

Wellbeing and Burnout in Mental Health Service
Providers:
i. Relationships with quality of care
ii. The domains influencing wellbeing in Practitioner
Psychologists

Cathy McLellan 2018

Supervised by: Professor Reginald Morris

Thesis submitted in partial fulfilment of the requirement for the degree of D.Clin.Psy. at Cardiff University and the South Wales Doctoral Programme in Clinical Psychology.

Acknowledgements

I would firstly like to thank all the inspiring people who kindly offered to participate in my study. All the people I spoke with were enthusiastic about the topic area and open to discussing very personal experiences. Without them this project could not have happened.

I would like to express my gratitude toward my supervisor Reg for supporting me throughout this process, and for his kind and detailed feedback. His support helped me to push forward and continue with my work, even during the times it felt unmanageable.

Finally, I would like to thank my wonderful partner who always knew when to ask and when not to ask. Thank you for giving me the right balance of distraction and pushing me to work. Thank you for lending me your laptop.

Abstract

This thesis investigated wellbeing and burnout in mental health settings.

Paper one reports a systematic review of literature pertaining to staff wellbeing and/or burnout in mental health services, and the relationship this has with quality of care from the perspective of both staff and users of services. Overall the studies reported relationships between staff burnout, and to a lesser extent, wellbeing, on the quality of care provided to service users.

Paper two reports an empirical study of the perceived domains that influence the wellbeing of practitioners working in psychological roles. The empirical paper adopted a qualitative methodology. Practitioners cited four key themes that they perceived to have an impact on their subjective wellbeing, and one further theme regarding what can be done to improve staff wellbeing.

Paper three provides a critical review of the work undertaken in part one and part two of the thesis. This section considers the relative strengths and limitations of both papers and provides suggestions for both clinical implications and areas for future research. This paper provides an opportunity for the author to reflect on their experience in completing both papers.

Contents

1. ‘The relationship between clinician burnout, wellbeing and quality of care in mental health settings: systematic review of clinician and service user perspectives’	1
1.1 Abstract.....	2
1.2 Introduction.....	3
1.2.1 Background.....	8
1.2.2 Aims of the current review.....	9
1.3 Methods.....	10
1.3.1 Search strategy.....	10
1.3.2 Study selection.....	11
1.3.3 Data extraction.....	12
1.3.4 Assessment of methodological quality.....	12
1.4 Results.....	13
1.4.1 Overview of quality.....	22
1.4.2 Measurement.....	31
1.4.3 Outcomes of the studies.....	37
1.5 Discussion.....	43
1.5.1 Summary of key findings.....	43
1.5.2 Limitations.....	45
1.5.3 Clinical implications.....	49
1.5.3 Implications for future research.....	50
1.5.5 Conclusion.....	51
1.6 References.....	53
2. ‘The Wellbeing of Practitioner Psychologists: Establishing the perceived domains that affect wellbeing’	56
2.1 Abstract.....	60
2.2 Introduction.....	61
2.2.1 Aims.....	69
2.3 Method.....	69
2.3.1 Design.....	69
2.3.2 Rationale.....	70
2.3.3 Ethical considerations.....	71
2.3.4 Participants.....	72
2.3.5 Data collection.....	74
2.3.6 Analysis.....	74
2.3.7 Researcher Perspective.....	75
2.4 Results.....	76
2.4.1 Personal support.....	78
2.4.2 ‘Traumatised systems’- the NHS context.....	80
2.4.3 Positive and negative job aspects.....	82
2.3.4 Inter-professional aspects.....	86
2.3.5 The drive to improve staff wellbeing.....	88
2.3.6 Synthesis of themes.....	89
2.5 Discussion.....	92
2.5.1 Limitations of the study.....	98
2.5.2 Implications for research.....	100
2.5.3 Implications for the profession.....	100

2.5.4 Conclusion	101
2.6 References.....	102
3. Critical review.....	108
3.1 Summary.....	109
3.1.1 Overview.....	109
3.1.2 The context of the research.....	109
3.2 The systematic review.....	112
3.2.1 Rationale for the systematic review.....	112
3.2.2 Completing the review.....	114
3.3.3 Quality of the data.....	123
3.3.4 Implications of the results.....	124
3.3.5 Conclusions.....	127
3.3 The empirical paper.....	128
3.3.1 Rationale for the empirical study.....	128
3.3.2 Review of the selected methodology.....	129
3.3.3 The research process.....	132
3.3.4 Ethical considerations.....	137
3.3.5 Implications of the empirical research.....	138
3.3.6 Conclusions.....	141
3.4 Competency development.....	141
3.4.1 Research skills.....	142
3.4.2 Communication.....	142
3.4.3 Organisational and systemic influence and leadership.....	143
3.4.4 Personal and professional issues.....	144
3.4.5 Reflections.....	144
3.5 Dissemination.....	148
3.5.1 Selection of journal for publication.....	149
3.6 Concluding statement.....	150
3.7 References.....	151
4 Appendix.....	158

List of Tables

Table 1: Search terms

Table 2: Demographics table

Table 3: Data extraction table

Table 4: Quality assessment table

Table 5: Validity of the measures included in the review

Table 6: Participant demographics

Table 7: Table of themes

Table 8: Synthesis of current findings to the literature

Table 9: Extract from reflective journal

List of Figures

Figure 1: PRISMA diagram

Figure 2: Thematic Map

List of Appendices

Appendix A: Journal publication guidance

Appendix B: AXIS tool

Appendix C: CASP tool

Appendix D: Ethical approval

Appendix E: Participant invitation sheet

Appendix F: Participant information

Appendix G: Participant consent form

Appendix H: Participant demographic questionnaire

Appendix I: Debrief sheet

Appendix J: Interview schedule

Appendix K: Phases of thematic analysis

1. The relationship between clinician burnout, wellbeing and quality of care in mental health settings: Systematic review of clinician and service user perspectives.

Written in preparation for submission to the Journal of Occupational Health

Psychology

Prepared in accordance with author guidelines provided in Appendix A.

Word Count: 7996 excluding abstract, tables, figures and references

1.1 Abstract

Introduction: The current evidence base reports staff working in mental health settings as experiencing reduced wellbeing and increased burnout (Dreison et al., 2018). The relationship between staff wellbeing, burnout and quality of care is well established in medical health teams (Dewa et al., 2017), however there are currently no systematic reviews to establish the relationship between wellbeing, burnout and quality of care in clinicians working in mental health services.

Aims: The current review aims to synthesise and critically review the developing literature pertaining to staff wellbeing, burnout and quality of care in mental health services.

Method: Search terms were developed and databases PSYCInfo, Web of Science, CINAHL searched according to PRISMA guidance (Moher et al., 2009). Following the process of study selection 8 papers were selected for review.

Results: The overall quality of reported studies was moderate. Overall studies adopted a cross-sectional design, which led to limitations in interpretation of the data. Studies consistently reported a relationship between mental health practitioner burnout and quality of care. The results of the relationship between wellbeing and quality of care were variable, possibly due to methodological issues. Studies found relationships between the constructs of wellbeing and burnout.

Conclusions: The study is the first to evaluate the evidence base relating to the relationship between burnout, wellbeing and quality of care in mental health service providers. Implications for future research and services are discussed, along with the limitations of the present review.

Key Words: Mental health, Quality of Care, Burnout, Wellbeing.

1.2 Introduction

In healthcare settings the importance of staff wellbeing is increasingly recognised in both policy and literature (Boorman, 2009; Francis, 2013). The Boorman report (2009) highlights the impact of organisation, work environment and population factors on the wellbeing, experience and individual agency of employees. Due to the nature of top- down pressures such as privatisation, austerity, financial cuts and targets in the current NHS context (Hall et al., 2016), healthcare staff can be left working in poor conditions with low levels of staffing, increased pressures to meet targets and heavy workloads (Dixon-woods et al., 2013). Thus, it is unsurprising that the literature reports healthcare staff as experiencing reduced levels of wellbeing in the workplace (Picker institute, 2015; Francis, 2013; Maben et al., 2012).

1.2i Definition of terms

Wellbeing

Various terms can be used interchangeably to define experiences of wellbeing (Dewa et al., 2016). Warr et al. (2011) provided a universally accepted definition of wellbeing in work as ‘individual and subjective functioning and experiences at work’. ‘Wellbeing’ is an umbrella term often used to define different constructs (Maben et al., 2012). There are two key domains of wellbeing commonly cited in the literature surrounding wellbeing at work. These embody subjective experiences at work, one is job satisfaction and the other is psychological and physiological aspects of work such as burnout and stress (Maben et al., 2012).

Burnout

Professionals who experience lower levels of wellbeing are at risk of experiencing occupational burnout (Maslach et al., 2016). Burnout is a well-recognised occupational hazard for those working in health professions (Maslach et al., 2016). Maslach and colleagues (2016, 1984) developed a widely accepted definition of burnout, describing it as a feeling of emotional exhaustion, depersonalisation and reduced feelings of personal accomplishment.

Review papers have examined the prevalence of occupational burnout specifically in mental health settings (Dreison et al., 2018; Morse et al., 2012; Lim et al., 2010; Paris and Hoge, 2010). Morse et al. (2012) claim that up to 55% of people working in mental health services in the UK experience work related burnout. The impact of this on individuals, services and client care is a topic of growing interest for researchers (Morse et al., 2012).

1.2ii The relationship between wellbeing and burnout

There has been conflict within the literature surrounding the relationship between wellbeing and burnout (Hall et al., 2016). Some authors allude towards burnout and wellbeing as being the same construct (Dreison et al., 2018; Maben et al., 2012, Warr et al., 2011), and others present the idea that burnout and wellbeing are separate constructs (Hall et al., 2016; Jahrami et al., 2013). The mechanism by which burnout is thought to impact on well-being is described as resulting from a depletion of personal resources that leads to a decline in one's sense of subjective wellbeing. Resources are reduced as workers cope with chronic stress and feelings of exhaustion,

which then leads to feelings of fatigue and psychological distress (Leiter and Maslach, 2001).

Few studies have focussed on the relationship between burnout and worker wellbeing (Lizano et al., 2015). A recent systematic review completed by Lizano et al. (2015) reviewed studies comparing wellbeing and burnout in human service workers. The authors concluded that overall, studies pertained to the negative impact of burnout on individual worker's wellbeing. Emotional exhaustion was found to have the strongest relationship with wellbeing when measured through job satisfaction. Levels of personal accomplishment and depersonalisation also correlated with measures of wellbeing. However, the overall significance of results was variable, leading authors to note that further research is required to fully understand the links between these constructs.

Burnout is often treated as a substitute measure of wellbeing (Lizano et al., 2015). However, the available literature is unable to conclude links between all dimensions of burnout and wellbeing dimensions and therefore wellbeing and burnout need to be considered as separate constructs (Hall et al., 2016).

1.2iii Theoretical models of wellbeing and burnout

The job demands resources model of staff wellbeing (Bakker et al., 2007), embodies the definition of burnout developed by Maslach and colleagues (Maslach et al., 2016; 1984) and presents the idea that higher levels of job demand (client interaction and balancing priorities) require clinician resources over time, which can lead to emotional exhaustion. When clinicians experience this they withdraw their personal

resources to manage demands, which can lead to depersonalisation (Bakker et al., 2007). It is possible that this leaves clinicians unable to implement good quality of care (Salyers et al., 2015).

1.2iv The impact of reduced wellbeing and burnout

Literature has identified the consequences of higher levels of staff burnout and reduced wellbeing for clinicians in terms of poorer mental and physical health (Dreison et al., 2018). For services, higher levels of burnout correlate with absenteeism and productivity at work (Maslach et al., 2016; Paris and Hoge, 2010).

There is a growing evidence base detailing the impact of poor staff wellbeing on consumer care (Dewa et al., 2017; Salyers et al., 2017). Patient satisfaction rates are higher and patient experience is better where the workforce is healthier and where there are high levels of staff engagement (West et al., 2012; Boorman, 2009). In the NHS 'Health and Wellbeing review' completed by Boorman. (2009), over 80% of NHS staff reported that the state of their health and wellbeing affects patient care.

Previous systematic reviews looking at the impact of burnout on client care in healthcare professionals concluded that quality of care declines when staff experience burnout (Dewa et al., 2017; Salyers et al., 2015). Higher levels of perceived staff burnout have been linked to increased inpatient admissions (Priebe et al., 2004), and negative feelings towards clients (Holmqvist et al., 2006). Some research found worse outcomes when clients perceive their therapist to have lower levels of wellbeing (Mistry et al., 2015). In addition to this, burnout has been associated with lower expectations for consumer outcomes (Salyers et al., 2013).

These results have been replicated with regards to wellbeing (Maben et al., 2012). A three-year mixed methods study reported by Maben et al. (2012) completed an evaluation of staff wellbeing and the impact of this in terms of quality of care within a health context in the NHS using both patient and staff perceptions as an indicator. The authors found that where patient experience was positive, staff wellbeing was also positive and vice versa. The relationship between staff wellbeing and patient experience was affected by organisational climate and team cohesion. Maben and colleagues, (2012) concluded that staff wellbeing was an antecedent for client perceptions of quality of care.

1.2v Measurement of wellbeing, burnout and quality of care

Measurement of wellbeing and burnout

The measurement of psychological wellbeing varies across literature, with many studies using burnout as a construct to define wellbeing (Dreison et al., 2018). Within healthcare, several studies have attempted to enumerate and measure staff experiences of wellbeing and the impact of this on clients (Salyers et al., 2017). Staff satisfaction is a distinct construct, which consists of beliefs, attitudes, and behaviors toward one's job (Weiss, 2002). Similar to burnout, the relationship between staff satisfaction and client outcomes has been documented within the health sector (Hall et al., 2016), and measures of staff satisfaction tend to form the basis of measurement of wellbeing (Lizano et al., 2015). In addition to this, the available evidence base is currently moving towards a positive psychology approach to measurement with some research quantifying 'work engagement' as the positive construction of burnout (Van Bogeaert et al., 2013).

Measurement of quality of care

The World Health Organisation (WHO, Hanefeld et al., 2006) identified six areas to measure quality of care in health settings. These are: effectiveness, efficiency, accessibility, equitability, acceptability and safety.

In mental health care, measurement of quality of care is particularly challenging due to a lack of validated measurement tools (Salyers et al., 2014; Kilbourne et al., 2010). Studies of health care staff have used self-reported quality of care scales to measure the impact of low levels of wellbeing and burnout on client outcomes (Salyers et al., 2017). In terms of patient perceptions of quality of care, most literature aims to measure patient satisfaction (Maben et al., 2012). Despite the broad nature and definition of patient satisfaction, most studies quantify this by patient reported experiences (Al-Abri et al., 2014). Batbaatar et al., (2017), referred to patient satisfaction as a person's experiences, feelings and perceptions of the quality of care received. A systematic review into the measurement of patient satisfaction in healthcare settings (Phillips et al., 2015) concluded that there are few reliable and valid tools to measure patient experience. Most current tools correspond to those concerned with the 'acceptability' measurement as identified by the world health organisation (Hanefeld et al., 2006).

1.2.1 Background to this study

Links between burnout and quality of care are detailed in both literature (Maben et al., 2012) and policy (Boorman, 2009; Francis, 2013). The currently available research on

this topic area varies widely between practitioner type, healthcare setting and measurement of staff wellbeing, burnout and quality of care (Salyers et al., 2017). No review has focussed specifically on mental health services, and reviews often focus on the element of patient safety as a quality indicator (Dewa et al., 2017). There have been six recent reviews (Dewa et al., 2017; Salyers et al., 2017; Hall et al., 2016; Humphries et al., 2014; Lee et al., 2013; Taris et al., 2007), all of which focus on assessing quality of care in medical settings. Two recent reviews by Salyers et al. (2017) and Dewi et al. (2017) expanded their search criteria to all healthcare providers across settings. Hall et al. (2016) focus on patient safety as a measure of quality, and Humphries et al. (2014) completed a narrative review restricted to medical hospital settings.

