demands-Resources Model of burnout (Demerouti et al., 2001). No research had yet been conducted into the prevalence of burnout in IAPT workers.

By investigating the hypotheses in relation to the total sample, PWPs and HI Therapists inferences could be made about which job characteristics might predict burnout in each group. Nearly two thirds of the total sample experienced burnout and PWPs were more likely to experience burnout than HI Therapists. For the total sample job role (being a PWP) and length of time worked in the IAPT service (two years or more) were predictors of burnout. For PWPs, overtime and working for two years or more in the IAPT service predicted burnout. There were no significant predictors of burnout in HI Therapists.

Recommendations for adapting job design were made with the aim of preventing burnout. The JD-RM was not supported by the results of the present study. Further research to replicate the findings of the present study, establish further predictors of burnout in IAPT workers and investigate the development of the relationship between job characteristics and burnout in greater detail and over time is recommended.
4.7 REFERENCES


Schaufeli, W. B., & Buunk, B. P. (1996). Professional burnout. In M. J. Schabracq, J. A. M. Winnubst & C. L. Cooper (Eds.), Handbook of work and health psychology (pp.311-348). West Sussex: John Wiley & Sons Ltd.


Schaufeli, W. B., Maslach, C., & Marek, T. (1993). The future of burnout. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), Professional burnout: Recent


APPENDICES

Appendix A. Approximate recruitment rates and response rate calculation
Appendix B. Formal letter of invitation to participate in the present study.
Appendix C. Participant Information Sheet (PIS)
Appendix D. Questionnaire
Appendix E. NHS R&D Department approval letters
Appendix F. Email with standard message (IAPT Services)
Appendix G. Leaflet
Appendix H. Poster
Appendix I. 250 word article published in ‘CBT Today’ BABCP publication.
Appendix J. Email message to participants recruited via CBT Today and BABCP
Appendix K. Text published on BABCP Forum website.
Appendix L. Ethical approval
Appendix M. Further detail of construction of study variables
Appendix N. Items on MHPSS and OLBI that overlap
Appendix O. Histograms of Exhaustion and Disengagement for the total sample
Appendix P. Rules of the codes and themes of the content analysis for job demands and a sample of the data.
Appendix Q. Rules of the codes and themes of the content analysis for job resources and a sample of the data.
Appendix A. approximate recruitment rates and response rate calculation

Feedback from service managers via email and telephone indicated that there were approximately 238 PWPs, 322 HI therapists and 74 Counsellors (634 in total) employed by the 15 IAPT services.

Participants not obtained via services were required to email the researcher to acquire the electronic link and Participant Information Sheet therefore it was possible to approximate how many participants might have been recruited via the BABCP magazine, online or both. Approximately 15 participants were recruited through the BABCP magazine alone and a further 35 participants were recruited either through the BABCP website or the BABCP magazine.

It was therefore estimated that a total of 212 participants were recruited via IAPT services and 50 participants were recruited via the other methods. Therefore 212 (out of 262) from the IAPT services of the potential approximate 634 is 33% response rate via this recruitment method.
Appendix B. Participant Information Sheet (PIS)

UNIVERSITY OF SURREY
Faculty of Arts and Human Sciences
Psychology
AD Building
Guildford, Surrey, GU2 7XH, UK
T: +44 (0)1483 689 441
F: +44 (0)1483 689 553

Participant Information Sheet

TITLE: Investigating the job demands and support available to IAPT workers

Introduction
My name is Sophie Westwood and I am a Trainee Clinical Psychologist working in the Psychology Department at the University of Surrey, based in Guildford. I am on a three-year postgraduate training programme in Clinical Psychology. As part of my training I am hoping to conduct research with Improving Access to Psychological Therapies clinical staff which includes Psychological Wellbeing Practitioners, High Intensity Therapists and Counsellors.

What is the study about?
I am researching different aspects of an IAPT worker’s role and their experience of their work and I would be grateful if you would help me with this by taking part in my study.

Do I have to take part?
No, taking part in this study is entirely up to you. To help you decide whether or not to take part, you can talk it over with friends, family, colleagues, health professionals and so on. You can also contact me for further information and I would be happy to answer any queries.

Even if you agree to take part, you can choose not to answer any of the questions in the study or you can withdraw from it at any time without giving a reason. Please be aware that if you do decide to withdraw from the study before completing it, your responses will be deleted. Your decision to participate or not will have no effect on your employment status. Your individual responses will not be shared with your employer.

What will I have to do?
You will be asked to participate in an online survey (or paper version) and you will be sent a link via your work email to access it.

How long will it take?
It will take approximately 15-20 minutes to complete. There are no right or wrong answers and you will be completing a variety of different short questionnaires.

How do I agree to take part?
It will be assumed that by participating in the online survey (or the paper version) you have consented to participate in the study and you understand the aims of the research. If you have any questions prior to completing the survey, please do not hesitate to contact me.
Does what I say get shared with anyone else?
What you say will remain confidential and will only be seen by the researchers. Your name and all personal details about you will be kept anonymous in the study.

Research is always supervised by someone senior, so my research supervisor may have access to the information about you during the research study. My supervisor's name and contact details are at the end.

No clinical professionals or management staff from your services will have access to the individual information you give me during the research. A report will be provided summarising all the participants' information but no participants will be identifiable.

All information gathered during this research study will remain confidential and be stored securely in a locked filing cabinet at the University of Surrey, in accordance with the Data Protection Act 1998. This will be destroyed after 5 years. Electronic files will be stored in password protected computers. Some of the data will be sent to the author of one of the measures used in the questionnaire who will use the data to validate the measure. Your age, gender, occupation and results from the particular measure will be passed on but you will not be identifiable.

What happens when the research study is completed?
I and my supervisors will be seeking to publish the findings of the research. Sometimes we present our research findings at meetings (for instance, to services that have participated in the research or at conferences). Again, all personal details about you will be kept confidential and no-one will be able to identify who you are. I can send you a copy of a summary of the research findings if you would like to contact me via email. This piece of research will be completed by September 2013.

What are the benefits of taking part?
The research provides an opportunity for you to reflect on your experiences of working in an IAPT service and whether you have been affected by work-related stress in IAPT services.

Changes to health services are based on the findings of research studies. It is only by researching real people and real issues, that we discover what's working and what needs improving. Your input is therefore vital.

If you choose to participate in the study you can be entered into a prize draw after completion of the questionnaire for the chance to win £75 worth of Amazon vouchers if you wish.

If you choose to enter the prize draw, your contact details will be kept separately from your responses to the questionnaire and stored confidentially by the researcher. No one else will have access to this information and it will be destroyed once the prize has been allocated.