The search strategies employed in the present review are restricted to individuals working in the mental health sector and thus different to those used in the previous reviews (Salyers et al., 2017; Dewa et al., 2017; Hall et al., 2016), meaning that different studies have been included in the current review. In addition to this, the aims of the present review are unique in that they encompass and focus around both patient and clinician perspectives.

1.2.2 Aims of the current review

The aim of the current study was to review and quantify studies linking mental healthcare provider wellbeing and/ or burnout to quality of care, to better understand the relationship between these constructs. The study aimed to capture all available research evaluating staff and/ or service user perspectives. The relationship between

staff wellbeing and user outcome in consumers of mental healthcare is an understudied topic (Morse et al., 2012), and this study aims to synthesize the currently available evidence base.

1.3 Methods

1.3.1 Search strategy

The review followed guidance from the ‘Preferred reporting items for systematic reviews and meta-analysis’ (PRISMA, Moher et al., 2009).

A systematic literature search of the following databases was conducted: PSYCInfo, Web of Science, CINAHL and PROSPERO. Google scholar was also searched to identify additional literature, and reference lists of relevant studies hand searched. The search strategy aimed to identify all available research suggesting a relationship between staff wellbeing and/ or burnout and quality of care outcomes in mental health settings from the perspective of staff and/or service users.

Initial search terms were developed using information from previous reviews (Dewa et al., 2017; Salyers et al., 2017), and were reviewed following scoping searches to include additional terms that had been identified. Boolean operators were used to combine search terms (Boland, Cherry and Dickson, 2013). The final terms used in search strategies are detailed in Table 1. The search was limited to those written in the English language.

Wellbeing and burnout	Quality of care indicator	Mental health setting
<i>Staff Burnout</i>	<i>Client care</i>	<i>Mental health setting*</i>
<i>Staff Coping</i>	<i>Client outcome</i>	<i>Psychiatric hospital*</i>
<i>Staff wellbeing</i>	<i>Client satisfaction</i>	<i>Psychiatric staff</i>
<i>Occupational wellbeing</i>	<i>Consumer outcome</i>	<i>Inpatient*</i>
<i>Clinician wellbeing</i>	<i>Consumer satisfaction</i>	<i>Unit*</i>
<i>Staff stress</i>	<i>Consumer care</i>	<i>Mental health</i>
<i>Occupational stress</i>	<i>Patient care</i>	<i>Mental health clinician*</i>
<i>Clinician stress</i>	<i>Patient outcome</i>	<i>Mental health</i>
<i>Clinician burnout</i>	<i>Patient satisfaction</i>	<i>practitioner*</i>
<i>Occupational burnout</i>	<i>Quality of care</i>	<i>Mental health nurse*</i>
<i>Staff satisfaction</i>	<i>Quality healthcare</i>	<i>Mental health worker*</i>
<i>Job satisfaction</i>	<i>Treatment outcome</i>	
<i>Occupational satisfaction</i>	<i>Therapeutic process</i>	
<i>Clinician satisfaction</i>		
<i>Staff motivation</i>		
<i>Occupational motivation</i>		
<i>Clinician motivation</i>		
<i>Clinician engagement</i>		
<i>Occupational engagement</i>		
<i>Work engagement</i>		
<i>Staff engagement</i>		

*Table 1: Search terms used in database searches. *= Terms expanded to include plural forms.*

1.3.2 Study selection

Relevant articles were selected using a screening process. Initially, titles were screened for relevance to the review topic. Following this, the author viewed the abstracts of the remaining articles. Full text articles were retrieved for all remaining articles.

Studies were included if they a) were published in English or had an English abstract available, b) Report data from mental health clinicians and/ or service users C) Contained research data that was either qualitative or quantitative in nature, or both. D) Studies were required to focus on **both** staff wellbeing and/ or burnout and quality

of care E) Studies were required to be published in peer-reviewed journals. Studies were excluded if they did not include populations from a mental health setting or if the primary sample was recruited from generic healthcare professions (i.e. Only a small portion of clinicians working in mental health).

1.3.3 Data extraction

The key data was extracted from each study chosen for the review. The extracted data included author, date, journal, study title, design, sampling, details of the methods, tools to measure outcome and key findings, in line with PICOS data extraction methods (Boland, Cherry and Dickson, 2013).

1.3.4 Assessment of methodological quality

When assessing the quality of studies, the research aimed to understand the extent to which identified studies employed methods to minimise bias and errors in their conduct, design and analysis. In order to minimise bias in quality assessment, data extraction was completed before the process of quality assessment commenced (Boland, Cherry and Dickson, 2013).

Previous quality frameworks have been developed for the use of intervention studies (Deeks et al., 2003), and subsequently many of the items reported were not applicable in the present systematic review. The AXIS tool (Appendix B, Downes et al., 2016) was selected for use in the review. The tool was initially developed to assess the quality of cross-sectional studies across disciplines as other observational quality

assessment tools focussed on cohort study data (Downes et al., 2016). As one of the papers included in the study was qualitative in design, the CASP tool, specifically developed for the evaluation of qualitative research, was selected for measuring the quality of this study (Appendix C, Critical Appraisal Skills programme, CASP, 2013).

1.4 Results

In total, eight studies were selected for analysis in this review (PRISMA, Figure.1), with one additional text inaccessible to the authors. A summary of demographic information included in the studies is provided in Table 2 and a summary description of papers is provided in Table 3.

The majority of studies were based on a sample of people working in the United States (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Landrum et al., 2012; Rossberg et al., 2008; Garman et al., 2002), One study included those working in the UK in their sample, (Mistry et al., 2015), and one study covered other European countries (Van Bogaert et al., 2013). Five studies did not clarify their specific population other than those working in mental health (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Landrum et al., 2012; Rossberg et al., 2009; Garman et al., 2002), one study adopted a sample of primarily nursing staff (Van Bogeaert et al., 2013), and one study focussed specifically on a sample of service users (Mistry et al., 2015). Community mental health was reviewed in four studies (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Landrum et al., 2012) and inpatient populations in three studies (Van Bogeaert et al., 2013; Rossberg et al., 2008; Mistry et al., 2015). Both inpatient and outpatient teams were explored in one study (Garman et

al., 2002). Three studies focussed on both staff and patient perceptions (Landrum 2012; Rossberg et al., 2008; Garman et al., 2002). One study reviewed patient experiences only (Mistry et al., 2015) and the majority looked at staff perceptions only (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014, Van Bogeart et al., 2013).

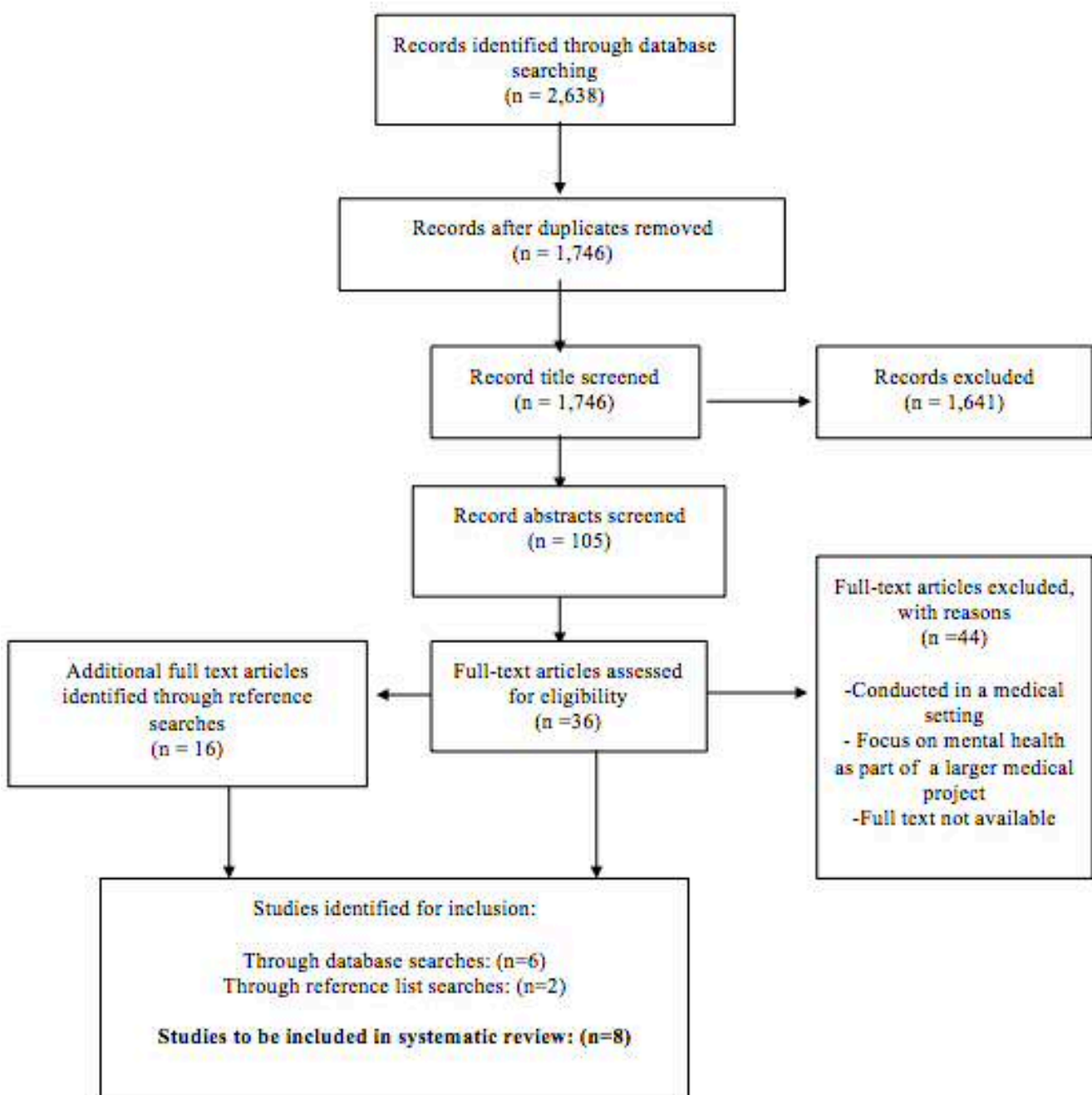


Figure 1: PRISMA table (Maben, 2009) detailing process of paper selection.

Table 2: Demographic information for studies included in the review

Study	Participant Numbers (N)	Participant age (SD)	Sex (%)	Ethnicity (%)	Educational background (%)	Length in mental health field/ time in current job: Mean years (SD)
<i>Studies reporting staff perceptions of wellbeing and quality of care</i>						
<i>Luther et al., (2016)</i>	<i>N=182</i>	<i>Clinicians age: 39.9 (12.2)</i>	<i>Female (80%)</i>	<i>White (86%)</i>	<i>Masters degree or above (41%)</i> <i>Education field (Psychology or social work, 47%)</i>	<i>Mean current job: 5 (6.2)</i> <i>Mean in mental health field: 8.8 (8.9)</i>
<i>Salyers et al., (2015)</i>	<i>N=120</i>	<i>Clinician age: 46.3 (11.7)</i>	<i>Female (69%)</i>	<i>White (77%)</i>	<i>Doctoral (18%)</i> <i>Masters (53%)</i> <i>Undergraduate (18%)</i> <i>Lower than degree level (10%)</i>	<i>Mean current job: 4.6 (5.7)</i> <i>Mean in mental health field 14.5 (10.7)</i>
<i>Salyers et al., (2014)</i>	<i>N=113</i>	<i>Not included</i>	<i>Female (83%)</i>	<i>White (96%)</i>	<i>Graduate degree (26%)</i> <i>Bachelor's degree (38%)</i> <i>Lower than degree level (36%)</i>	<i>Mean current job: 6.7 (6.2)</i> <i>Mean in mental health field 10.5 (8.2)</i>
<i>Van Boegert et al., (2013) (a,b)</i>	<i>N=357 32 clinical units</i>	<i>Clinician age: 35.9 (10.4)</i>	<i>Female (78%)</i>	<i>Not included</i>	<i>Registered nurses (65.5%)</i> <i>Practical nurses (23.6%)</i> <i>Non-registered caregivers (10.6%)</i>	<i>Mean current job: 6.2 (6.4)</i> <i>Mean in nursing: 12.3 (9.6)</i>
<i>Studies reporting staff and patient perceptions of wellbeing and quality of care</i>						
<i>Landrum et al.,</i>	<i>N= 89</i>	<i>Clinician age 47 years</i>	<i>Female (61%)</i>	<i>White (76%)</i>	<i>Bachelors degree or</i>	<i>Mean in mental health</i>

(2012)	<i>Clinical programmes</i>	<i>Clients age: Median age 33 years</i>	<i>Clients: (65%) male</i>	<i>Clients: White (68%)</i>	<i>higher (73.5%)</i>	<i>field:: 5</i> <i>Clients: in treatment for over 30 days.</i>
<i>Rossberg et al., (2008)</i>	<i>Not included</i>	<i>Clients age: Not included</i>	<i>Not included</i>	<i>Not included</i>	<i>Clients: No information collected</i> <i>Staff: Day staff included (physicians, psychologists, nurses, aides). No additional information collected.</i>	<i>Not included</i>
<i>Garman et al. (2002)</i>	<i>N= 405 clients N= 333 staff (Team level analysis)</i>	<i>Clinician age: 44 (10) Client age: Not included</i>	<i>Female (75%)</i>	<i>Non—Caucasian (21%)</i>	<i>Doctoral degree (7%) Masters level qualification (34%) College level education (17%) High school level of qualification. (11%)</i>	<i>Mean current job: 8.2 (6.5)</i>
<i>Studies reporting patient perceptions of staff wellbeing and quality of care</i>						
<i>Mistry et al. (2015)</i>	<i>N= 21 clients</i>	<i>Client age: From wards with high staff morale age range: 26-35 yrs. From wards with low staff morale: Mean age range 26-35 years</i>	<i>From wards with high staff morale: Female (60%) From wards with low staff morale: Male (89%)</i>	<i>High staff morale wards: White British, (50%) White and Black Caribbean (17%) Low staff morale wards: White British (33%), Black African (22%)</i>	<i>Not included</i>	<i>Not included</i>

Table 3: Characteristics of studies included in the review

Author	Participants	Population	Country of study	Study design	Measures of wellbeing / Burnout	Measure of quality of care	Outcomes
Studies measuring staff perceptions of wellbeing and quality of care							
Luther et al., (2016)	N= 182	2 community mental health services	United states	Cross-sectional	<p>Burnout: Maslach burnout inventory human service provider (MBI-HS, Maslach et al., 1996)</p> <p>Wellbeing:</p> <p>Work- Life: Work-family conflict measure (Carlson et all, 2000)</p> <p>Job satisfaction: Single Item measures of job satisfaction and turnover intention.</p>	Self-report quality of care scale (Salyers et al. 2014) plus 11 added questions on the impact on quality of care	Participants who reported working overtime reported significantly increased burnout and work–life conflict and significantly lower job satisfaction and quality of care than those not working overtime.
Salyers et al., (2015)	N=120	Community mental health service	United States	Cross-sectional	<p>Burnout: Maslach burnout Inventory for human services providers (MBI-HS, Maslach et al., 1996)</p>	Survey data was attached to burnout measure including open ended questions	Clinicians perceived a variety of ways in which burnout may affect how they work with people and, ultimately, consumer outcomes.

Salyers et al., (2014)	N=113	Community mental health service	United States	Cross-sectional	<p>Burnout: Maslach burnout inventory for human services (Adapted) (MBI-HS, Maslach et al., 1996)</p> <p>Wellbeing: Job Satisfaction: ‘Jobs diagnostic survey’ (Hackman and Oldham, 1974)</p> <p>Expectations of consumer recovery: ‘The Provider Expectations for Recovery Scale,’ A 10-item scale adapted from the 16-item ‘Consumer Optimism Scale’ (Salyers et al., 2013)</p> <p>Intentions to turnover: Single item measures</p>	Self reported quality of care scale- developed specifically for this study (SR-QoC, Salyers et al., 2014)	<p>Burnout, particularly personal accomplishment, and to a lesser extent depersonalization, were predictive of overall self-reported Quality of Care.</p> <p>Personal accomplishment was the aspect of burnout most closely associated with both overall self-reported quality and client-centered care</p>
Van Bogaert et al., (2013) a. Also includes:	N= 357 Team level analysis completed	2 Inpatient mental health hospitals- Data collected across 32 units.	Belgium	Cross sectional	<p>Burnout: Maslach burnout inventory for human services (MBI-HS, Maslach et al., 1996)</p>	Self reported quality of care- likert scale developed by authors.	Correlations were found between burnout and job satisfaction. emotional exhaustion particularly correlated with lower levels of job

<p>Van Bogaert et al (2013)b.</p> <p>Same study sample, however swapped analysis of 'burnout' to 'work engagement'.</p>					<p>Wellbeing: Practice environment: Revised nursing work index (Aiken and Patrician, 2000)</p> <p>Workload: 6-item scale</p> <p>Job satisfaction: Job experiences: likert satisfaction scale.</p> <p>Van Bogaert et al (2013) b.: Work Engagement: Utrecht Work engagement scale (Schaufeli et al., 2006)</p>		<p>satisfaction.</p> <p>All constructs of burnout correlated with quality of care, particularly depersonalisation. emotional exhaustion correlated with quality of care when measured at the unit level, not on an individual level.</p> <p>Low levels of reported emotional exhaustion and depersonalization predicted good ratings of quality of care.</p> <p>Results of Van Bogaert et al (2013)b:</p> <p>High-perceived workload correlated with perceptions of quality of care.</p> <p>Work engagement in turn showed stronger impacts on job</p>
---	--	--	--	--	--	--	---

							outcomes than on perceived quality of care.
Studies measuring both staff and client perceptions of wellbeing and quality of care							
Landrum et al., (2012)	N =89 programmes Team level analysis completed	Community mental health	United states	Cross-sectional	Wellbeing: Survey of Organisational Functioning (TCU SOF, Institute of behavioural research, 2005) Work environment: counsellor perceptions of stress, burnout, and work satisfaction at each program	Client engagement: Client Evaluation of Self and Treatment (CEST scale, Moura et al., 2013)	Staff stress negatively predicted client participation in treatment. Burnout was related to stress but was not related to participation/engagement. Staff stress was a positive predictor of burnout.
Rossberg et al., (2008)	N=129 clients N=359 staff	Psychiatric inpatient	United states	Longitudinal : Repeated cross sectional study over 11 years	Wellbeing: Job satisfaction: General satisfaction index (GSI, no reports of source) Work environment: Working Environment Scale-10 (WES-10 Rossberg et al., 2004)	Patient satisfaction: Ward Atmosphere Scale-Revised (Rossberg and Friis, 2003) General Satisfaction Index (GSI, no reports of source)	The study revealed a strong correlation between patient satisfaction and staff satisfaction. Working conditions of staff are related to both patient satisfaction and the patients' perceptions of the treatment environment. Working environment is important for the

							quality of care perceived by patients.
Garman et al., (2002)	N=405 clients N= 333 staff Team level analysis completed	Psychiatric inpatient and outpatient mental health teams	United states	Cross - sectional	Burnout: Maslach burnout inventory (MBI, Maslach et al., 1996)	Patient satisfaction: Consumer satisfaction survey (CSS), a modified version of the Patient satisfaction inventory (Corrigan and Jakus, 1993).	Burnout had a significant relationship with patient satisfaction. The emotional exhaustion component of burnout had the clearest relationship to client satisfaction and outcomes.
Studies measuring client perceptions of staff wellbeing and quality of care							
Mistry et al., (2015)	N= 21 clients	Psychiatric inpatient	England	Qualitative	n/a-	Semi-Structure Interviews asking open ended questions related to client perceptions of staff morale and its' impact on consumer care and outcomes.	Clients saw staff morale as having a significant impact on patient wellbeing and vice-versa.

1.4.1 Overview of the quality of included studies: Critical Evaluation

Overall, the included studies were of variable quality (Table 4). Two studies were deemed as being high quality (Van-Bogeaert et al., 2013; Garman et al., 2002), three studies were deemed to be of moderate quality (Luther et al., 2016; Mistry et al., 2015; Salyers et al., 2014), one of moderate to low quality (Salyers et al., 2015) and two of lower quality when compared to others (Landrum et al., 2012; Rossberg et al., 2008).

The studies included in the systematic review were critically appraised for the limitations that may impact on the rigour of this area of this literature. This was additionally captured in the quality appraisal tool question ‘Were the limitations of the study discussed?’.

Of the studies included in the review, all studies attempted to capture and discuss possible limitations to the study. This was particularly evident in the study completed by Garman et al., (2002), who highlighted a number of limitations relevant to the whole body of research. Other studies (Mistry et al., 2015; Landrum et al., 2012; Rossberg et al., 2008) did make reference to the limitations of the studies, however were not overly descriptive in their interpretations.

The differences in the overall quality of included studies were partially due to the sample selection, with a number of studies reporting potential sample bias (Salyers et al., 2015; Mistry et al., 2015; Landrum et al., 2012). For example, some studies reported data from one particular place of work (Salyers et al., 2015), whereas others

attempted to account for this bias by including different treatment environments (Garman et al., 2002), or by completing team level analysis (Van Bogeart et al., 2013). Some studies attempted to account for sample bias by controlling for time spent in specific clinical duties and excluding participants who did not spend adequate time working with patients (Van Bogeart et al., 2013; Luther et al., 2016).

Whilst all studies included samples and participants who were working in a mental health setting, the results of studies are not generalizable to all individuals working in all mental health settings due to the variability of services provided to individuals experiencing psychological distress. The recruitment methods and demographics of samples across all studies were restricted to individuals working either in inpatient or outpatient services with little information about the nature of work completed by individuals.

None of the included studies attempted to justify sample size and few accounted for non-response rates. There was a possibility of response rate leading to bias of results in two studies. Garman et al. (2002), report only a 65% response rate, including only 31 psychiatric teams out of a possible 48, and Van Bogeart et al., (2013) report a 68% response rate. The authors do not attempt to explain or understand those units that did not respond and participate.

As participation was voluntary across all studies it is possible that the sample adopted across all studies did not represent the general population of people working within mental health services. Landrum et al. (2012) highlighted that the sample used may only be representative of individuals who were experiencing difficulties in the work

place and may not have captured the views of those who were well adjusted to their work environment. Indeed, the studies that failed to include demographic information for non-respondents (Garman et al., 2002; Van Bogaert et al., 2013) possibly encountered this bias in their sample.

Table 4: Results of quality assessment. Table is split between quantitative quality assessment (n=7) and qualitative quality assessment (n=1).

Quality items were given a Y (yes) response if they fulfilled criteria, N (no) if they did not, P (partial fulfilment) and U (Unknown).

Quantitative measure (AXIS Tool)	Luther et al., (2016)	Salyers et al., (2015)	Salyers et al., (2014)	Van Bogeart et al., (2013)	Landrum et al., (2012)	Rosberg et al., (2008)	Garman et al., (2002)
Q1: Were the aims/objectives of the study clear	Y	Y	Y	Y	Y	Y	Y
Q2: Was the study design appropriate?	Y	Y	Y	Y	Y	Y	Y
Q3: Was the sample size justified?	N	N	N	N	N	N	N
Q4: Was the population clearly defined?	Y	Y	Y	Y	Y	N	Y
Q5: Was the sample frame taken from a representative population so that	P	P	P	Y	Y	P	Y

<i>it was representative?</i>							
<i>Q6: Was the selection process likely to select representative participants?</i>	P	P	P	P	Y	Y	Y
<i>Q7: Were measures undertaken to categorise non-responders?</i>	P	P	P	Y	Y	N	Y
<i>Q8: Were risk factor and outcome variables measured appropriate to the study aims?</i>	Y	P	Y	Y	P	P	Y
<i>Q9: Were measures trialled, piloted or published previously?</i>	Y	Y	Y	Y	U	U	Y
<i>Q10: Is it clear what statistical methods were used?</i>	Y	Y	Y	Y	Y	Y	Y
<i>Q11: Were methods sufficiently described to enable repetition?</i>	Y	Y	Y	Y	Y	Y	Y

<i>Q12: Were the basic data adequately described?</i>	Y	Y	Y	Y	Y	Y	Y
<i>Q13: Does the response rate raise concerns about non-response bias?</i>	N	N	N	P	N	U	P
<i>Q14: Was information about non-responders described?</i>	N	N	N	Y	Y	N	Y
<i>Q15: Were the results internally consistent?</i>	Y	Y	Y	Y	Y	Y	Y
<i>Q16: Were the results for the analysis presented?</i>	Y	Y	Y	Y	Y	Y	Y
<i>Q17: Were the discussions and conclusions justified by the results?</i>	P	P	Y	Y	Y	Y	Y
<i>Q18: Were the limitations of the study discussed?</i>	Y	Y	Y	Y	Y	Y	Y
<i>Q19: Were there funding sources or conflicts that may affect the authors</i>	N	N	U	N	N	U	N

<i>interpretation of results?</i>							
<i>Q20: Was ethical approval or consent of participants obtained?</i>	Y	Y	Y	Y	U	U	Y
<i>Overall determined quality*</i>	Moderate	Moderate to low	Moderate	High	Low	Low	High

<i>Qualitative Measure (CASP Tool)</i>	Mistry et al., (2015)
<i>Q1: Was there a clear statement of aims?</i>	Y
<i>Q2: Is qualitative methodology appropriate?</i>	Y
<i>Q3: Was the research design appropriate?</i>	Y
<i>Q4: Was the recruitment strategy appropriate?</i>	P
<i>Q5: Was the data collected in a way that addressed the research</i>	P

<i>Q6: Has the relationship between researcher and participants been considered?</i>	U
<i>Q7: Ethical issues considered?</i>	Y
<i>Q8: Was the data analysis rigours?</i>	Y
<i>Q9: Was there a clear statement of findings?</i>	Y
<i>Q10: Is the research valuable?</i>	Y
<i>Overall determined quality*</i>	Moderate

** Overall quality of included studies was determined through comparison of the results of quality indicators between studies and through discussion and interpretation with research supervisor and the independent-rater.*

The majority of studies used cross-sectional data, which fit with the overall aims of studies. However, all of the included studies highlighted that the direction of relationships could not be determined. Due to the nature of completing cross-sectional studies clear conclusions could not be made to fully answer the research questions presented across the studies. This reduced the overall quality of the studies. One study adopted a longitudinal approach (Rossberg et al., 2008), however was deemed to be of lower quality due to the choice of measurement instruments.

There were good levels of internal consistency reported within studies, with all studies employing appropriate use of statistical testing and providing complete results. However, analysis relied on self-report data, which is vulnerable to bias (Salyers et al., 2014). Studies completed their analysis on a team level basis in three of the included studies (Van Bogeart et al., 2013; Landrum et al., 2012; Garman et al., 2002) whereas the others reviewed the relationship at an individual level.

Across the studies, there were poor attempts to control for confounding variables. The majority of studies did not indicate consideration of confounds, with only four studies attempting to discuss this (Van-Bogeart et al., 2013; Landrum et al., 2012; Rossberg et al., 2008; Garman et al., 2002).

None of the included studies attempted to account for other factors external to work-related domains, which may have accounted for experiences of burnout and a reduced sense of wellbeing. The rigour of studies may have been enhanced by including measures of external factors such as personal, family, social and environmental factors that may have enhanced burnout and reduced a sense of wellbeing to fully capture the experiences of clinicians.

As discussed previously, the nature of the definition of wellbeing and burnout is a key difficulty when developing the literature. Whilst studies measuring burnout were well described and quantified, studies focussing on staff wellbeing were less deterministic with the definitions used to describe the construct of wellbeing. In addition to this, none of the included studies attempted to discuss what constitutes good quality of care, and none of the included studies described a clear definition of what this was. This has implications for the choice of measurement, which is a key criticism to this body of literature.

There appeared to be variability in the use of outcome measures, with a number of studies reporting the use of validated tools in the measurement of burnout, and to a lesser extent, wellbeing (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Van-Bogeaert et al., 2013; Garman et al., 2002), yet fewer studies reporting the use of validated measures specifically related to quality of care (Luther et al., 2016; Salyers et al., 2014).

1.4.2 Measurement

Studies measured both burnout and wellbeing using a variety of tools. The measurement of burnout appeared relatively consistent across studies, whereas the measurement of wellbeing was variable across the included studies, with some quantifying wellbeing through job satisfaction (Garman et al., 2002) and others through generic workplace measures (Rossberg et al., 2008). Some studies opted to utilise measures of both burnout and wellbeing in their studies.

The selected tools varied in quality and authors did not consistently report psychometric properties. Psychometric properties were reported in the form of face validity ratings, internal consistency and convergent validity to other measures (Salyers et al., 2015).

Table 5 provides a summary of the measures used by the included studies and the reported validity and reliability.

Measure	Study using the measure	Did the study comment on the reliability and validity of the included measure?
Measures of burnout		
Maslach Burnout Inventory adapted for Human Services (MBI-HS, Maslach et al., 1996)	Luther et al. (2016) ; Salyers et al. (2015); Salyers et al. (2014); Van Bogeart et al. (2013a)	Yes- Good reliability and validity
Maslach Burnout Inventory (MBI, Maslach et al., 1996)	Garman et al. (2002)	Yes- Good reliability and validity
Survey of Organisational functioning scale (SOF, Institute of Behavioural Research., 2005)	Landrum et al. (2012)	No
Utrecht work engagement scale (UWES, Schaufeil et al., 2002)	Van Bogeart et al. (2013a)	Yes- Good reliability and validity
Measures of Wellbeing		

Job satisfaction		
Job Diagnostic Survey (Hackman and Oldham., 1974).	Salyers et al. (2014)	Yes- Good reliability and validity
Job Satisfaction Index	Rossberg et al. (2008)	No
Work- family conflict measure (WFCM, Carlson et al., 2000)	Luther et al. (2016)	No
Single Report Items (included in other measures)	Luther et al. (2016) Van Bogeart et al. (2013)	Yes- Good reliability and validity
Work environment		
Working Environment Scale-10 (WES-10, Rossberg et al., 2004).	Landrum et al. (2012) Rossberg et al. (2008)	No
Practice environment: Revised nursing work index (Aiken and Patrician, 2000)	Van Bogeart et al. (2013b)	Yes- Good reliability and validity
Measures of Quality of Care		
Staff rated Quality of Care		
Self-Reported Quality of Care scale (SR-QoC, Salyers et al., 2014)	Salyers et al. (2014) Luther et al. (2016)	Yes- Undetermined levels of reliability and validity at this stage in the development of the measure.
Patient rated Quality of Care		
The Client Satisfaction	Rossberg et al. (2008)	Yes- Good levels of

survey	Garman et al. (2002)	reliability and validity.
The Ward Atmosphere Scale + General satisfaction index	Rosberg et al. (2008)	No
The Client evaluation of self and treatment scale (CEST, Moura et al., 2012)	Landrum et al. (2012)	No

Table 5: Reported validity of measures used in included studies.