Are there any downsides of taking part?
If you find a question too personal or upsetting in any way, you don't have to answer it. You can also take a break at any time during the survey. Some people may find that reflecting on their experiences at work may bring up upsetting feelings or memories. If this happens and you would like some support you can contact:
Organisations such as 'ACAS' (http://www.acas.org.uk/index.aspx?articleid=1461) or 'The Stress Management Society' (http://www.stress.org.uk/) provide information on stress and how to cope with it.

Your GP if you are concerned about the effect of stress on your health.

You may wish to call the Samaritans on 08457 90 90 90.

Dr Paul Davis, Clinical Tutor, University of Surrey (please see contact details at the end of this form)

What if there is a problem?
If you have any concerns about any aspect of the way you have been treated during the course of the research study, then you can contact my Supervisor, Dr Nan Holmes, Clinical Psychologist, or an independent contact, Dr Paul Davis, a Clinical Tutor on the Clinical Psychology Doctorate Programme at the University of Surrey.

Who is organising and funding the research?
This piece of research is funded by the University of Surrey.

Has the research been approved by any committee?
The study has been approved by the Faculty of Arts & Human Sciences at the University of Surrey Ethics Committee and also the appropriate National Health Service (NHS) Research and Development Departments.

~~~~~~~~~
Thank you for taking the time to consider participating in this study.
I look forward to hearing from you.

Research being conducted by:
Your name: Sophie Westwood, Title: Trainee Clinical Psychologist, Work address: Department of Clinical Psychology, University of Surrey, Guildford, Work telephone number: 01483 689 441 (please leave a message with Charlotte King and I will respond as soon as possible. I am available at University every Monday and Tuesday and will be able to respond to your queries on these days). Email: s.westwood@surrey.ac.uk

Supervised by:
Supervisor's name: Dr Nan Holmes, Title: Clinical Director Psych. D Clinical Psychology Training Programme, Work address: Department of Clinical Psychology, University of Surrey, Guildford, Surrey, GU2 7XH Work telephone number: 01483 689 433 Email: n.holmes@surrey.ac.uk

Independent contact:
Name: Dr Paul Davis, Title: Clinical Tutor, Psych. D Clinical Psychology Programme Work address: Department of Clinical Psychology, University of Surrey, Guildford, Surrey, GU2 7XH Work telephone number: 01483 686863

Appendix C. Questionnaire
Questionnaire investigating the Job Demands and Support available to IAPT workers.

It is estimated that this questionnaire should take no longer than 15-20 minutes to complete.

Your responses will remain anonymous and will be kept confidentially.

I have read and understood the Participant Information Sheet and understand that by completing the questionnaire I consent to participate in the study.

Do you agree to go on?

YES NO

Information about your job as an IAPT worker

1. Your job role: (please circle)
   Psychological Wellbeing Counsellor High Intensity Therapist
   Practitioner (PWP) HI Therapist

2. Please state the number of contracted hours that you work per week:

   ........................................................................................................................

3. How many years of experience do you have of working in the mental health field prior to your current IAPT role?

   ........................................................................................................................

4. How many years have you worked for the IAPT service you are currently employed by?

   ........................................................................................................................

5. Are you a Case Management Supervisor? (please circle)

   YES NO

   If yes, please state how many hours of Case Management supervision you provide to other IAPT staff in a typical week:

   ........................................................................................................................

6. Are you a Clinical Supervisor? (please circle)
YES    NO

If yes, please state how many hours of Clinical Supervision you provide to other IAPT staff in a typical week:

........................................................................................................................................

7. How many hours of Case Management Supervision do you receive in a typical week? (Please only respond if you are a Psychological Wellbeing Practitioner)

........................................................................................................................................

8. How many hours of Clinical Supervision do you receive in a typical week?

........................................................................................................................................

9. Approximately how many patients do you currently have on your caseload?

........................................................................................................................................

10. Considering your current caseload, approximately what percentage of patients are experiencing mild to moderate depression or anxiety disorders? (for example, up to a PHQ-9 score of 19 and up to a GAD-7 score of 15)

........................................................................................................................................

11. Considering your current caseload, approximately what percentage of patients are experiencing moderate to severe depression or anxiety disorders? (for example, a PHQ-9 score of 20 and above and a GAD-7 score of 15 and above)

........................................................................................................................................

12. Approximately how many hours of telephone patient contact do you conduct in a typical week?

........................................................................................................................................

13. Approximately how many hours of individual face-to-face patient contact do you conduct in a typical week?

........................................................................................................................................

14. Approximately how many hours of group patient contact do you have in a typical week?
15. Approximately how many hours of total patient contact (including telephone, face-to-face and group contact) do you have in a typical week?

16. Do you have an allocated desk with a computer to work from? (please circle)
   
   YES   NO
   
   If you answered NO, approximately how many times in a typical week do you have difficulties with finding a desk/computer to work from?

17. In a typical week, approximately how many times do you have difficulties with accessing clinical space to provide patients with treatment? (difficulties can include problems with travelling between different sites)

18. In a typical week, how many hours do you spend inputting data into an electronic database and fulfilling your administration duties?

19. Approximately how many hours of overtime do you work in a typical week?

20. How aware are you of IAPT targets e.g. recovery rates, national league tables? (please circle)
   
   Not aware  A little aware  Moderately aware  Very aware  Very much aware
   
21. What is/are the most demanding aspect(s) of your role which might impact on your wellbeing?

22. What aspect(s) of the job help to alleviate any stress that might have been created as a result of your role?

23. Are there any aspects of your work that you find rewarding and if so, what are they?