1.4.2i Measures of Burnout

Six studies measured burnout (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Van Bogaert et al., 2013a; Landrum et al., 2012; Garman et al., 2002;). Four studies (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Van Bogaert et al., 2013a) used the Maslach Burnout Inventory adapted for Human Services (MBI-HS Maslach et al., 1996), and one adopted the generic Maslach Burnout Inventory, (Maslach et al., 1996; Garman et al., 2002). One study (Landrum et al., 2012) measured burnout using a Survey of organisational functioning scale (SOF, Institute of Behavioural Research, 2005), however authors did not provide psychometric properties of this tool in their analysis.

The Maslach Burnout Inventory (Maslach et al., 1996) measures levels of Depersonalisation, emotional exhaustion and personal achievement and is one of the widely used measures of burnout in healthcare settings (Rothenberger et al., 2017). It has good internal consistency, stability over time, and convergent validity with related constructs (Maslach et al., 1996). All studies separated the dimensions of burnout within their study.

1.4.2ii Work engagement

Van-Bogeaert et al., (2013b), argued that mental healthcare is moving towards a positive psychology approach and measurement should now move from burnout towards work engagement. The authors used the dataset collected from their primary study (Van Bogeaert et al., 2013 a) and substituted the burnout scale with aspects of work environment, workload and job experiences to form a work engagement scale (UWES- Utrecht Work Engagement Scale, Schaufeil et al., 2002), a validated tool tested for factor structure, reliability and consistency (Van Bogeaert et al., 2009; Van Bogeaert et al., 2013).

1.4.2ii Measures of wellbeing

Job satisfaction

Job satisfaction was measured by Salyers et al. (2014) using the ‘Job Diagnostic Survey’ (Hackman and Oldham, 1974). The authors reported on the internal consistency of the measure and convergent and divergent validity. Rossberg et al. (2008), utilised the general satisfaction index (GSI) to determine job satisfaction. The authors did not note its’ psychometric properties or the authors of the index. Both Van Bogeaert et al. (2013) and Luther et al. (2016) alternatively measured job satisfaction using the single report items, which have shown to be reliable and valid measures in healthcare settings (Nagy et al., 2002).

1.4.2iv Additional measures of wellbeing

Other studies reported levels of staff wellbeing using measures of the work environment (Landrum et al 2012; Rossberg et al., 2008). However, authors did not report psychometric properties of the measures. Measures of ‘intentions to turn over’ and ‘expectations of consumer recovery’ were included in one study (Salyers et al., 2014). The psychometric properties of the tools include good levels of internal consistency (Salyers et al., 2017).

1.4.2v Measuring Quality of care

Staff rated quality of care

Four studies measured quality of care using staff ratings (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Van- Bogeart et al., 2013). Studies inconsistently reported psychometric properties for scales. Salyers et al. (2014), developed a 25-item scale specifically for the study, and Luther et al. (2016), adopted this scale, adding an additional eleven items. It is difficult to determine the reliability and validity of these tools as they were subject to adaptation and are in the early stages of development (Salyers et al., 2014).

1.4.2vi Patient rated quality of care

Patient rated quality of care was generally measured in terms of satisfaction. Patient satisfaction was reviewed in two studies (Rossberg et al., 2008; Garman et al 2002). The measures adopted in this study included 'The Client Satisfaction Survey' - a modified version patient satisfaction inventory (Garman et al., 2002; Corrigan and Jakus, 1993). Prior research had found this tool to have acceptable internal and test-retest reliability (Garman et al., 2002). Rossberg et al. (2008) measured satisfaction with treatment environment using the 'Ward Atmosphere Scale' (Rossberg and Friis, 2003) in combination with a general satisfaction index. However, the authors did not note psychometric properties of either scale.

One study attempted to quantify client experience by measuring client levels of engagement (Landrum et al., 2012). They utilised the 'Client Evaluation of Self and Treatment Scale' (CEST, Moura et al., 2013). The authors did not note its' psychometric properties.

Overall, studies to measure patient perceptions of quality of care used measures with poor reliability and validity. One study (Mistry et al., 2015) used qualitative methodology semi-structured interviews to gain better insight into the views of patients on staff morale. Given the lack of validated tools to measure this, this method of measurement appeared promising.

The findings of the studies are summarised below in relation to the aims of this review: to review and quantify studies linking mental healthcare provider wellbeing and/ or burnout to quality of care, and to better understand the relationship between these constructs.

1.4.3 Study Outcomes

Each study reported data outcomes of a significant relationship between clinician wellbeing and/ or burnout and outcomes in terms of quality of care and/or patient satisfaction. Three studies focussed on both staff and patient perceptions (Landrum et al., 2011; Rossberg et al., 2008; Garman et al., 2002). One study reviewed patient experiences only (Mistry et al., 2015) and the majority looked at staff reports only (Salyers et al., 2015; Salyers et al., 2014; Luther et al., 2016; Van Bogeart et al., 2013).

1.4.3i Studies reporting staff reports of burnout and /or wellbeing and quality of care

(Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014 and Van Bogeart et al., 2013)

Four studies reported staff perceptions of burnout, wellbeing and quality of care. Of the studies one measured burnout only (Sayers et al., 2015), three attempted to measure burnout and wellbeing (Luther et al., 2016; Salyers et al., 2014; Van Bogeart et al., 2013), and the study completed by Van Bogeart et al. (2013a) additionally reviewed their dataset to measure

work engagement (Van Bogeart et al., 2013b). One study was assessed as higher quality (Van-Bogeart et al., 2013), one as moderate (Salyers et al., 2014) and one as moderate to low (Salyers et al., 2015), partially due to the focus on self-report of staff as opposed to including a measurement of client rated quality of care.

The results of the studies indicated that burnout has a significant relationship with self-reported quality of care (Luther et al., 2016; Salyers et al., 2015; Salyers et al., 2014; Van Bogeart et al., 2013). In their results, Salyers et al. (2015) reported that 58% of participants described burnout as having a negative impact on quality of their care, and 68% claimed it had negative impact on user outcomes.

When separating the specific constructs of burnout as highlighted by Maslach et al (1996), experiencing a sense of personal accomplishment was found to have the biggest relationship to quality of care in two studies (Salyers et al., 2014; Van Bogeart et al., 2013). Depersonalization was evaluated as having a relationship with self-reported quality of care in all three studies (Salyers et al., 2015; Salyers et al., 2014; Van Bogeart et al., 2013). Emotional exhaustion was only found to significantly correlate with quality of care in one study (Van Bogeart et al., 2013). It is worth noting that the relationship between personal accomplishment and quality of care was left unreported in the study by Salyers et al. (2015). Luther et al., (2016) completed a study into the implications of working overtime on burnout, job satisfaction and quality of care using self-report data from clinicians. Their results showed that participants working overtime reported significantly higher levels of burnout in terms of depersonalisation and emotional exhaustion, and significantly lower levels of personal accomplishment.

Van Bogeart et al. (2013) reviewed their initial study and utilised 'Work engagement' as a positively framed parallel construct to burnout (Van Bogeart et al., 2013b). A key strength to this was the contribution to the 'Practice Environment and Outcome model', providing a contribution to the development of psychological theory in the area of occupational wellbeing. The authors found that a supportive work environment, staff engagement and positive job outcomes linked to positive perceived quality of care.

Salyers et al. (2014) also utilised measures of wellbeing in their study. They reported that clinician wellbeing, as measured by job satisfaction, did not have a relationship with overall quality of care. However, when separating the domains of quality of care measured in to, 'client centered care', 'general work conscientiousness' and 'work errors', authors found a significant relationship between wellbeing and general work conscientiousness. The authors suggested that conscientiousness reflected organisational commitment, and those with low job satisfaction may be able to separate their capacity to give clients good quality care from the effort they put in to meeting organisational standards. This fits with Hobfoll's (1989) theoretical model of conservation of resources. In contrast to these findings, Luther et al. (2016) found a significant relationship between lower levels of job satisfaction and quality of care ratings. The authors concluded that working overtime can lead to increased feelings of burnout and reduced wellbeing, which in turn has a relationship with the quality of care provided to patients.

In combination, these studies demonstrate the perceived relationship between burnout, wellbeing and quality of care for clinicians. These studies suggest the importance of feelings of personal accomplishment and a productive working environment in fostering a positive sense of wellbeing, and suggest the positive impact of this, alongside the negative impact of

feelings of depersonalization on quality of care. Whilst suggestive of the direction of the relationship, the use of cross-sectional designs mean these studies are unable to determine causation.

1.4.3ii Studies reporting both staff and client perceptions of burnout and/or wellbeing and quality of care

(Landrum et al., 2012; Rossberg et al., 2008 and Garman et al., 2002)

Of the three studies reporting both client and staff perceptions of wellbeing and/or burnout and quality of care, one study measured burnout (Garman et al., 2002), one measured wellbeing (Rossberg et al., 2008), and one measured both (Landrum et al., 2012). The results appeared variable, possibly due to the methodological rigour of studies, with only one (Garman et al., 2002) in this category scoring high in quality and the other two (Landrum et al., 2012; Rossberg et al., 2008) being of lower quality in comparison to others.

Garman et al (2002) analysed their results on a team-unit level. Their overall findings suggested that team level burnout has an impact on client satisfaction, and thus quality of care. When separating measurements of burnout constructs into depersonalization, emotional exhaustion and personal accomplishment (Maslach et al., 1996), personal accomplishment was very significantly correlated to patient experience, similar to the findings of the studies reporting staff perceptions.

In contrast to the findings of Salyers et al. (2015, 2014) and Van Bogaert et al. (2013a), Garman et al. (2002), reported that emotional exhaustion had the clearest relationship to client satisfaction. Their study findings did not relate depersonalisation to client satisfaction

overall. One possible reason for the discrepancies between studies reporting staff perceptions and this study was the level of analysis. Both of the studies reported by Salyers et al. (2014, 2015), were completed on an individual basis, whereas the results for Garman et al. (2002), were completed on a team unit level.

Rossberg et al., (2008), measured aspects of wellbeing through 'job satisfaction' in their study. They reported a significant relationship between patient satisfaction and staff satisfaction, that is, staff satisfaction scores correlated positively with patients recoded levels of satisfaction. The authors of this study concluded that a satisfactory working environment for staff members working in mental health settings seemed important to the quality of care as perceived by patients.

Landrum et al., (2012), reported results of the relationship of both wellbeing and burnout with quality of care. The study found results conflicting to the other studies (Garman et al., 2002; Rossberg et al., 2008). They did not find burnout or job satisfaction to have a relationship with levels of engagement in clients. This finding may be explained by methodological weaknesses to the study. Firstly, the study aimed to measure client engagement, a construct not used in other research, which primarily reviews patient satisfaction using alternate methods. In addition to this, the measure of burnout was not separated into constructs and measures made no reference to psychometric properties. The use of unvalidated tools means that these findings must be interpreted with caution. It is worth noting however, that the study did find a relationship between staff stress and occupational burnout.

1.4.3iii Studies reporting client perceptions of burnout and/ or wellbeing and quality of care

Mistry et al., (2015)

The results of patient satisfaction and perceptions were reported by (Mistry et al., 2015). This study was evaluated as being of moderate quality. The authors highlighted the importance of opportunities for staff to spend time with patients in developing a sense of satisfaction with the quality of care provided. Indeed, literature reports that a strong therapeutic relationship is associated with better patient satisfaction in mental health settings (Sweeney et al., 2014), and the authors argue that this relationship is particularly important in inpatient mental health environments as staff are required to spend a lot of time with patients. The participants noted that good teamwork between staff enhanced quality of care in inpatient wards. Participants also saw staff morale as interrelated with patient morale and satisfaction.

1.4.3iv The relationship between burnout and wellbeing

(Luther et al., 2016; Salyers et al., 2014; Van-Bogeaert et al., 2013; Landrum et al., 2012)

All of the studies comparing wellbeing and burnout noted a relationship between these constructs (Luther et al., 2016; Salyers et al., 2014; Van Bogeaert et al., 2013; Landrum et al., 2012). Luther et al. (2016), reported that participants experienced significantly more burnout when working overtime, which participants felt led to reduced wellbeing (job satisfaction). Landrum et al. (2012) measured staff wellbeing through considering the work environment and satisfaction. Whilst their results did not identify burnout as having a relationship with client engagement, as discussed previously, the authors did find a relationship between staff wellbeing and burnout, in that staff experiences of stress were a positive predictor of burnout. Salyers et al. (2014), found that job satisfaction negatively correlated with all three domains of job burnout. In addition to this Van-Bogeaert et al. (2013a), found that low team level

emotional exhaustion predicted levels of job satisfaction. In their second paper (Van Bogeart et al., 2013b) the authors also found that positive work engagement, a positively constructed form of burnout, was important to staff wellbeing through its' propensity to lead to enhanced job satisfaction.

1.5 Discussion

1.5.1 Summary of key findings

In summary, of the eight studies chosen for inclusion in this review the majority found a significant relationship between clinician burnout and/or wellbeing and perceived quality of care. All studies measuring burnout, wellbeing and quality of care noted a relationship between staff wellbeing and burnout.

1.5.1i Studies measuring burnout

Overall, the studies measuring all three constructs of wellbeing, burnout and quality of care (Luther et al., 2016; Salyers et al., 2014; Van Bogeart et al., 2013; Landrum et al., 2012) reported significant relationships between burnout or work engagement and quality of care (Luther et al., 2016, Salyers et al., 2014; Van Bogeart et al., 2013). Landrum et al., 2012, did not find a relationship between burnout and quality of care, however, this study was of lower quality and chose to measure quality of care through measures of 'client engagement' as opposed to satisfaction.

The studies focussed only on burnout and quality of care (Salyers et al., 2015; Garman et al., 2002) both reported a significant relationship between burnout and quality of care. Whilst

both studies reported a significant relationship, when separating the construct of burnout, Garman et al. (2002), found emotional exhaustion to have the strongest relationship to client perceptions of quality of care. In contrast to this, Salyers et al. (2015), reported depersonalisation to have a relationship with quality of care whilst emotional exhaustion did not. Interestingly, Salyers et al. (2015), reported that the lack of significant result with regards to emotional exhaustion may have been indicative of staff feeling too exhausted to notice that the quality of their care had reduced. Garman et al. (2002), measured client perceptions in their study as opposed to staff-reported quality of care (Salyers et al., 2015), which may explain the variability in these results. Future research is required in this area to determine the importance of utilising service users in measuring quality of care.

1.5.1ii Studies measuring wellbeing

Variable relationships between wellbeing and quality of care were reported. Of the five studies that measured wellbeing (Luther et al., 2016; Salyers et al., 2014; Van-Bogeaert et al., 2013; Landrum et al., 2012; Rossberg et al., 2008), only three studies in this category suggested a relationship between wellbeing and quality of care (Luther et al., 2016; Landrum et al., 2012; Rossberg et al., 2008), with another finding some correlation between wellbeing and quality of care in terms of 'general work conscientiousness' but not overall quality of care (Salyers et al., 2014). Van Bogeaert et al. (2013), did not compare their measure of wellbeing to quality of care. The variability in the relationships between wellbeing and quality of care may be due to methodological flaws in the choice of measurement for wellbeing. Only one qualitative study measured the self-reported experiences of clients (Mistry et al., 2015). As the methodology adopted was qualitative, no measure of staff wellbeing or burnout was adopted, however the overall results demonstrated that clients

viewed staff wellbeing as being important and having a bi-directional relationship with their own sense of wellbeing.

The results of the present review are largely consistent with the findings of previous reviews (Dewa et al., 2017; Salyers et al., 2017; Humpheries et al., 2014), which determined a relationship between psychological burnout in healthcare staff and the quality of client care. This review provides added value by examining studies specifically based in mental health services. However, it is important to note that the overall quality of included studies was only moderate. The limitations of the included studies and current review will be discussed below.

1.5.2 Limitations

1.5.2i Limitations of the studies included in the review

Study design

The design adopted by included studies was predominantly cross-sectional. Whilst results reported were relatively consistent across studies, the nature of cross-sectional design means that results cannot distinguish the direction of the relationship, for example whether poor quality of care led to reduced feelings of wellbeing as opposed to reduced wellbeing leading to poor quality of care. The studies could only determine that there was a relationship, and therefore the results must be interpreted with caution. As cross-sectional studies report finding at one point in time the studies were not able to assess the implications of poor staff wellbeing for patients over time. Indeed, Maslach et al. (1986), argue that the use of cross-sectional design in studies measuring burnout is not appropriate as burnout is considered to be a developmental process.

A common problem highlighted during the quality assessment ratings was the lack of controls in place for confounding variables. Whilst some studies attempted to discuss confounds (Garman et al., 2002) the majority of studies did not. Because of this studies were unable to conclude that other factors would not impact on experiences of quality of care and factors that mediate or moderate this relationship may have been left undetected.

Sample Selection

Within the reviews, samples were not fully described in all studies, particularly for those involving clients and service users. There may have been a sample bias present in a number of studies. Some studies noted the implications of selecting participants who had been in services for a longer period of time, potentially a sample of people who were likely to be more satisfied with care and vulnerable to the impact of social desirability.

Measures

There were difficulties in the measurement of wellbeing across the reported studies and results for burnout data were more consistent than studies measuring wellbeing, possibly due to the choice of measurement. There were varying constructs used to measure wellbeing including both job satisfaction and generic workplace measures (Rossberg et al., 2008). Some research draws together the above constructs and uses terms inter-changeably, whilst some defines them as separate constructs (Maben et al., 2012). The lack of consistency in use of terminology has been reflected in other reviews (Salyers et al., 2017). In order to develop a coherent literature and evidence base, future studies should aim towards consistency in the measurement of constructs.

Whilst some studies chose to use validated measures, predominantly those of burnout (Maslach et al., 1996) a number of studies adopted measures that were not fully validated or widely used in the literature (Rossberg et al., 2008), particularly when measuring experiences of quality of care (Salyers et al., 2014). Some studies relied on single item measures to determine perceptions of quality of care (Luther et al., 2016). Whilst not validated, some literature suggests that single item measures can be valid predictors of quality of both job satisfaction and care (Nagy et al., 2002).

The nature of the review focussed on studies that relied on self-report measures. Whilst self-report measures are sensitive and provide a depth of information, data is subject to self-selection bias (Downes et al., 2016). This is particularly important when considering the findings of Salyers et al. (2015), who suggested that clinicians experiencing emotional exhaustion were less likely to report an impact on the quality of care provided to clients. The authors concluded that clinicians might not observe the impact of psychological burnout on the quality of care they provide. This may explain some of the variability in results between self-reported and client reported data. These findings suggest that self-report measures may not capture the true ratings of quality of care. An alternate to self-report measures may be to measure quality using objective data. Indeed, a number of medical studies measure burnout and quality ratings using supervisor and management ratings (Taris et al., 2007).

1.5.2ii Strengths and limitations of the review

Defining constructs

There is variability within the literature surrounding the differences between constructs of wellbeing and burnout (Hall et al., 2016). A recent systematic review did not provide clear

conclusions on the nature of the relationship between the two constructs, however did note that there was a relationship (Lizano et al., 2015). Given the uncertainty of the previous literature, and the nature of the measures used in this study, it was decided that burnout and wellbeing would be considered as separate constructs. Indeed, some authors caution against the use of a ‘catch all’ term encompassing burnout and wellbeing together (Hall et al., 2016). However, others argue that this allows for multi-level analysis and discussion (Maben et al., 2012). The link between wellbeing and burnout was demonstrated throughout the results of this review, however the author felt that separating the constructs fit better with the current evidence base (Hall et al., 2016; Lizano et al., 2015).

Search strategy

Search terms were developed broadly to ensure that all research pertaining to staff wellbeing and burnout was included in the search results. Journals were confined to English-language studies only. The results of the search strategy may have been vulnerable to a publication bias due to the inclusion criteria limiting included studies to those published in peer-reviewed journals.

Quality assessment

The AXIS tool (Downes et al., 2016) was selected for use in determining quality of the included studies. This tool was recently developed to fill an existing gap in the available tools to assess the quality of studies with a cross-sectional design. However, the developed tool is still in the early stages of validation (Downes et al., 2016). An alternative method of assessing quality may have been to use the STROBE tool (Von Elm et al., 2007). However, its’ authors did not advocate for the use of this tool in quality assessment ratings.

Data Synthesis

Whilst the present review provides a detailed account of the quality of reviewed studies, some previous reviews into the area of healthcare have attempted to synthesise and review data using meta-analysis (Salyers et al., 2017). Meta-analysis was not seen as an appropriate form of analysis in the current review due to the heterogeneity of measures used. Indeed, Boland, Cherry & Dickenson, (2013) do not advocate for the use of meta-analysis in studies reviewing observational data.

1.5.3 Clinical implications

The systematic review confirmed findings seen in previous reviews of healthcare staff. There seems to be a relationship between staff wellbeing, burnout and quality of care both from the perspective of staff and service users. These findings have important implications for clinical practice in terms of interventions to support staff and improve client experience.

Enabling staff to achieve a sense of personal accomplishment in their work may be an important intervention in fostering a good sense of wellbeing (Garman et al., 2002; Salyers et al., 2014), which may be achieved through providing a culture where staff are able to feel valued in their work, allowing for higher levels of input into organisational practices (Landrum et al., 2012).

Introducing programmes into units aimed at improving the quality of staff- client relationships may serve to improve both staff morale and client experience (Mistry et al., 2015). Initiatives such as the ‘Productive mental health ward initiative’ (Van Bogaert et al., 2017) have attempted to foster better staff- client relationships with promising results.

1.5.4 Implication for future research

Of the included studies, most research has been published in the past 10 years, highlighting the recent drive to determine the impact of clinician wellbeing on quality of care. The studies included in the review largely adopted a cross-sectional design, which limits the generalisability of results. As the evidence base continues to develop it would be useful for studies to adopt longitudinal designs in order to ascertain the impact of clinician wellbeing on patient quality of care over time. The available evidence base points towards the need for further evaluation of intervention studies (Salyers et al., 2015). This would provide additional information about the causality of relationships.

The measurement of staff wellbeing and/ or burnout, and quality of care remains difficult and tools should be continually developed and validated to ensure accurate measurement of constructs. In addition to this, the current evidence base does not provide clear conclusions towards the nature of the relationship between wellbeing and burnout, despite the literature detailing a relationship (Lizano et al., 2015). In the current review, studies identified a relationship between burnout and practitioner wellbeing. Future studies should aim to approach the relationship between burnout and wellbeing with more rigor. This will lead to the development of validated tools and understanding in the measurement of these constructs.

The present systematic review emphasized the importance of considering both practitioner and service user perspectives of the relationship between staff levels of burnout and wellbeing and its' relationship with quality of care in future research studies. The discrepancies reported in the studies between those involving service user ratings and

clinician rated levels of burnout and the relationship of this to quality of care support the findings of Salyers et al., (2016), in that clinicians experiencing higher levels of burnout may be less likely to notice the impact of this on quality of care provided. This is an important area for consideration in future research, and the literature should aim to continue to develop an evidence base to establish the differences between staff-reported and service-user reported quality of care when clinicians are rated as having high levels of burnout and low levels of wellbeing. Enhancing our understanding of these discrepancies may drive forward the way in which quality of care is determined and measured in future research.

The majority of studies included in the review measured burnout, wellbeing and quality of care at an individual level. Studies reporting team-based analysis (Van-Bogeaert et al., 2013; Garman et al., 2002) highlighted the nature of working in mental health services, where team-led approaches are predominantly adopted. Some research suggests that burnout is ‘contagious’ within health care teams (Pettita et al., 2017). Because of this future research should aim to explore and analyse the impact of burnout within a team as opposed to on an individual basis.

1.5.5 Conclusions

This review is the first to systematically analyse the links between mental health provider wellbeing, burnout and quality of care and provides a unique understanding of these constructs in the area of Mental Health. Despite the limitations in methodological quality of included studies, the results of the review suggest that poor wellbeing and increased feelings of burnout have a significant relationship with client satisfaction and thus quality of care. The findings of this review are consistent with previous studies exploring wellbeing, burnout and

quality of care in medical settings. This systematic review is unique to mental health service providers and provides novel insights into the discrepancies between studies reporting service user perspectives and clinician perspectives of the relationship between burnout and poor wellbeing and quality of care. This finding highlights the importance of involving service-user perspectives in future research studies. Whilst we cannot conclude that low levels of wellbeing and clinician burnout leads to poor quality of care, we can conclude that there is a relationship between the two constructs that requires an in-depth exploration through further research.

1.6 References

- Aiken, L. H., & Patrician, P. A. (2000). Measuring organizational traits of hospitals: the Revised Nursing Work Index. *Nursing research*, 49(3), 146-153. doi:10.1097/00006199
- Al-Abri, R., & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. *Oman medical journal*, 29(1), 3. doi:10.5001/omj.2014.02
- Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of managerial psychology*, 22(3), 309-328. doi: 10.1108/02683940
- Batbaatar, E., Dorjdagva, J., Luvsannyam, A., Savino, M. M., & Amenta, P. (2017). Determinants of patient satisfaction: a systematic review. *Perspectives in public health*, 137(2), 89-101. doi:10.1177/1757913916634136
- Boland, A., Cherry, G., & Dickson, R. (Eds.). (2017). *Doing a systematic review: A student's guide*. Sage.
- Boorman, S. (2009) NHS Health and Wellbeing Review London: Department of Health. Accessed online in December 2017 at:

<http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing/the-way-to-health-and-wellbeing/outcomes-from-the-boorman-review-recommendations>
- Carlson, D. S., Kacmar, K. M., & Williams, L. J. (2000). Construction and initial validation of a multidimensional measure of work–family conflict. *Journal of Vocational behavior*, 56(2), 249-276. doi:10.1006/jvbe.1999.1713
- CASP (2013) Critical appraisal skills program: making sense of evidence. Oxford: CASP UK (www.casp-uk.net) Accessed online in January 2018 at:
<https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist.pdf>
- Corrigan, P. W., & Jakus, M. R. (1993). The Patient Satisfaction Interview for partial hospitalization programs. *Psychological Reports*, 72(2), 387-390. doi:10.1037/1076-8998
- Deeks, J., Dinnes, J., D'Amico, R., Sowden, A., Sakarovich, C., Song, F. (2003) Evaluating non-randomised intervention studies. *Health technology assessment*, 7(27): 1-173
- Dewa, C. S., Loong, D., Bonato, S., & Trojanowski, L. (2017). The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ open*, 7(6), doi:10.1136/bmjopen-2016-015141
- Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., ... & Willars, J. (2013). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ quality & safety*, s-2013. Doi:10.1136/bmjqs-2013-002471

- Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ open*, 6(12), e011458. Doi:10.1136/bmjopen-2016-011458
- Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology*, 23(1), 18-30. doi:10.1037/ocp0000047
- Francis, R. (2015, February 11). Freedom to Speak Up - An independent review into creating an open and honest reporting culture in the NHS.
- Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology*, 7(3), 235. doi:10.1037/1076-8998.7.3.235
- Hackman, J. R., & Oldham, G. R. (1974). The job diagnostic survey: An instrument for the diagnosis of jobs and the evaluation of job redesign projects (No. TR-4).. Yale University New Haven Department of Administrative sciences. Accessed online in February 2018 at : <http://www.dtic.mil/docs/citations/AD0779828>
- Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS ONE*, 11(7), e0159015. <http://doi:10.1371/0159015>
- Hanefeld, J., Jackson, T. (2017) 'Understanding and measuring quality of care:dealing with complexity. *Bulletin of the World Health Organization* 2017; 95:368-374. Doi: 10.2471/BLT.16.179309.
- Holmqvist, R., & Jeanneau, M. (2006). Burnout and psychiatric staff's feelings towards patients. *Psychiatry research*, 145(2), 207-213. doi:10.1016/j.psychres.2004.08.012
- Institute of Behavioral Research. (2005). TCU Survey of Organizational Functioning (TCU SOF). Fort Worth: Texas Christian University, Institute of Behavioral Research. Accessed online in January 2018 at: <https://www.ibr.tcu.edu/wp-content/uploads/2013/06/SOF-sg.pdf>
- Humpheries, N., Morgan, K., Conry, MC., McGowan, Y. (2014) Quality of care and health professional burnout: narrative literature review. *International Journal of Health Care Quality Assurance*. 27:293– 307. doi:10.1108/IJHCQA-08-2012-0087.
- Jahrami, H., Thomas, A., Saif, Z., Peralta, F., Hubail, S., Panchasharam, G., & AlTajer, M. (2013). The relationship between burnout and job satisfaction among mental health workers in the psychiatric hospital, Bahrain. *The Arab Journal of Psychiatry*, 24, 69-76. Doi:10.12816/0000101
- Kilbourne, A. M., Keyser, D., & Pincus, H. A. (2010). Challenges and opportunities in measuring the quality of mental health care. *The Canadian journal of psychiatry*, 55(9), 549-557. Doi: 10.1177/070674371005500903

- Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of substance abuse treatment, 42*(2), 222-230. Doi: 10.1016/j.jsat.2011.10.011
- Lee, R. T., Seo, B., Hladkyj, S., Lovell, B. L., & Schwartzmann, L. (2013). Correlates of physician burnout across regions and specialties: a meta-analysis. *Human resources for health, 11*(1), 48. Doi:10.1186/1478-4491-11-48
- Leiter, M. P., & Maslach, C. (2001). Burnout and quality in a sped-up world. *The Journal for Quality and Participation, 24*(2), 48. Retrieved May 15, 2018 from HighBeam Research: <https://www.highbeam.com/doc/1P3-79079051.html>
- Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling, 47*, 86-96 doi:10.1002/j.2161-1920.2010
- Lizano, E. L. (2015). Examining the impact of job burnout on the health and well-being of human service workers: A systematic review and synthesis. *Human Service Organizations: Management, Leadership & Governance, 39*(3), 167-181. doi: 10.1080/23303131.2015.1014122
- Luther, L., Gearhart, T., Fukui, S., Morse, G., Rollins, A. L., & Salyers, M. P. (2017). Working overtime in community mental health: Associations with clinician burnout and perceived quality of care. *Psychiatric rehabilitation journal, 40*(2), 252. Doi: 10.1037/prj0000234
- Maslach, C., & Jackson, S. E. (1984). *Burnout in organizational settings*. Applied Social Psychology Annual, 5, 133-153.
- Maslach, C., Jackson, S. & Leiter, M. (1996). *Maslach Burnout Inventory Manual 3rd edition*. California: CPP Mountain View.
- Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111. doi:10.10022031
- Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A., Murrells, T., & Morrow, E. (2012). Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. Southampton: NIHR Service Delivery and Organization Programme. Accessed online in March 2018 at: http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1819-213_V01.pdf
- Mistry, H., Levack, W. M., & Johnson, S. (2015). Enabling people, not completing tasks: patient perspectives on relationships and staff morale in mental health wards in England. *BMC psychiatry, 15*(1), 307 doi: 10.1186/s1288-015-0690-8
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine, 6*(7), doi: 10.1371/journal.pubmed.1000097.

- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39(5), 341-352 doi: 10.1007/s10488-011-0352-1
- Moura, A. D., Ferros, L., & Negreiros, J. (2013). Evaluation and monitoring instrument: Client Evaluation of Self and Treatment. *Archives of Clinical Psychiatry (São Paulo)*, 40(4), 165-166. doi: 10.1590/s0101-608320
- Mumvuri, M., & Pithouse, A. (2010). Implementing and evaluating the Productive Ward initiative in a mental health trust. *Nursing Times*, 106(41), 15. Accessed online in January 2018 at: <https://www.nursingtimes.net/download?ac=1259143>
- Nagy, M. S. (2002). Using a single item approach to measure facet job satisfaction. *Journal of occupational and organizational psychology*, 75(1), 77-86. doi:10.1348/096317902167658
- Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The journal of behavioral health services & research*, 37(4), 519-528. doi:10.1007/s11414-009-9202-2
- Petitta, L., Jiang, L., & Härtel, C. E. (2017). Emotional contagion and burnout among nurses and doctors: Do joy and anger from different sources of stakeholders matter?. *Stress and Health*, 33(4), 358-369. doi: 10.1002/smi.2724
- Philips, M., Street, M., Haesler, E. (2015). A systematic review of reliable and valid tools for the measurement of participation in healthcare. *British medical journal of quality and safety*, 25(2), 110-7. doi:10.1136/bmjqs-2015-004357.
- Pickering Institute, the (2015). Understanding staff wellbeing, its impact on patient experience and healthcare quality. Accessed online in January 2018 at: <http://www.pickering.org/wp-content/uploads/2015/06/2015-06-10-StaffWellbeingBriefing.pdf>
- Priebe, S., Fakhoury, W. K., Hoffmann, K., & Powell, R. A. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social psychiatry and psychiatric epidemiology*, 40(3), 223-232 doi:10.1007/s00127-005-0880-7
- Rössberg, J. I., Eiring, Ø., & Friis, S. (2004). Work environment and job satisfaction. *Social Psychiatry and Psychiatric Epidemiology*, 39(7), 576-580. doi:10.1007/s00127-004-0791-z
- Rössberg, J. I., & Friis, S. (2003). A suggested revision of the Ward Atmosphere Scale. *Acta Psychiatrica Scandinavica*, 108(5), 374-380. doi: 10.1034/j.1600-0447.2003.00191
- Rössberg, J. I., Melle, I., Opjordsmoen, S., & Friis, S. (2008). The relationship between staff members' working conditions and patients' perceptions of the treatment environment. *International Journal of Social Psychiatry*, 54(5), 437-446. doi:10.1177/0020764008090689
- Rothenberger, D. A. (2017). Physician burnout and well-being: a systematic review and framework for action. *Diseases of the Colon & Rectum*, 60(6), 567-576. doi:10.1097/DCR.0000000000000844

Salyers, M. P., Brennan, M., & Kean, J. (2013). Provider Expectations for Recovery Scale: Refining a measure of provider attitudes. *Psychiatric rehabilitation journal*, 36(3), 153. Doi: 10.1037/prj0000010

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: A meta-analysis. *Journal of general internal medicine*, 32(4), 475-482. doi:10.1007/1160601638869

Salyers, M. P., Flanagan, M. E., Firmin, R., & Rollins, A. L. (2015). Clinicians' perceptions of how burnout affects their work. *Psychiatric Services*, 66(2), 204-207. doi:10.1176/appi.ps.201400138

Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R. L., Gearhart, T., Noll, J. P., Williams, S., & Davis, C.J. (2014). Burnout and Self-Reported Quality of Care in Community Mental Health. Administration and Policy in Mental Health and Mental Health Services Research. doi: 10.1007/s10488-014-0544-6

Salyers, M. P., Hudson, C., Morse, G., Rollins, A. L., Monroe-DeVita, M., Wilson, C., & Freeland, L. (2011). BREATHE: A pilot study of a one-day retreat to reduce burnout among mental health professionals. *Psychiatric Services*, 62(2), 214-217. doi:10.1176/ps.62.2.6202_0214

Salyers, M. P., Rollins, A. L., Kelly, Y. F., Lysaker, P. H., & Williams, J. R. (2013). Job satisfaction and burnout among VA and community mental health workers. *Administration and Policy in Mental Health and Mental Health Services Research*, 40(2), 69-75. doi: 10.1007/s10488-011-0375-7

Schaufeli, W. B., Bakker, A. B., & Salanova, M. (2006). The measurement of work engagement with a short questionnaire: A cross-national study. *Educational and psychological measurement*, 66(4), 701-716. doi: 10.1177/0013164405282471

Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., . Slade, M. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study. *PLoS One*, 9(7). Doi:10.1371/0100153

Taris, T. W. (2006). Is there a relationship between burnout and objective performance? A critical review of 16 studies. *Work & Stress*, 20(4), 316-334. doi:10.1080/02678370601065893

a. Van Bogaert, P., Kowalski, C., Weeks, S. M., & Clarke, S. P. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and quality of nursing care: a cross-sectional survey. *International journal of nursing studies*, 50(12), 1667-1677. doi: 10.1016/ijnurstu.2013.05.010

Van Bogaert, P., Meulemans, H., Clarke, S., Vermeyen, K., & Van de Heyning, P. (2009). Hospital nurse practice environment, burnout, job outcomes and quality of care: test of a

structural equation model. *Journal of advanced nursing*, 65(10), 2175-2185. doi:10.1111/j.1365-2648.2009.05082.x

Van Bogaert, P., Verspuy, M., Wouters, K., Slootmans, S., Van der Straeten, J., Van Aken, P., & White, M. (2017). The Productive Ward Program™: A Two-year Implementation Impact Review Using a Longitudinal Multilevel Study. *Canadian Journal of Nursing Research*, 49(1), 28-38. doi:10.1177/0844562116686491

b. Van Bogaert, P., Wouters, K., Willems, R., Mondelaers, M., & Clarke, S. (2013). Work engagement supports nurse workforce stability and quality of care: nursing team level analysis in psychiatric hospitals. *Journal of Psychiatric and Mental Health Nursing*, 20(8), 679-686. doi:10.1111/jpm.12004

Von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., Vandenbroucke, J. P., & Strobe Initiative. (2007). The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *PLoS medicine*, 4(10), doi:10.1371/0040296

Warr, P. (2011). *Work, happiness, and unhappiness*. Psychology Press.

Weiss, H. M. (2002). Introductory comments: Antecedents of emotional experiences at work. *Motivation and Emotion*, 26(1), 1-2. doi:10.1023/A:1015138223398

2. The wellbeing of Practitioner Psychologists:
establishing the perceived domains that affect
wellbeing.

Written in preparation for submission to the 'Journal of Occupational Health Psychology'.

Prepared in accordance with author guidelines provided in Appendix A

Word Count: 7,987 excluding abstract, tables, figures and references

2.1 Abstract

Introduction Research and policy both identify wellbeing as an important area of study (Maben et al., 2012; Boorman, 2009). Research consistently sites people working in healthcare settings as experiencing a reduced sense of wellbeing, which can lead to occupational burnout (Maslach et al., 2016). Within mental healthcare, a growing body of research has attempted to identify the specific factors that impact on the psychological wellbeing of its staff (Lasalvia et al., 2009).

Methods and analysis Practitioner Psychologists were recruited from the Division of Clinical psychology (DCP) and the Psychological Professions Network (PPN) using convenience sampling. Semi-structured interviews were carried out with 15 participants, all of which worked for the NHS. Results were transcribed and analysed using thematic analysis.

Results The thematic analysis highlighted five key themes. The key themes were; personal support, 'traumatised systems'- the NHS context, positive and negative job aspects, inter-professional job aspects and a drive to improve staff wellbeing. Key themes were separated into sub-themes.

Discussion The results largely replicate findings in the previous literature with different professional groups. The study contributes to a developing evidence base by providing one of the only in depth, qualitative analysis of Practitioner Psychologists perceptions of the domains that impact on wellbeing in the workplace.

Conclusion The present study provides a new insight into how Practitioner Psychologists perceive their wellbeing at work. The results were used as part of a wider research agenda to develop a validated quantitative measure of the wellbeing of psychological staff.

Key Words: Psychological practitioner, Wellbeing, Occupational wellbeing, thematic analysis, qualitative.

2.2 Introduction

In the UK, being in paid employment is typically viewed as beneficial for health and wellbeing (Modini et al., 2016), and the importance of staff wellbeing is increasingly recognised in both policy and literature (Picker Institute, 2015; Francis, 2013; Boorman, 2009).

Reports such as the ‘Boorman NHS health and wellbeing review’ (Boorman, 2009) highlight correlations between good levels of staff wellbeing and positive outcomes for both patients and organisations. Such reports also detail a less promising picture, linking poor levels of staff wellbeing with higher levels of occupational stress leading to low levels of staff retention, increased burnout and higher rates of sickness absence (Boorman, 2009). This is reflected in the higher than average incidences of work related illness in healthcare and social care than other employment sectors (Maslach et al., 2016).

The NHS ‘Five year forward view report’ (NHS England, 2014) highlights staff wellbeing as a key concern for the NHS in attracting and maintaining skilled staff. However, due to the nature of top down pressures such as privatisation and targets (Hall et al., 2016) healthcare staff can be left working in poor conditions with low levels of staffing, increased pressures to meet targets and heavy workloads (NHS England, 2014).

2.2.i Wellbeing

Wellbeing is generally considered to be good mental and physical health, alongside high levels of job satisfaction (Maben et al., 2012). Two main dimensions of wellbeing are generally defined within the literature (Maben et al., 2012). The first relates to the subjective

experiences of people within the workplace in terms of job satisfaction and negative and positive aspects of work, with a focus on positive affect (Warr et al., 2011). The second commonly used definition relates to more negative aspects of wellbeing including psychological and physiological aspects such as stress, anxiety burnout and exhaustion related to the workplace (Fisher et al., 2009).

2.2.ii Wellbeing and Burnout

The relationship between occupational wellbeing and negative constructs such as burnout, low job satisfaction, stress and anxiety is frequently cited in literature (Dreison et al., 2018; Lizano et al., 2015). Perhaps the most commonly cited construct linked to poor wellbeing in the workplace is the construct of ‘burnout’ (Maslach et al., 2016). Professionals who experience lower levels of wellbeing are at risk of experiencing occupational burnout (Maslach et al., 2016). When stress is experienced chronically it results in burnout, an exhaustion of physical and emotional resources, leading to feelings of emotional exhaustion, depersonalisation and decreased feelings of personal accomplishment (Maslach et al., 2001). The inter-connected relationship between wellbeing and burnout is cited in the literature (Lizano et al., 2015; Galvin & Smith, 2015) and mitigating and reducing burnout have been shown to have a positive impact on improving people's feelings of subjective wellbeing (Qu-Hy et al., 2015). In studies of mental health clinicians, including those working in psychological roles, high burnout has been associated with impaired clinician wellbeing (Steel et al., 2015; Maslach et al., 2001).

The impact of occupational burnout can prevail across one’s life and impact personal and social wellbeing (Maslach, 2016). Professionally, research reports that reduced wellbeing can

lead to impaired performance, reduced concentration, absenteeism and difficulties with clients and colleagues (Sharpio et al., 2007).

2.2.iii Theoretical models

The ‘Job Demands and Resources Model’ (JD-R, Bakker et al., 2007) presents the antecedents and outcomes of occupational wellbeing through grouping job attributes to two categories of demands and resources. The theory purports that factors pertaining to job resources such as support, supervision and autonomy facilitate occupational wellbeing, whilst job demands such as work overload, role conflict and job complexity are related to reduced wellbeing and increased levels of burnout (Crawford et al., 2010). Hobfoll also provides a theoretical framework to understand stress and wellbeing through the ‘Conservation of Resources’ model (COR, Hobfoll et al., 2001). According to the model, individuals strive to acquire and maintain resources, which in turn maintains a sense of positive wellbeing. When there is a threat to perceived resources (job resources, environmental resources) an individual experiences distress and this leads to job dissatisfaction and reduced experiences of occupational wellbeing.

2.2.iv The implications of poor wellbeing

While the impact of poor practitioner wellbeing on client outcomes has not yet been definitively established (Salyers et al., 2017), within mental health settings, higher levels of perceived staff burnout have been linked to increased inpatient admissions (Priebe et al., 2004), and some research reports worse outcomes when clients perceive their therapist to have lower levels of wellbeing (Mistry et al., 2015).

2.2.v Wellbeing in mental health services

A recent meta-analysis by Dreison et al. (2018), described experiences of burnout as prevalent in mental health providers, and it is estimated that between 21-48% of employees in mental health services experience feelings of emotional exhaustion, burnout and reduced levels of wellbeing (Morse et al., 2012).

2.2.vi The wellbeing of psychologists

The practice of psychology is a rewarding career, but also exposes the clinician to high job demands, high levels of responsibility and emotional pressures, all known to lead to occupational stress (Simionato et al., 2018; Rupert et al., 2015; Volpe, 2014; Lee et al., 2011).

There is a growing body of literature detailing the effects of job related stress and burnout on psychological practitioners (Simionato et al., 2018; Sciberras et al., 2018, Rupert et al., 2015; Bearnse et al., 2013; Lee et al., 2011; Lim et al., 2010; Rupert et al., 2005; Barnett & Hillard 2001). A recent survey by New Savoy Partnership claimed that 49% of psychological practitioners would meet the diagnostic criteria for depression (New savoy partnership, NSP, 2016), a finding echoed in a recent systematic review exploring burnout in psychological therapists, where researchers highlighted the association between reduced psychological wellbeing and burnout (Simionato et al., 2018).

2.2.vii Work related factors affecting wellbeing

A moderate amount of research has been conducted on the particular stresses and experiences of wellbeing psychological clinicians have as a result of their work (Simionato et al., 2018; Rupert et al., 2015; Lee et al., 2011; Lim et al., 2010; Hannigan et al., 2004). A review of

burnout in Practitioner Psychologists highlighted the various work related demands that increase the prevalence of burnout (Simionato et al., 2018). The authors reported that more experienced clinical psychologists experience less distress than junior clinical psychologists. The authors concluded that increased experience may lead to an enhanced sense of personal accomplishment and confidence in work. Steel et al. (2015), also noted that newly qualified clinicians may experience disillusionment when comparing their expectations coming in to a psychological career to the reality of the job.

A meta-analysis of factors related to burnout in psychological therapists completed by Lee et al. (2011) concluded that higher levels of control and autonomy at work correlated with an improved sense of wellbeing, and that higher levels of autonomy came with experience. This possibly accounts for the differences in distress levels between experienced and newly qualified practitioners (Steel et al., 2015; Lee et al., 2011).

Rupert et al. (2005, 2007), completed a survey of working environments and their contribution to feelings of burnout in Practitioner Psychologists. Psychologists working in public settings reported higher rates of stress and reduced levels of wellbeing in comparison to those in independent practice. Indeed, these findings have been further replicated in studies comparing the public and private sector (Hanningan et al., 2004; Craig and Sprang., 2010; Kaeding et al., 2017). Those in the public sector cite heavier caseloads, pressure to complete administrative duties, client complaints and lower levels of control and autonomy as environmental factors affecting their wellbeing (Rupert et al., 2007). One protective factor of a public setting, however, was the opportunity to work as part of a team, sharing resources and having a sense of shared responsibility (Lasalvia et al., 2009).

Building on this, Rupert et al. (2015), further highlighted the importance of having support within the working environment. However, it is difficult to interpret overall results as these studies have methodological flaws and measure different aspects of relationships and support networks. Despite these flaws, in their meta-analysis, Lee et al. (2011), found a significant relationship between co-worker support and positive staff experiences of personal accomplishment.

Clinicians that work longer hours are more likely to experience a reduced sense of wellbeing (Rupert et al., 2015). In addition to the workload, the variety of work also appears important to positive functioning (Lasalvia et al., 2009). In their study, Lasalvia et al., 2009, found that clinicians with a high rate of client contact experienced a reduced sense of wellbeing. Interestingly, these results have not been replicated in other literature with studies finding increased paperwork to have a negative impact on wellbeing (Rupert et al., 2015, 2005). Conversely these studies cited increased levels of client work as improving clinician's sense of personal achievement (Rupert et al., 2015). However, some research suggests that clients experiencing chronic conditions with multiple problems and slow change processes can be draining for clinicians to work with (Bassett and Lloyd, 2001), and it appears that balance of tasks are important in maintaining good clinician wellbeing (Rupert et al., 2015).