Please find below a set of statements with which you may agree or disagree. Using the scale, please indicate the degree of your agreement by circling the number that corresponds with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I always find new and interesting aspects in my work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. There are days when I feel tired before I arrive at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. It happens more and more often that I talk about my work in a negative way</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. After work I tend to need more time than in the past in order to relax and feel better</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I can tolerate the pressure of my work very well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Lately I tend to think less at work and do my job almost mechanically</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I find my work to be a positive challenge</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. During my work I often feel emotionally drained</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Over time, one can become disconnected from this type of work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. After working I have enough energy for my leisure activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Sometimes I feel sickened by my work tasks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
12. After my work I usually feel worn out and weary  
13. This is the only type of work that I can imagine myself doing  
14. Usually I can manage the amount of my work well  
15. I feel more and more engaged in my work  
16. When I work I usually feel energized  

(For appendix copy of questionnaire only: Disengagement items are 1, 3(R), 6(R), 7, 9(R), 11(R), 13, 15. Exhaustion items are 2(R), 4(R), 5, 8(R), 10, 12(R), 14, 16. (R) means reversed item when the scores should be such that higher scores indicate more burnout).

(MHPSS) The following have been found to be sources of pressure at work in healthcare. Please respond by circling the numbers which represent the extent to which each item applies to you (i.e. represents a source of pressure at work for you)

<table>
<thead>
<tr>
<th>Item</th>
<th>Does not apply to me at all</th>
<th>Applies to me a little</th>
<th>Applies to me</th>
<th>Strongly applies to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Too much work to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Ending treatment with patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Lack of support from management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Conflict with other professionals e.g. doctor, nurse...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Lack of adequate staffing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Feeling inadequately skilled for dealing with emotional needs of patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Not enough time with family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Major Research Project Appendices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Too many different things to do</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>9. Dealing with death or suffering</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>10. Relationship with line manager</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>11. Conflicting roles with other professionals</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>12. Lack of financial resources for training courses/ workshops</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>13. Uncertainty about own capabilities</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>14. Inability to separate personal from professional role</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>15. Not enough time to complete all tasks satisfactorily</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>16. No change or slowness of change in patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>17. Communications and flow of information at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>18. Working in a multi-disciplinary team</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>19. Shortage of adequate equipment/supplies</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>20. Feeling inadequately skilled for working with difficult patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>21. Taking work home</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>22. Too many patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>23. Difficult and/or demanding patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>24. Poor management and supervision</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Major Research Project Appendices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Criticism by other professional e.g. doctor, nurse, colleague</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26.</td>
<td>Lack of adequate cover in potentially dangerous environment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27.</td>
<td>Doubt about the efficacy of therapeutic endeavours</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28.</td>
<td>Relationship with spouse/partner affects work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29.</td>
<td>Working too long hours</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30.</td>
<td>Physically threatening patients</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31.</td>
<td>The way conflicts are resolved in the organisation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32.</td>
<td>Lack of emotional support from colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33.</td>
<td>Inadequate clerical/technical back-up</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34.</td>
<td>Keeping professional/clinical skills up-to-date</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35.</td>
<td>Work emphasises feelings of emptiness and/or isolation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>36.</td>
<td>Not enough time for recreation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Does not apply to me at all</td>
<td>Applies to me a little</td>
<td>Applies to me</td>
<td>Strongly applies to me</td>
</tr>
<tr>
<td>37.</td>
<td>Managing therapeutic relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38.</td>
<td>Organisational structure and policies</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39.</td>
<td>Difficulty of working with certain</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Major Research Project
Appendices

colleagues

40. Poor physical working conditions 1 2 3 4
41. Fear of making a mistake over a patient’s treatment 1 2 3 4
42. Inadequate time for friendships/social relationships 1 2 3 4

(For appendix copy of questionnaire only: Workload subscale items= 1, 8, 15, 22, 29, 36; Client-related difficulties subscale items= 2, 9, 16, 23, 30, 37; Organisational structure and processes subscale items= 3, 10, 17, 24, 31, 38; Relationships and conflicts with other professionals subscale items= 4, 11, 18, 25, 32, 39; Lack of resources subscale items= 5, 12, 19, 26, 33, 40; Professional self-doubt subscale items= 6, 13, 20, 27, 34, 41; Home-work conflicts subscale items= 7, 14, 21, 28, 35, 42).

Information about you

1. Your age in years:

2. Your gender: (please circle)

   Female      Male

3. Your ethnic group: (please circle)

<table>
<thead>
<tr>
<th>WHITE</th>
<th>ASIAN/ASIAN BRITISH</th>
<th>MIXED/MULTIPLE ETHNIC GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>English/ Welsh/ Scottish/Northern Irish/ British</td>
<td>Indian Pakistani Bangladeshi Chinese</td>
<td>White &amp; Black White &amp; White</td>
</tr>
</tbody>
</table>
Thank you for completing this questionnaire.

By submitting this questionnaire you are consenting to take part in the study entitled ‘Investigating the Job Demands and Support available to IAPT workers’.

**You are now eligible to enter the prize draw of £75 of Amazon vouchers!**

Please fill in an **email address**

that the researcher can contact you through should you win:

This information will be kept confidentially and separate from your questionnaire data to protect your anonymity.

Only the researcher, Sophie Westwood, will have access to this information which will be kept confidentially.

It will be destroyed following the completion of the prize draw.
Appendix D. NHS R&D Department approval letters

Solent NHS Trust
NHS Trust
2nd Floor Adelaide Health Centre
Western Community Hospital Campus
William Macleod Way
Southampton
Hampshire, SO16 4XE
T: 023 8060 8925

Ref: SW /cl
22nd May 2012

Miss Sophie Westwood
Department of Psychology
AD Building
University of Surrey
Guildford
Surrey, GU2 7XH

Dear Sophie

R&D No.: SR/023/12
Study Title: Investigating the Job Demands and Support Available to IAPT Workers

In accordance with the Department of Health’s Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and permission from the Department of Research and Development (R&D) prior to commencement.