2.2.viii Personal factors affecting wellbeing

There is a growing body of literature to suggest that individual therapist factors have an impact on wellbeing (Simionato et al., 2018; Lee et al., 2011). The evidence base highlights difficulties in personal life outside of work (Rupert et al., 2009), perfectionist traits (Kaeding, 2017; D'Souza, 2011) and personal resources (Emery et al., 2009) as being important factors in determining the wellbeing of psychological practitioners.

Simionato et al. (2018), completed a systematic review of studies into personal risk factors associated with burnout in psychotherapists. Of the forty studies reviewed, the authors found that personal risk factors to experiencing burnout were related to age, experience, personality and personal beliefs, coping mechanisms and social support.

A systematic review of stress and stress management in clinical psychology professions highlighted a number of corresponding findings to those of Simionato et al. (2018). Hannigan et al. (2004), proposed a range of personal protective qualities that moderate and reduce the impact of stress for psychological practitioners. The authors argued that this included social support, self-esteem, coping skills, feelings of mastery, personal control and emotional stability and physiological release mechanisms.

2.2.ix Interventions

There appears to be a dearth of research in the area of interventions to support the wellbeing of psychological practitioners (Dreison et al., 2018; Hannigan et al., 2004). A recent meta-analysis reviewed the last 35 years of research into interventions to support the wellbeing of mental health staff (Dreison et al., 2018). Interventions were broadly categorised in to those at an organisational level with a focus on training and education, versus those that were person-directed with a focus on building skills and resilience, or both combined. The authors found interventions on an organisational level to be promising, whereas the data around individual interventions were more difficult to interpret. The authors concluded that a combined approach to promote wellbeing of mental health staff would be most effective (Dreison et al., 2018).

2.2.x Help seeking behaviours

Despite the recognition in policy of the importance of health care staff wellbeing (DH Department of health, 2011), the available evidence base details continued distress amongst many health care professions (Dreison et al., 2018; Francis, 2013; Boorman, 2009).

Whilst many practitioners seek personal therapy, there are equally many factors that act as a barrier to participation (Bearse et al., 2013), including organisational and professional factors (Hannigan et al., 2004). Bearse et al. (2013), present the notion that practitioners working in mental health may find it threatening to seek help which leads to fears of ‘becoming a client’. Smith and Moss. (2009) argue that mental health practitioners, and in particular psychological practitioners, are susceptible to mental health difficulties, yet lack the appropriate services to support their own mental health needs.

2.2.xi Summary

The available literature highlights the need to enhance our understanding of both the causes of and impact of reduced emotional wellbeing in the field of psychology (Sciberras et al., 2018; Smith and Moss, 2009). The distress of practitioner psychologists is an important topic area for further research (Bearse et al., 2013), and previous research has focussed on survey data as opposed to in-depth exploration (Hannigan et al., 2004). There are only two other qualitative studies focussed around in-depth interviews with psychologists to the authors knowledge (Sciberras et al., 2018; Papadomarkakai et al., 2008), one of which (Sciberras et al. 2018) was not based within a UK population and thus results are not generalizable to staff working in the NHS. Both studies have methodological flaws, with a small sample size (Papadomarkakai et al., 2008).

2.2.1 Aims of this study

The aim of this project is to identify the specific domains that are perceived as having an impact on the wellbeing of Practitioner Psychologists. This information will be used as part of a wider research agenda to develop a psychometric measure to assess wellbeing of psychological practitioners. Further research on job burnout and distress are crucial for providers and clients (Dreison et al., 2018). Increasing awareness of the factors resulting in impairment could also increase our understanding of the barriers Practitioner Psychologists face in accessing support (Smith and Moss, 2009).

2.3 Method

2.3.1 Design

This research utilised a qualitative design. Practitioner Psychologists living across the United Kingdom were interviewed using a semi-structured interview. The focus of the research was to identify what specific factors were perceived as impacting on staff wellbeing in the workplace. The analysis was completed using inductive thematic analysis (Braun and Clarke, 2013).

2.3.1.i Introduction to qualitative research

Qualitative research is traditionally used to explore and understand perspectives, behaviours and contexts (Braun and Clarke, 2013). It can be used to develop understanding in areas that are not yet well understood (Fossey et al., 2002). Qualitative research explores subjective experience and sense making (Willig, 2008), it requires interpretation from the researcher and is often used as an exploratory stage in the research process (Braun and Clarke, 2006). As

opposed to developing a specific hypothesis, qualitative research uses questions to lead to an enhanced understanding of the questions being asked (Fossey et al., 2002).

2.3.2 Rationale for this study

This research focuses on the personal work experiences of Practitioner Psychologists. The current evidence base and understanding of the factors associated with reduced emotional wellbeing of Practitioner Psychologists is in its infancy and is currently reliant on survey information as opposed to in depth analysis (Hannigan et al., 2004). For this reason a qualitative methodology was selected. Inductive thematic analysis was the approach that was utilised for this research.

Thematic analysis was selected over other forms of qualitative data analysis such as Grounded Theory and Interpretative Phenomenological Analysis. It was not the intention of the researcher to develop a theoretical model (McLeod et al., 2011), and thus Grounded Theory was not seen as an applicable methodology for the present study. IPA requires an in depth analysis of the personal experiences of participants (McLeod et al., 2011). As there has been little research in the presenting topic area, IPA analysis was not required at this stage. IPA is wedded to a theoretical epistemology, which can influence the process of theme development (Shinebourne et al., 2011). The present study aimed to take a bottom-up, data-driven approach to analysis to ensure the themes were strongly linked to the data (Fereday et al., 2006) and it was determined that inductive thematic analysis was the most applicable methodology for the present study.

Inductive thematic analysis is a widely used form of data analysis (Nowell et al., 2017) and the procedure is used to analyse data in a flexible, in-depth manner (Braun and Clarke, 2006). The advantages to using thematic analysis include its theoretical flexibility and suitability to conceptualizing the various perceptions (Nowell et al., 2017). This is done by examining patterns of meaning across data sets through familiarization, data coding, and theme development (Braun and Clarke, 2006). The use of inductive thematic analysis reviews datasets from the ‘bottom up’, thus allowing the identification of a broad range of themes (Fereday et al., 2006). Inductive thematic analysis is also suitable for larger data sets (Braun and Clarke, 2013), and thus was viewed as being appropriate in the present study.

2.3.3 Ethical considerations

This research was reviewed and received ethical approval by Cardiff University Research Ethics Committee. See appendix D for Research and Development approval documentation. The author adopted guidance from Cardiff University site procedures and the British Psychological Society Code of Ethics and Conduct (BPS, 2018) when completing the study.

Participants were given information pertaining to the research and informed consent was gained from participants in writing (Appendix G). Participants were also informed of their right to withdraw from the research at any point.

Participants were informed about confidentiality and risk procedures using the participation information sheets. They were made aware of: how their information would be stored, how long it would be stored and what would be included in the anonymised research report.

2.3.4 Participants

2.3.4.i Recruitment

Participants were recruited from the Division of Clinical Psychology (DCP) and Psychological Professions Network (PPN) using convenience sampling.

Involvement was requested from professionals through two channels:

1. Call for recruitment via an email from the British Psychological Society to all Division of Clinical Psychology members.
2. Call for recruitment via email and a weekly news bulletin to members of the Psychological Professions Network (PPN) North West.

2.3.4.ii Inclusion criteria

Participants were eligible to participate in the research providing they met the following criteria;

- Adults of a working age (18 years +) from the following professions: clinical psychologist, cognitive behaviour therapist, counselling psychologist, counsellor, psychoanalyst, psychological therapist, psychological wellbeing practitioner, psychotherapist, and psychiatrist.

Participants were excluded from the research if they did not sit under the above categories or if they were under 18 years of age.

During the process of recruitment it became clear that respondents were all working as 'Practitioner Psychologists'. This is possibly as a result of the recruitment of participants through professional bodies supporting Practitioner Psychologists only. This led to a sample

bias as respondents were not from other professional groups and the results of the study cannot be generalised to other professional groups beyond those working as Practitioner Psychologists.

2.3.4.iii Recruitment procedure

The initial email calling for participants included a copy of a 'Participant information sheet' (Appendix E, F). The researcher sent copies of a participant information sheet, demographic questionnaire (Appendix H) and consent form (Appendix G) to potential interviewees via post with a pre-paid envelope. Following receiving completed written consent, the researcher arranged a suitable interview slot to either visit participants or to complete interviews via Skype.

2.3.4.iv Sample Size

Small samples are preferable to allow a focus on the depth, rather than breadth, of rich qualitative data (Crouch et al., 2006). Some authors stipulate that between 10-20 interviews are optimum when completing qualitative research (Braun and Clarke, 2013). The author opted to complete up to 20 interviews and review the dataset in action with relation to theoretical saturation (Fugard et al., 2015). With homogenous groups theoretical saturation typically occurs after 12 interviews (Guest et al., 2006). In the present study, it was determined that theoretical saturation had been met after 15 interviews. In total 15 interviews were coded for analysis.

2.3.5 Data Collection

2.3.5.i Development of research materials

A semi-structured interview schedule was developed to elicit the participants' experiences of wellbeing (Appendix J). The interview schedule was developed using the results of previous staff surveys completed by the 'New Savoy Partnership' (NSP, 2016). Questions pertained to areas of social, personal and workplace wellbeing. An initial illustrative interview schedule was reviewed and authenticated by a group of four local clinical psychologists.

2.3.5.ii Procedure

Participants were interviewed either through Skype or in person depending on their location. Interviews were conducted for up to one hour and a half. The researcher completed interviews only after receiving written consent from participants. Interviews were conducted and recorded using a tape recorder. Following the interview participants were given a debrief sheet (Appendix I) and the opportunity to ask any follow up questions.

2.3.6 Analysis

Braun and Clarke's (2006) phases of thematic analysis guide were used as a framework to guide the analysis of the data, and the following steps were used in data extraction and analysis (Appendix K):

- Familiarising ones-self with the data
- Coding
- Searching for themes

- Reviewing themes
- Defining themes
- Reporting of analysis

The process of data analysis can be described in Appendix K. The author initially transcribed the dataset and developed an understanding of key conversations to familiarize oneself with the data. Following this the dataset was coded using sentence-by-sentence coding leading to focussed codes. Key themes were derived and defined from matching coded items. This was reviewed in light of the entire dataset and a table of themes and quotes was developed (Appendix K).

Credibility checks ensure that that interpretation and analysis of qualitative data is valid (Barker and Pistrang, 2005). In order to enhance the validity of the themes identified, subsequent peer review of the proposed themes was sought from six Practitioner Psychologists working in the local area. In addition to this, participants from the initial recruitment were contacted with details of the themes and asked to validate results.

2.3.7 Researcher perspective

Qualitative research requires the researcher to disclose their theoretical perspective and assumptions to enhance the validity of the analysis (Braun and Clarke, 2013). The author maintained a reflective journal throughout the research process in order to maintain reflexivity (Fossey et al., 2002). Within this the author noted their ‘insider’ position (Gallais, 2008) as a clinical psychologist in training. During the process of the data collection, the researcher noticed that their own wellbeing was compromised by some of the stories held by

others. The author was able to reflect on the nature of their own experiences of wellbeing in the work place. Whilst it was difficult to listen to participants speaking in a negative way, the author generally felt that they maintained a good sense of wellbeing in the workplace. This is possibly due to the enhanced levels of support provided through supervision as a trainee clinical psychologist, an experience in contrast to the levels of support the participants described as having. It is also possible that the nature of being on training may have provided the trainee from being exposed to NHS processes such as cutbacks. Gaining a better understanding of the nature of the NHS has influenced the authors' view of themselves as a Clinical Psychologist. The author now feels that they have a better understanding of working within the NHS and has developed a passion for their role in advocating for a healthy work place in their future career. In developing the above reflections the author realised the importance of 'bracketing' (Fischer, 2009).

Using a reflective journal and supervision from both peers and research supervisors, the author was able to 'bracket' (Fischer, 2009) their assumptions to help ensure that the data collection was not led by preconceived ideas about the factors that would have an impact on practitioner functioning.

2.4 Results

Participant demographics can be seen in Table 6. The analysis yielded five main themes, which were grouped into the following domains; personal support, NHS context, positive and negative job aspects, inter-professional agents and drive to improve staff wellbeing (Appendix K). Key domains were broken down into subordinate themes, which can be seen in Table 7.

Demographic Indicator	Response (%)
Gender	Female: 93% Male: 7%
Ethnicity	White background: 93% Mixed ethnicity: 7%
Age	25-34: 40% 35-44: 27% 45-54: 13% 33-64: 20%
Job Role	Clinical Psychologist: 87% Counselling Psychologist: 13%
Specialty	Adult: 60% Children and Young People: 27% All age service: 13%
Time employed in current post	< 5 years: 80% 5-10 years: 13% 11-20 years: 7%
Current banding according to NHS agenda for change	Band 7: 53% Band 8: 47%
Type of organisation employed by	NHS: 73% Private Provider: 7% Mixed NHS and Other: 20%
Time spent in clinical duties (Casework)	Mean: 66% (SD:22%)

Table 6: Demographic information collected from participants

Superordinate theme	Subordinate themes
Personal Support	<i>Friends and family</i> <i>Colleagues</i> <i>Supervision</i>
‘Traumatised Systems’- the NHS context	<i>Demands and Pressure</i> <i>Hopelessness</i>
Positive and negative job aspects	<i>Control and Autonomy</i> <i>Feeling Valued</i> <i>Opportunities to learn</i> <i>A ‘Safe space’</i> <i>Balance</i> <i>Synergy of job with personal life</i>
Inter-professional agents	<i>Management</i> <i>Understanding</i>
Drive to improve staff wellbeing	<i>Hope</i> <i>Support for staff</i>

Table 7: Results of qualitative data analysis

2.4.1 Personal Support

This theme demonstrates the positive experiences participants described of feeling supported by other people. All participants described support as being a key factor in enhancing wellbeing both personally and in the workplace. The theme is grouped in to three key sub-themes surrounding who support is provided by. Sub-themes are explored below.

2.4.1. i Support provided by friends and family

Participants spoke about gaining a sense of belonging from friends and family, a non-judgemental person to listen to them and the importance of emotional support from those relationships. These things were key to enhancing a sense of wellbeing.

P6: 'I suppose the big thing is a sense of connection, a sense of belonging, I think it depends on the relationship so, for example, my relationship with my partner is obviously massively important to me as someone who I think we have a strong connection bond and we rely on each other for lots of things and for kind of emotional support.'

2.4.1.ii Support provided by colleagues

Participants spoke about the importance of having colleagues to talk to and gain support from in enhancing wellbeing. Participants felt contained with having others to 'check-in' with and felt a sense of camaraderie through shared experiences with others.

P2: 'You know, everyone was really looking out for each other because you're all in the same boat. Um, but there is more a sense of the camaraderie, or kind of like a network, supportive network there.'

Equally, participants spoke about the ability of colleagues to inhibit and reduce a sense of wellbeing when there is not a sense of cohesion in the team.

P15: 'I think if the team isn't feeling cohesive and supportive, that is most likely to have an effect on me....I think that would have a big impact on both my kind of mental health but my physical health as well so I think that is the biggest one for me.'

2.4.1.iii Support gained through supervision

Participants spoke about gaining a sense of containment from clinical supervision and the importance of having a knowledgeable supervisor who had confidence in the skills and abilities of the person, enabling them to develop in their role.