Solent NHS Trust has reviewed the documentation submitted for the above research study and I am pleased to confirm NHS permission. The Sites where you are permitted to undertake the research are listed in the attached appendix. The addition of a new site(s) must be notified to Solent Research by submitting an SSI form and for PICs, a revised R&D Form.

I would like to bring your attention to the attached list of conditions of approval and specifically to the mandatory requirement to record the recruitment for all sites within this Trust onto the e-edge™ database. Your study will be subject to monitoring and you will be required to comply with the requests in addition to the submission of annual reports.

Documents Reviewed

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>V1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>Participant Information Sheets</td>
<td>V1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>V1</td>
<td>17/01/12</td>
</tr>
<tr>
<td>Invitation Letter</td>
<td>V1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>Poster</td>
<td>V1</td>
<td>24/04/12</td>
</tr>
</tbody>
</table>

Solent NHS Trust Headquarters
Adelaide Health Centre, William Macleod Way, Milford, Southampton SO16 4OE
Telephone: 023 8060 8900 Fax: 023 8053 8740 Website: www.solent.nhs.uk
I wish you every success with your study and look forward to hearing from you.

Yours sincerely

Dr Sarah Williams
Research Manager
Ref: AB
10th October 2012

Miss Sophie Westwood,
Dept of Psychology,
AD Building, University of Surrey,
Guildford.
GU2 7XH.

Dear Miss Westwood,

RM&G Reference Number: SSPC/039/12
Study Title: Investigating the job demands and support available to IAPT workers

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and permission from the Department of Research and Development (R&D) prior to commencement.

On behalf of Hampshire PCT, the Shared RM&G Service reviewed the documentation submitted for the above research study and I am pleased to confirm NHS permission. The sites where you are permitted to undertake the research are listed in the attached appendix. The addition of a new site(s) must be notified to the Shared RM&G Service by submitting an SSI form and for PICs, a revised R&D Form.

I would like to bring your attention the attached list of conditions of approval and specifically to the mandatory requirement to record the recruitment for all sites within this Trust onto the e-edge™ database. Your study will be subject to monitoring and you will be required to comply with the requests in addition to the submission of annual reports.

Documents Reviewed

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>R&amp;D form</td>
<td></td>
<td>30/04/12</td>
</tr>
<tr>
<td>SSI form</td>
<td></td>
<td>13/08/12</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>University of Surrey Ethics Committee Favourable Opinion Letter</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>CV Sophie Westwood</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>CV Nan Holmes</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>CV Linda Morrison</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>Data Protection Form</td>
<td></td>
<td>02/10/12</td>
</tr>
<tr>
<td>Indemnity confirmation</td>
<td></td>
<td>30/07/12</td>
</tr>
<tr>
<td>Service Invitation Letter</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>PIS</td>
<td>1</td>
<td>24/04/12</td>
</tr>
<tr>
<td>Poster</td>
<td>1</td>
<td>24/04/12</td>
</tr>
</tbody>
</table>

I wish you every success with your study and look forward to hearing from you.

Yours sincerely

Alexandra Babbage
Research Governance Officer
Hampshire & IOW Shared RM&G Service
Miss Sophie Westwood  
Trainee Clinical Psychologist  
Surrey Borders Partnership NHS Foundation Trust  
Department of Clinical Psychology  
AD building University of Surrey  
Guildford  
GU2 7XH

17 July 2012

Dear Miss Westwood

Trust Approval: R&D2012/081 Title: Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers.

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval relates to work in the Mood, Anxiety and Personality CAG and to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including extending to other Trust directorates will require further approval from this Trust and where appropriate the relevant Research Ethics Committee: Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.

http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/314_RD_Approval_Amendment_Form_V2.doc

I note that the University of Surrey, Guildford will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health’s Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework.

• Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy. http://www.iop.kcl.ac.uk/iopweb/blob/downloads/locator/1313_SLaM_Confidentiality_Policy_v4.pdf

• Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.

• Informing the Trust’s Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

• Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

• Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.

• Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust’s approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

Jenny Liebscher
R&D Governance Delivery Manager
SLaM/IOP R&D Office

Enc. R&D Approval Amendment Form
Dear Sophie,

Research Title: Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers

Principal Investigator: Ms Sophie Westwood
Project reference: PF520
Sponsor: University of Surrey

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.

- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.

- The PI must ensure appropriate procedures are in place to action urgent safety measures.

- The PI must ensure the maintenance of a Trial Master File (TMF).

Terms and conditions of Approval, version 1.1 29/05/2012
- The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).

- The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.

- The PI must report any cases of suspected research misconduct and fraud to the Research Office.

- The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.

- Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.

- Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

- Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.

- All research carried out within South West London & St George's Mental Health NHS Trust must be in accordance with the principles set out in the Department of Health's Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact me on 020 8725 3463 (St. George's), e-mail: esboda@saul.ac.uk.

Yours sincerely,

Enitan Eboda (Ms)
Research & Development Co-ordinator
On behalf of the Research & Development Committee.

Terms and conditions of Approval, version 1.1 29/05/2012
16 February 2012

Our Ref: 2012/08
Study title: Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers

Dear Sophie

Confirmation of Trust Management Approval

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the protocol and subject to a favourable ethical opinion from the University of Surrey.

If there are any changes to the study protocol, the R&D Department must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed.

The R&D Department is required to monitor the progress of all research in the Trust under the Department of Health’s Research Governance Framework. You will be contacted in due course with a request for reports of progress, and for a brief final report of research findings.

If you have any questions about the above, or you require any other assistance, then please contact the R&D Department.

I wish you every success with the study.

Yours sincerely

Dr Justin Wilson
Medical Director

The Community Health Services for Berkshire East and Berkshire West are part of Berkshire Healthcare NHS Foundation Trust as of 8th April 2011
Dear Sophie,

This letter provides the formal Southern Health NHS Foundation Trust approval required for your project to commence. Details of information that the R & D Office will require during the period of your research can be found within the enclosed researchers pack. Your project is now registered on the R&D database with identification number SHT054. It would be helpful if you could use this number on all correspondence with the R & D Office.

Please note that this trust approval (and your ethics approval) only applies to the current protocol. Any changes to the protocol can only be initiated following further approval from the ethics committee via a protocol amendment; the R&D office should be informed of these changes.

This approval is conditional on members of the research team either being substantively employed by the Trust or having appropriate Honorary Research contracts in place before they start data collection. Please contact the R&D Department to confirm requirements for any new members of the research team.

This letter also confirms that University of Surrey will act as Research Sponsor and will provide indemnity under arrangements for student projects.

In the event that this study is adopted to the UKCRN Clinical Research Portfolio, may we take this opportunity to remind you of your responsibility for uploading accrual data for the research site. If you have any difficulty with this process please let us know.

The conditions of this approval require you as Principal Investigator to ensure that the study is conducted within the Research Governance framework and I encourage you to become fully conversant with the Research Governance Framework (RGF) on Health and Social Care document. Any breaches of the RGF constitute non-compliance with the RGF and as a result Trust approval may be withdrawn and the project suspended until such issues are resolved.

It is the responsibility of the R&D office to monitor all research taking place within Southern Health NHS Foundation Trust. Please visit the Trust website to ensure that you are familiar with our policies and procedures. http://www.southernhealth.nhs.uk/research/conductina-in-research/

Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

With best wishes,

Yours sincerely,

Research & Development

An NHS Teaching Trust with the University of Southampton

Trust Headquarters, Maples, Horseshoe Drive, Titchbury Mound, Colmore, Southampton SO4 2RZ.
Miss Sophie Westwood
Department of Psychology
AD Building, University of Surrey
Guildford
GU2 7XH

Dear Miss Westwood,

I am pleased to confirm that the following study has now received R&D approval, and you may now start your research in the trust(s) identified below:

<table>
<thead>
<tr>
<th>Trust Name</th>
<th>REC Reference</th>
<th>R&amp;D Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central North West London NHS Foundation Trust</td>
<td>N/A</td>
<td>12MHS27</td>
</tr>
</tbody>
</table>

Please ensure that all members of the research team are aware of their responsibilities as researchers which are stated in page 2. For more details on these responsibilities, please check the R&D handbook or NoCLoR website: [http://www.noclor.nhs.uk](http://www.noclor.nhs.uk)

We would like to wish you every success with your project

Yours sincerely,

Mabel Saiii
Senior Research Governance Officer
Dear Miss Westwood,

Our ID: 1495/NOCI/2012
TITLE: Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers.

Thank you for your application to the Sussex NHS Research Consortium for research governance approval of the above named study.

I am pleased to inform you that the study has been approved, and so may proceed. This approval is valid in the following Organisations:

- Sussex Community NHS Trust

The final list of documents reviewed and approved is as follows:

- NHS R&D form (submission code: 95589/318116/14751, signed and dated 30/04/2012)
- NHS Site-Specific Information form (submission code: 95589/318107/6/729/154134/242196, signed and dated 30/04/2012)
- Project Proposal (version 1, dated 24/04/2012)
- Participant Invitation Letter (version 1, dated 17/01/2012)
- Participant Information Sheet (version 1, dated 12/04/2012)
- Questionnaire: Investigating the job demands and support available to IAPT workers (version 1, dated 24/04/2012)
- CV for Dr Nan Holmes (unsigned and undated, received 15/05/2012)
- CV for Linda Morrison (unsigned and undated, received 15/05/2012)
- CV for DR Jackie Allt (signed and dated 02/05/2012)
- CV for Sophie Westwood (unsigned and undated, received 15/05/2012)
- LRDO Sign-off (signed and dated 21/05/2012)
- University of Surrey favourable ethical opinion letter (signed and dated 23/03/2012)
- Zurich Municipal Insurance Certificate (policy number: NHE-17CA01-0013, signed and dated 08/07/2011)

Your research governance approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application.
2. You notify the Consortium Office should you deviate or make changes to the approved documents.
3. You alert the Consortium Office by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of research governance approval.

5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Good luck with your work.

Yours sincerely,

Miss Hannah Haines
Research Governance Officer

Email: hannah.haines@wsht.nhs.uk
Tel: 01903 260223 ext. 4394
Fax: 01903 209884

cc: Mrs Lorraine Southby, R&D Manager, Sussex Community NHS Trust.
Dear Miss Westwood

Protocol: Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers.

ReDA Ref: CB1207/4

I am pleased to inform you that the Joint Research Management Office for Barts Health NHS Trust and Queen Mary University of London has approved the above referenced study and in so doing has ensured that there is appropriate indemnity cover against any negligence that may occur during the course of your project, on behalf of East London Foundation Trust. Approved study documents are as follows:

<table>
<thead>
<tr>
<th>Type</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posters</td>
<td>1</td>
<td>24/04/2012</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>1</td>
<td>24/04/2012</td>
</tr>
<tr>
<td>Questionnaire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>24/04/2012</td>
</tr>
</tbody>
</table>

Please note that all research within the NHS is subject to the Research Governance Framework for Health and Social Care, 2005. If you are unfamiliar with the standards contained in this document, or the BH and OMUL policies that reinforce them, you can obtain details from the Joint Research Management Office or go to: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicvAndGuidance/DH_4108962

You must stay in touch with the Joint Research Management Office during the course of the research project, in particular:

- If there is a change of Principal Investigator
- When the project finishes
- If amendments are made, whether substantial or non-substantial

This is necessary to ensure that your R&D Approval and indemnity cover remain valid. Should any Serious Adverse Events (SAEs) or untoward events occur it is essential that you inform the Sponsor within 24 hours. If patients or staff are involved in an incident, you should also follow the Trust Adverse Incident reporting procedure or contact the Risk Management Unit on 020 7480 4718.

We wish you all the best with your research, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Yours sincerely

Gerry Leonard, Head of Research Resources

Copy to: Glenn Moulton, University of Surrey (g.moulton@surrey.ac.uk)
21 September 2012

Miss Sophie Westwood
Trainee Clinical Psychologist
University of Surrey
Department of Clinical Psychology, AD Building,
Guildford, GU2 7XH

Dear Miss Westwood

Student Research: Investigating the job demands and resources available to Improving Access to Psychological Therapies (IAPT) workers

I am writing formally to confirm that the R&D Committee gave management permission ("R&D approval") to the above project on 24 May 2012.

We note that, under the harmonised Governance Arrangements for Research Ethics Committees (GAfREC), your research involves NHS staff recruited as research participants by virtue of their professional role and therefore does not require NHS REC review.

A Letter of Access will not required for you to access identifiable staff data in the form of returned paper and online questionnaires as this will be outside of NHS facilities.

This management permission is conditional upon the following:

- Submission of a progress report 12 months from today's date. Annual progress reports should be submitted thereafter until the end of the study. If the study has not started within 12 months of this management permission, you should give an explanation for the delay in the first progress report
- If you plan to extend the duration of the study beyond the period specified in your initial R&D application, you should notify the R&D Office in writing, giving reasons for the extra time needed to complete the research
- You should notify the R&D Office in writing of the conclusion or early termination of the study and send a summary of the final research report within 12 months of the end of the study. As a minimum, you should state whether the study achieved its objectives, the main findings, and arrangements for publication or dissemination of the research, including any feedback to participants

I wish you every success with your study.

Yours sincerely

Alexandra Punter
Research Management and Governance Manager

cc: Dr Nan Holmes/Dr Linda Morison, Dept of Psychology, UoSurrey (Academic Supervisors)
Appendix E. Formal letter of invitation to participate in the present study

Dear IAPT manager/team leader,

RE: Invitation to participate in research study, 'Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers.'

I am writing to invite your IAPT service to participate in this research study. The aim of the study is to investigate whether Psychological Wellbeing Practitioners, HI therapists and Counsellors in IAPT services experience any emotional strain at work, and if they do, what, if any, external factors might be related to this. Emotional strain has been implicated in the development of burnout, hence the concern to assess if it is present in staff. The main objective of the study is to identify if any particular demands of the job are related to emotional strain and if any of the resources available to them at work help to alleviate this and enhance engagement. By looking specifically at these external factors, I hope to provide practical and low cost recommendations to enhance employee wellbeing.

I am hoping to recruit Psychological Wellbeing Practitioners, High Intensity Therapists and Counsellors.

The study will involve completion of a questionnaire (paper or online) which may take approximately 15-20 minutes to complete. Please see the attached Questionnaire (paper form) for your information. Participants can choose to enter a prize draw once they have submitted the questionnaire with a chance to win £75 worth of Amazon vouchers once the questionnaire has been completed.

All individual responses to the questionnaire will be anonymous; services will not be identifiable in the results.

I do hope your service will agree to participate in this research. If you need further details about the research I would be happy to come and talk to your team to introduce the study to them. We will provide you with a report of the findings when the research is completed.

Yours sincerely,

Sophie Westwood
Trainee Clinical Psychologist, University of Surrey

Supervised by
Dr Nan Holmes
Clinical Director, Psych.D Clinical Psychology Training Programme
RE: For the attention of all Psychological Wellbeing Practitioners, High Intensity workers and Counsellors.

Dear PWP's, HI workers and Counsellors,

I am writing to ask for your help with a research project aiming to improve the understanding of IAPT workers' experience of their jobs.

My name is Sophie Westwood and I am a trainee clinical psychologist studying at the University of Surrey conducting some research on 'Investigating the job demands and support available to IAPT workers'.

The study has been approved by the Faculty of Arts and Human Sciences Ethics committee at the University of Surrey and by the appropriate NHS Research and Development Departments (Berkshire NHS R&D).

The attached Participant Information Sheet tells you all about the project. I would be very grateful if you would read it and then click on the link to complete the questionnaire..

http://www.fahs.surrey.ac.uk/survey/IAPTworkers/

Once you have completed the study you will be offered the chance to enter a prize draw to win £75 worth of Amazon vouchers.

Thank you so much for your help,

Sophie

Sophie Westwood
Trainee Clinical Psychologist
Department of Clinical Psychology, AD Building, University of Surrey, Guildford, Surrey, GU2 7XH
Would you like to participate in research to help to understand IAPT workers experience of their jobs?

Please fill in a paper questionnaire available in your service or go to the link below to fill it in online:

http://www.fahs.surrey.ac.uk/survey/IAPTworkers/

You will be in with a chance of winning £75 of Amazon vouchers if you choose to enter the prize draw!

If you have any questions concerning this research please contact the researcher, Sophie Westwood (Trainee Clinical Psychologist), either at the University of Surrey- 01483689441 or via email s.westwood@surrey.ac.uk
Would you like to participate in research to help improve the understanding of IAPT workers' experience of their jobs?

I am a Trainee Clinical Psychologist at the University of Surrey conducting a piece of research entitled:

'Investigating the job demands and support available to IAPT workers'

You can take part by filling in a questionnaire either on paper or online which will take up to 15-20 minutes.

If you fill in and submit the questionnaire you can choose to be entered into a

PRIZE DRAW for £75 of Amazon vouchers

If you have any questions concerning this research please contact the researcher, Sophie Westwood, either at the University of Surrey- 01483689441 or via email s.westwood@surrey.ac.uk
Appendix I. 250 word article for ‘CBT Today’ BABCP publication

IAPT workers wanted for research project

As many readers will know, IAPT services deliver NICE-approved, evidence-based treatment primarily for depression and anxiety disorders. The workforce comprises PWPs, High Intensity Therapists and Counsellors.

Mindful that no research has yet been published on IAPT workers’ experience of their job roles, I am undertaking research into the different aspects of the IAPT worker’s role and how this affects their wellbeing and experience of their job.

If you are a PWP, High Intensity Therapist or Counsellor working for an IAPT service, I invite you to participate in my research project by completing a 20-minute questionnaire. The study has been approved by the Ethics Committee at the Faculty of Arts & Human Sciences, University of Surrey.

Please contact me at s.westwood@surrey.ac.uk for more information and a paper or electronic copy of the questionnaire. If you choose to participate, you will be entered into a prize draw after completion of the questionnaire for the chance to win £75 in Amazon vouchers.

Sophie Westwood, Trainee Clinical Psychologist, University of Surrey

CBT Today: October 2012
Appendix J. Email message to participants recruited via CBT Today and BABCP website.

RE: For the attention of all Psychological Wellbeing Practitioners, High Intensity workers and Counsellors.

Dear XXXX,

Thank you very much for your interest in the project.

Please see the Participant Information Sheet attached and the email below for the electronic link to the questionnaire.

Please do not distribute the questionnaire in your IAPT service. People who want to complete the questionnaire will need to contact me directly.

Many thanks,

Sophie

Sophie Westwood
Trainee Clinical Psychologist
Department of Clinical Psychology, AD Building, University of Surrey, Guildford, Surrey, GU2 7XH

Dear PWP's, HI workers and Counsellors,

I am writing to ask for your help with a research project aiming to improve the understanding of IAPT workers' experience of their jobs.

My name is Sophie Westwood and I am a trainee clinical psychologist studying at the University of Surrey conducting some research on 'Investigating the job demands and support available to IAPT workers'.

The study has been approved by the Faculty of Arts and Human Sciences Ethics committee.

The attached Participant Information Sheet tells you all about the project. I would be very grateful if you would read it and then click on the link to complete the questionnaire.....

http://www.fahs.surrey.ac.uk/survey/IAPTworkers/

Once you have completed the study you will be offered the chance to enter a prize draw to win £75 worth of Amazon vouchers.
Thank you so much for your help,

Sophie

Sophie Westwood
Trainee Clinical Psychologist

Department of Clinical Psychology, AD Building, University of Surrey, Guildford, Surrey, GU2 7XH
Appendix K. Text published on BABCP website.

For the ‘Generation PWP’ forum:

Title: PWP and HI Therapists wanted!

Are interested in taking part in a 15-20 minute questionnaire based research study investigating the wellbeing of Psychological Wellbeing Practitioners and High Intensity Therapists and their experiences of their job roles?

Please email Sophie Westwood, Trainee Clinical Psychologist, studying at the University of Surrey at s.westwood@surrey.ac.uk for more information and to request the questionnaire in either online or paper format.

Many thanks for your time.

For the ‘Everything Else’ forum:

Title: PWPs, HI Therapists & Counsellors wanted!

Do you work for an Improving Access to Psychological Therapies (IAPT) service?

Are interested in taking part in a 15-20 minute questionnaire based research study investigating the wellbeing of Psychological Wellbeing Practitioners, High Intensity Therapists and Counsellors and their experiences of their job roles?

Please email Sophie Westwood, Trainee Clinical Psychologist, studying at the University of Surrey at s.westwood@surrey.ac.uk for more information and to request the questionnaire in either online or paper format.

Many thanks for your time.
Appendix L. Ethical approval from the Faculty of Arts and Human Sciences

23rd March 2012

Dear Sophie

Reference: 735-PSY-12 (NHS Approved)
Title of Project: ‘Investigating the job demands and support available to Improving Access to Psychological Therapies (IAPT) workers’

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has now given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely

[Signature]

Dr Adrian Coyle
Chair

Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Sophie Westwood
Trainee Clinical Psychologist
School of Psychology
University of Surrey
Appendix M. Further detail of construction of variables in the present study

Table 1

*Further details of the construction of each variable in the present study and how each is represented as either a job demand or job resource*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Variable</th>
<th>Measurement</th>
<th>Representation of high scores on job demands/resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLBI</td>
<td>Exhaustion</td>
<td>Likert scale of 1-4. Mean score calculated for each subscale.</td>
<td>Higher levels of Exhaustion/Disengagement.</td>
</tr>
<tr>
<td></td>
<td>Disengagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MHPSS

*Job demands*  
Workload  
Likert scale of 1-4. Mean score calculated for each subscale.  
A greater source of stress i.e. a greater job demand.  
Home-work conflict  
Client-related difficulties

*Job resources*  
Organisational and structural processes  
Likert scale of 1-4. Mean score calculated for each subscale.  
A greater source of stress i.e. lack of job resources.  
Relationships and conflicts with other professionals  
Professional Self-Doubt  
Lack of Resources
<table>
<thead>
<tr>
<th>Scale</th>
<th>Variable</th>
<th>Measurement</th>
<th>Representation of high scores on job demands/resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IAPT Job characteristics (as measured by non-standard questionnaire)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job role</td>
<td>PWP or HI Therapist</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Number of contracted hours per week</td>
<td>Hours contracted per week</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Years of mental health work experience (MH work experience)</td>
<td>Years</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Years worked in the IAPT service</td>
<td>Years</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Supervising staff</td>
<td>Hours per week</td>
<td>Greater job demand</td>
<td></td>
</tr>
<tr>
<td>Caseload</td>
<td>Number of patients</td>
<td>Greater job demand</td>
<td></td>
</tr>
<tr>
<td>Mild-mod difficulties</td>
<td>Percentage of patients on caseload</td>
<td>Greater job demand</td>
<td></td>
</tr>
<tr>
<td>Mod-severe difficulties</td>
<td>Percentage of patients on caseload</td>
<td>Greater job demand</td>
<td></td>
</tr>
<tr>
<td>Scale</td>
<td>Variable</td>
<td>Measurement</td>
<td>Representation of high scores on job demands/resources</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------</td>
<td>-----------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Patient contact</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Telephone contact</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Face-to-face contact</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Group contact</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Inputting data</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Overtime</td>
<td>Hours per week</td>
<td>Greater job demand</td>
</tr>
<tr>
<td></td>
<td>Awareness of targets</td>
<td>Likert scale</td>
<td>Greater job demand</td>
</tr>
<tr>
<td>Job resources</td>
<td>Supervision received</td>
<td>Hours per week</td>
<td>Greater job resource</td>
</tr>
<tr>
<td></td>
<td>Desk difficulties</td>
<td>Number of</td>
<td>Lack of job resource</td>
</tr>
<tr>
<td></td>
<td></td>
<td>difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>accessing a desk per week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical space difficulties</td>
<td>Number of</td>
<td>Lack of job resource</td>
</tr>
<tr>
<td></td>
<td></td>
<td>difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>accessing clinical space per week</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix N. Overlapping items on the MHPSS and OLBI

Table 2

*Items on the MHPSS which overlap with items of the OLBI.*

<table>
<thead>
<tr>
<th>No.</th>
<th>Subscale</th>
<th>Item</th>
<th>No.</th>
<th>Subscale</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Home-work conflict</td>
<td>Not enough time with family</td>
<td>4</td>
<td>Exhaustion</td>
<td>After work I tend to need more time than in the past in order to relax and feel better</td>
</tr>
<tr>
<td>36</td>
<td>Workload</td>
<td>Not enough time for recreation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Workload</td>
<td>Working too long hours</td>
<td>12</td>
<td>Exhaustion</td>
<td>After my work, I usually feel worn out and weary.</td>
</tr>
</tbody>
</table>
Appendix O. Histograms of exhaustion and disengagement for the total sample

Histogram

Mean = 2.57
Std. Dev. = .55
N = 202
Appendix P. Content analysis rules of job demands of codes and themes and a sample of data

Table 3

The rule of each code

<table>
<thead>
<tr>
<th>Code</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin</td>
<td>Any comment relating to the demands of administration duties/work.</td>
</tr>
<tr>
<td>Ageist work practices</td>
<td>Any comment with the word ageist or ageism present.</td>
</tr>
<tr>
<td>Awareness of targets</td>
<td>Any comment relating to negative experiences of ‘targets’.</td>
</tr>
<tr>
<td>Burnout</td>
<td>Any comment with the word ‘burnout’.</td>
</tr>
</tbody>
</table>
Constraints of one therapeutic model: Any comment relating to the limitations of singular therapeutic approach/model.

Continuous change in the organisation: Any comments relating to constant change in the organisation.

Emotional exhaustion: Any comments relating to negative emotions and exhaustion.

High volume of workload: Any comment pertaining to an increased or unmanageable number of patients/caseload.

<table>
<thead>
<tr>
<th>Code</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of autonomy</td>
<td>Any comment relating to a lack of autonomy.</td>
</tr>
<tr>
<td>Lack of career prospects</td>
<td>Any comment relating to negative aspects of 'career'.</td>
</tr>
<tr>
<td>Lack of staff</td>
<td>Any comment relating to a shortage of staff whether this be due to sickness, etc.</td>
</tr>
<tr>
<td>Lack of time to reflect</td>
<td>Any negative comment relating to lack of time for reflection.</td>
</tr>
<tr>
<td>Lone working</td>
<td>Any comment relating to negative experiences of working alone or in isolation.</td>
</tr>
<tr>
<td>Code</td>
<td>Rule</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient work</td>
<td>Any comment relating to negative experiences of patient work.</td>
</tr>
<tr>
<td>Physical environment</td>
<td>Any issues relating to the physical elements of the office environment such as poor equipment, lack of desks, poor IT, etc.</td>
</tr>
<tr>
<td>Poor management</td>
<td>Any comment relating to negative aspects of management either clinical, case management or line management.</td>
</tr>
<tr>
<td>Poor supervision</td>
<td>Any comments relating to negative experiences of ‘supervision’.</td>
</tr>
<tr>
<td>Risk</td>
<td>Any comment relating to patient risk/complexity/safe guarding.</td>
</tr>
<tr>
<td>Stress</td>
<td>Any comment with the word ‘stress’.</td>
</tr>
<tr>
<td>Time pressure at work</td>
<td>Any comments relating to lack of time to complete tasks.</td>
</tr>
<tr>
<td>Training commitments</td>
<td>Any comment relating to negative experiences of continuing professional development, training opportunities, skills workshops, etc.</td>
</tr>
<tr>
<td>Unpleasant work culture</td>
<td>Any comments relating to unpleasant work culture or politics at work.</td>
</tr>
</tbody>
</table>
Table 4

*The codes of each master theme*

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management/structural pressures</td>
<td>High volume of workload; time pressure at work; physical environment; lone working; unpleasant work culture; awareness of targets; lack of staff; continuous change; ageist work practice, poor management.</td>
</tr>
<tr>
<td>Training and development</td>
<td>Training commitments; lack of career prospects; lack of autonomy; poor supervision.</td>
</tr>
<tr>
<td>Emotional impact</td>
<td>Emotional exhaustion, stress, burnout; lack of time to reflect.</td>
</tr>
</tbody>
</table>
Patient issues

Constraints of working with one therapeutic model; risk; patient work.

Table 5
Sample of data
<table>
<thead>
<tr>
<th>Comments</th>
<th>Codes</th>
<th>Master themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>managing work with low support from managers, low career prospects/feeling trapped, low pay, competitive colleagues, poorly skilled supervisor, not enough sessions, doubting efficacy of therapies</td>
<td>Awareness of targets</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td>Seeing people back to back with no breaks. Working by self in GP practices where don’t have so many opportunities to talk with colleagues emotionally draining</td>
<td>Poor management</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td></td>
<td>Poor supervision</td>
<td>Training and development</td>
</tr>
<tr>
<td></td>
<td>Poor career prospects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time pressure at work</td>
<td></td>
</tr>
<tr>
<td>Politics of the organisation. Management not treating people equitably.</td>
<td>Time pressure at work</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td>Organisational constraints on interview rooms. Emotional demands of being a therapist. Admin role inputting clinician contacts assessments etc.</td>
<td>High volume of workload</td>
<td>Emotional impact</td>
</tr>
<tr>
<td></td>
<td>Lone working</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional exhaustion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poor management</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td></td>
<td>Unpleasant work culture</td>
<td></td>
</tr>
<tr>
<td>Listening to traumatic issues from clients on a consistent basis</td>
<td>Physical environment</td>
<td>Emotional impact</td>
</tr>
<tr>
<td></td>
<td>Emotional exhaustion</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td></td>
<td>Admin</td>
<td></td>
</tr>
<tr>
<td>Reaching service targets</td>
<td>Emotional exhaustion</td>
<td>Emotional impact</td>
</tr>
<tr>
<td>When I have to do group work on top of normal</td>
<td>Awareness of targets</td>
<td>Management/structural pressures</td>
</tr>
<tr>
<td></td>
<td>High volume of work</td>
<td>Management/structural pressures</td>
</tr>
</tbody>
</table>
workload.

Preparing for our PWP role play exams.

Training and having assessments at university whilst working the other days. Having to do study and reading in own time whilst carrying out full time work.

<table>
<thead>
<tr>
<th>workload</th>
<th>Training commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>pressures</td>
<td>Management/structural pressures</td>
</tr>
</tbody>
</table>

Appendix Q. Rules for codes and master themes of content analysis of job resources

Table 6
### The rules of each code

<table>
<thead>
<tr>
<th>Code</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colleagues</td>
<td>Any comment relating to positive experiences of colleagues, peers or workers.</td>
</tr>
<tr>
<td>Team support</td>
<td>Any comment relating to positive experiences of the ‘team’.</td>
</tr>
<tr>
<td>None</td>
<td>Any comment with the word ‘none’ or relating to an absence of job resources.</td>
</tr>
<tr>
<td>Patient contact</td>
<td>Any comment mentioning the rewards of being in contact or working with patients.</td>
</tr>
<tr>
<td>Supervision</td>
<td>Any comment relating to the positive aspects of ‘supervision’.</td>
</tr>
<tr>
<td>Good management</td>
<td>Any comment relating to the positive aspects of clinical, case management or line management or management of the service.</td>
</tr>
<tr>
<td>Other opportunities</td>
<td>Any comment relating to the positive aspects of training, career development, professional and personal development.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Any comment relating to positive experiences of ‘autonomy’.</td>
</tr>
<tr>
<td>Physical issues</td>
<td>Any positive comments relating to the physical aspects of the office or work environment such as having access to clinical space, a permanent desk and adequate IT.</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Time for administration duties</td>
<td>Any positive comments relating to time provided for administration</td>
</tr>
<tr>
<td>Training</td>
<td>Any positive comment relating to ‘training’ opportunities.</td>
</tr>
<tr>
<td>Flexible working hours</td>
<td>Any positive comments relating to working hours.</td>
</tr>
<tr>
<td>Personal stress-management</td>
<td>Any positive comments relating to personal stress-management learned from patient work.</td>
</tr>
<tr>
<td>Reduced travel:</td>
<td>Any positive comments relating to travel.</td>
</tr>
</tbody>
</table>

**Table 7**

*Codes of each master theme*
<table>
<thead>
<tr>
<th>Master theme</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer support</td>
<td>Colleagues and team.</td>
</tr>
<tr>
<td>Service-related resources</td>
<td>Physical issues, good management, supervision, other opportunities,</td>
</tr>
<tr>
<td></td>
<td>autonomy, flexible working hours, reduced travel, personal stress-</td>
</tr>
<tr>
<td></td>
<td>management, training, time for administration duties.</td>
</tr>
<tr>
<td>Helping people</td>
<td>Patient contact.</td>
</tr>
<tr>
<td>Absence of aspects alleviating stress</td>
<td>None.</td>
</tr>
</tbody>
</table>

Table 8

*Sample of data*
<table>
<thead>
<tr>
<th>Comments</th>
<th>Codes</th>
<th>Master themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking to colleagues</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Supervision</td>
<td>Supervision</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>Colleagues.</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>Supervision</td>
<td>Supervision</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>Supervision, peer support.</td>
<td>Supervision</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>Contact with clients</td>
<td>Patient contact</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>Friends I have made from doing the IAPT course and made an effort to</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>stay in touch with/catch up when we can. Have a chat after a rubbish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>day/session where possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having good supervision and risk procedures Having opportunities to see</td>
<td>Supervision</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>and catch up with colleagues face to face</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>Nothing.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Supportive colleagues.</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>Supportive line manager.</td>
<td>Good management</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>The team</td>
<td>Team</td>
<td>Peer support</td>
</tr>
<tr>
<td>Supervision and management, collegiate support. Working off site at</td>
<td>Supervision</td>
<td>Service-related resources</td>
</tr>
<tr>
<td>satellite venue and away from office.</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>Physical issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not enough that specifically addresses this issue above</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Team spirit</td>
<td>Team</td>
<td>Peer support</td>
</tr>
<tr>
<td>Informal discussion with colleagues</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td>Supportive team.</td>
<td>Team</td>
<td>Peer support</td>
</tr>
<tr>
<td>Peer socialising, supervision and team meetings, being involved in other projects aside from caseload e.g. working parties,</td>
<td>Colleagues</td>
<td>Peer support</td>
</tr>
<tr>
<td></td>
<td>Team</td>
<td>Service-related resources</td>
</tr>
<tr>
<td></td>
<td>Other opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervision</td>
<td></td>
</tr>
</tbody>
</table>