P7: 'Having a good supervisor can really be very containing and very important for your emotional supervision, for your emotional wellbeing. I think, for me clinical supervision has always been a really important part of emotional wellbeing in the workplace.'

2.4.2 'Traumatised Systems': The NHS Context

Participants referred to the current context of the NHS, with one participant referring to this as a 'traumatised system'. Participants felt that the demands and pressures placed on to them, led to feelings of hopelessness and significantly reduced both their wellbeing and that of their colleagues.

2.4.2.i Demands and Pressure

Individuals felt that the emotional wellbeing of staff was not a current priority and that the level of pressure and demands placed on them felt unmanageable.

P11: 'I think in a time of austerity in the NHS, more and more is being asked of people, with fewer and fewer supports, and although there's room for improvement, I think there's only so much you can ask of people. So I think, demands need to be realistic.'

Participants spoke about a sense of pressure to continue to deliver services to a high quality standard, and spoke about incongruence between feeling as if they were trying to do too much, yet feeling that they were not doing enough.

P2: 'What was one of the most important things that can reduce well being at work? I think (...) the pressures, I think when it feels like expectations are beyond what you can manage, er, it feels, um, incongruent with what you feel able to sustain.'

2.4.2.ii Hopelessness

Participants felt hopeless about not being able to meet the demands placed on them.

P4: 'It sounds like... a demand that can't really be met, it just feels like you're getting squeezed and squeezed and squeezed.... I don't think you can kind of survive buying into that kind of model of just asking more and more and more but not really being able to do that. Yeah, so it's just... it feels impossible.'

Participants spoke about the impact on morale when trying to achieve goals that often feel unobtainable.

P7: 'I think people can know that they're trying very hard and still not achieving goals, even though they know they're kind of unobtainable goals (...) You feel very criticised. And that can just take a toll on people's self- confidence and on their, um, on their, their morale really. People just feel very low.'

2.4.3 Positive and negative job aspects

Individuals highlighted the specific factors they felt had an impact on their sense of wellbeing in terms of control and autonomy, feeling valued, having opportunities to learn and achieving a good sense of balance in the workplace.

2.4.3.i Control and Autonomy

The opportunity to experience choice and autonomy over ones work enhanced levels of wellbeing for the participants.

P1: ' I do have that ability to, to manage my diary in a way that suits me, not only the demands of the job, but optimises my efficacy.'

Conversely, participants spoke about the negative impact the lack of control and choice can have on emotional wellbeing.

P15: 'If the control is taken away from you, and it has a big impact on emotions, I think. On morale, on energy, and just all kinds of feelings of, I can't give any more, you know.

Emotional exhaustion. And that's where the burnout comes from. That lack of control over your environment.'

2.4.3.ii Feeling Valued

Participants experienced a positive sense of wellbeing with the thought that people had an interest in them both personally and professionally.

P10: 'feeling respected and listened to and that what I do makes a difference in the workplace. Having my work recognised by people and by management I guess, and having positive feedback from colleagues (enhances wellbeing).'

Equally, the negative impact of not feeling valued was highlighted in the interviews.

P4: 'Not being recognised, either the work that you're doing not being recognised or the stresses that you are under not recognised. Everybody is in a stressful environment but you know, if that's kind of minimalized or normalised, I think that can be really harmful.'

2.4.3.iii Opportunities to learn

Participants felt that opportunities to learn were helpful in enhancing feelings of wellbeing.

P14: 'Learning as well. I think it's a key motivator for me, I love learning things and I can happily work away at something really difficult if I feel like I am learning something. If I feel that I'm learning and developing as a therapist I'm really happy to continue.'

Participants felt positive about the utility of performance reviews, viewing them as an opportunity for learning and development.

P8: 'I think it's an opportunity to reset each year and think about learning and development and that's something that keeps me motivated and wanting to do this job. I think appraisals can be used to actually give a sense of positive wellbeing when you've got development targets happening.'

2.4.3.iv A 'safe space'

Participants spoke about the importance of having a secure and soothing environment in which to work.

P10: 'If you have a secure base, a physical secure base makes a massive difference.'

P9: 'We've had a really big issue around rooms lately and I've found that it has really, really negatively impacted on (my wellbeing) more than I thought it would. It's something about our team not really being understood and not being accommodated practically and sort of more psychologically as well.'

The impact of the physical environment spans beyond a sense of safety and has an impact on the capacity for practitioners to complete their work.

P3: 'It impacts on my ability to concentrate, so to write reports and get your letters done and to have sometimes difficult conversations whilst all of that's going on around you. And because those things take longer, that impacts on stress levels.'

2.4.3.v Balance

Participants felt it was important for a sense of positive wellbeing to have flexibility in their duties and balance in terms of the variety of clinical caseload.

P11: 'I think having a balanced, a variety of psychological problems that we're working with really helps. Variety, variety is a really positive aspect of the work, of the job, and I think ensuring that I have that variety on a daily basis is really helpful.'

Achieving a good level of work/life balance was also highlighted in the interviews.

P7: 'Having a good work/life balance I think is very important. I know when I work a lot of long hours I might be home, but I'm too tired to enjoy that time.'

Participants spoke about the difficulties they experience in achieving balance with their workload, and the negative effect this has on wellbeing.

P6: '(It feels..)Unmanageable. Overwhelmed is a big one. I think if there is so much to do, I think it's that idea of you don't know what to prioritise, your head is all in a spin and actually you can't get anything done almost because you've got just so many different things.'

2.4.3.vi Synergy of job with personal life

Interviewees spoke about viewing their wellbeing at work as being interconnected with all other aspects of their life, including both their personal wellbeing and their social wellbeing.

P3: 'I get my sense, my own personal sense of value and worth massively from work, and if that's making me feel stressed or doubtful or anything like that, personally it spills over into my personal life hugely.'

2.4.4 Inter-professional Agents

Participants spoke about the impact of working in systems where there are a variety of professionals, with interviewees describing a lack of understanding between professionals and the use of line management as having a negative impact on their wellbeing.

2.4.4.i Inter-professional line management

It was felt that supervision from other professional groups was less personal which had a negative impact on ones sense of learning and feelings of development, impacting negatively on wellbeing.

P4: 'I've always been supervised by my manager which is I think quite problematic. So it's often seen as not really a space for me to... be able to explore what's going on and to develop my kind of abilities or my practice. Yeah, so it's not particularly use... I've not really found it particularly useful aspect of my work but I would like it to be.'

Participants felt that being managed by professionals who were also monitoring their performance was not helpful to feelings of wellbeing.

P7: 'But I do feel that your clinical supervisor should be someone you can trust (...) if that person is your performance manager, then that becomes exceptionally difficult, whereas they might press you then on performance issues which takes away from your time to discuss more emotional and social issues.'

2.4.4.ii Understanding

Participants described a lack of understanding between individuals from different professional backgrounds.

P1: 'I think a lack of understanding of each other's role can be a negative, can have a negative impact on well being. So, um, yeah, so a lack of understanding in terms of what I have to juggle at work, because there are so many different aspects, so many different roles within a clinical psychologist job spec.'

There appeared to be a positive impact on wellbeing when participants were surrounded by colleagues from a similar professional background with a better understanding of problems and a similar level of training.

P1: 'I suppose what's important socially is, um, having colleagues who understand again the nature of my work - so, other psychologists, having psychologists around is really helpful.'

Participants spoke about the negative impact of working in services with staff working from different theoretical backgrounds that struggled to understand psychological ideas.

P9: 'In a way we're a bit of a marginalised team because we're in a very medicalised setting and they don't quite get what our team does. It changes and sometimes our team can feel more marginalised than others. If our team is feeling marginalised and not really understood so that will have an impact.'

2.4.5 Drive to improve staff wellbeing

There appeared to be hope amongst participants that things can improve. Participants spoke about the benefits of social support and the need to implement and incorporate this into working practices.

2.4.5.i Hope

Participants appeared enthusiastic about the present research study, and this seemed to engender hope that the current context may be able to change.

P8 'I think what you are doing is great. I think it should, if it could be measured and included in reporting that would be really useful rather than the only statistic being staff leaving.'

2.4.5.ii Support for staff

Participants felt that in order to enhance wellbeing in teams, further support would be beneficial for staff.

P7 'If there was more of a positive psychology approach rather than wait until you're sick and then go off and seek support, if there were staff support groups, if there were some drop in sessions that staff could access if they are feeling stressed, I think that would reduce burnout and make the workplace more enjoyable.'

2.4.6. Synthesis of themes

During the interviews, it became apparent that clinician wellbeing was moderated by the different themes identified in the research. A moderator was defined by Barron and Kenney (1986), as *'A variable that affects the direction and/ or strength of the relation between an independent or predictor variable and a dependant or criterion variable'*.

One particular area that participants spoke about was how 'Personal support' in both areas of colleagues and friends and family acted as a moderator to their perception of negative job aspects;

P5 'I think I could cope with the worlds worst patients in a horrible environment if I had the support of the people around me.'

In addition to this, participants highlighted the importance of inter-professional agents in moderating their experience of personal support, with participants speaking about the importance of having colleagues from the same profession to enhance feelings of being supported through shared understanding.

P10 'I do feel like I get some support from my colleagues because they are lovely people but then again I know that if it's colleagues that have got a similar training to me and background, somehow...it, it sounds awful but it means more.'

Themes also overlapped in the area of ‘Traumatised systems- NHS contexts’ and ‘Positive and negative job aspects’, particularly the negative feelings associated with being undervalued;

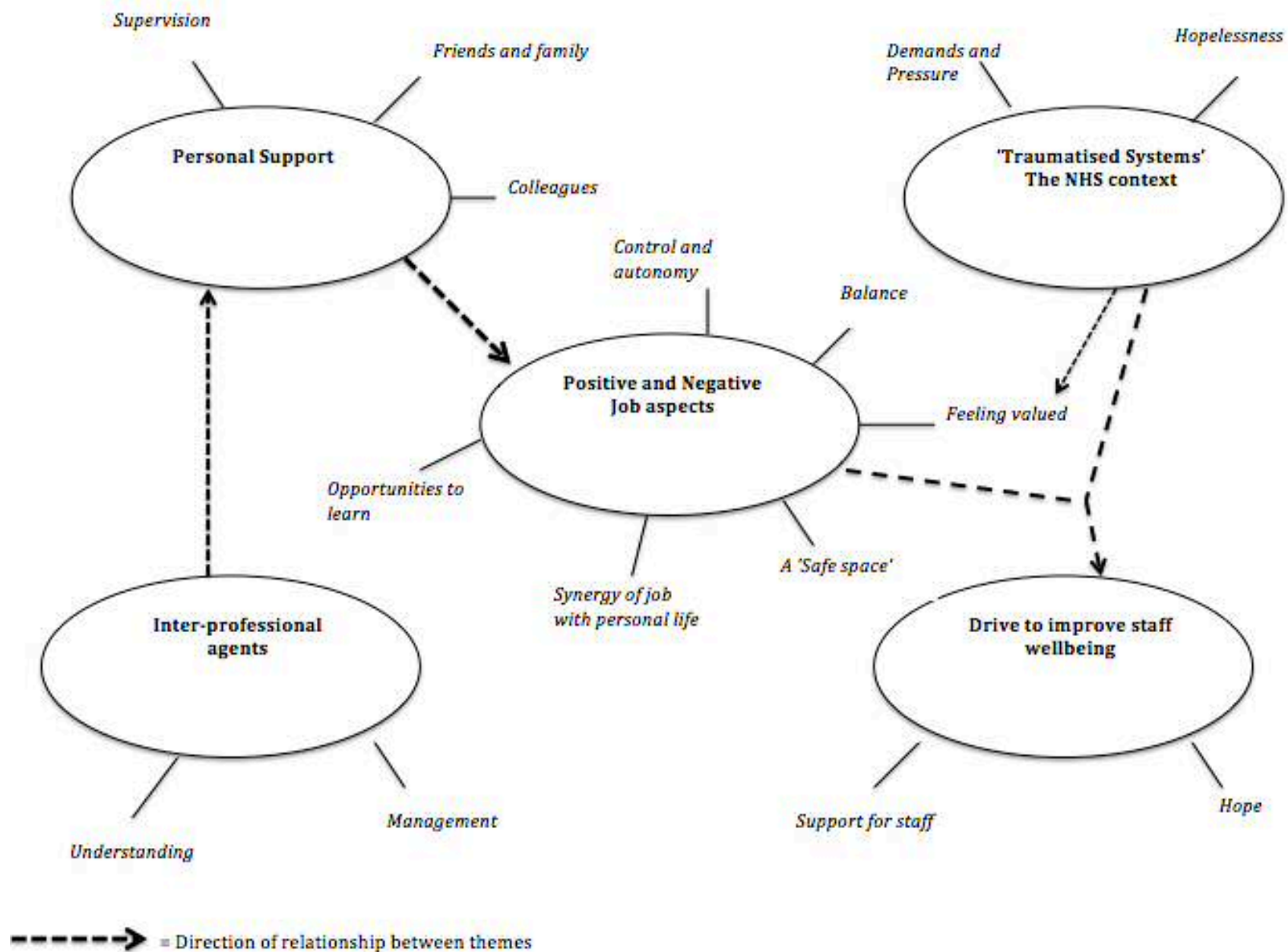
P2: ‘When the approach is very target-oriented, and the culture is generally target, money, funding, um and the whole system is set up towards that, it makes me feel really um, like I’m just a cog in a wheel and I don’t feel fully valued.’

It appeared that the positive and negative aspects of working in their job in combination with the current NHS context led to a drive to improve staff wellbeing.

P13 ‘What would need to happen for change to be made is that it would need to be proven that there would be a financial benefit in it for services, which I think there would be. You know, I think we would probably look at reduced sickness and increased productivity. I really hope that they look in to this.’

The themes derived from the interviews and direction of relationships can be shown in the thematic map detailed in Figure 1. (Arrows indicate the direction of influence).

Figure 2. Thematic Map detailing superordinate and subordinate themes, and synthesis of themes.



2.5 Discussion

The aim of the present study was to identify the domains that participants perceived to have an impact on the wellbeing of Practitioner Psychologists working in the United Kingdom. The results of the study highlighted five key themes Practitioner Psychologists felt had an impact on their emotional wellbeing in the workplace.

Personal support held an important role for participants in enhancing wellbeing, both within and outside of work. It appeared that support held a moderating role to other themes identified in the research, in that increased levels of support counterbalanced some of the other negative job aspects. Working in a ‘traumatised’ system felt devaluing for participants and led to reduced experiences of wellbeing whilst inter-professional aspects such as understanding of differing professional roles held importance to participants. Another theme identified in the research was a drive to improve staff wellbeing. Key themes were broken down into subthemes, which detail the specific areas within domains that influenced wellbeing.

2.5.i Contextualizing the current research with previous findings

A moderate amount of research has been completed into the particular stressors psychologists experience in their working careers (Dreison et al., 2018; Rupert et al., 2015; Lee et al., 2011; Papadomakarki et al., 2008; Hannigan et al., 2004). Table 8 details the synthesis between the themes highlighted in the current study to those detailed in previous literature.

Theme identified in the present study	Literature highlighting research corresponding to themes
Personal Support	Beaumont et al 2016 ; Rupert et al., 2015; Lee et al., 2011; Lasalvia et al., 2009; Papadomarkaki et al., 2008; Rupert et al., 2007; Hannigan et al., 2004
‘Traumatised Systems’- the NHS context	Scriberras et al., 2018; Kaeding et al., 2017; Steel et al., 2015; Francis., 2013; Boorman, 2009; Papadomarkaki et al., 2008.
Positive and negative job aspects	Control and Autonomy: Steel et al., 2015; Johnson et al., 2011; Lee et al., 2011; Papadomarkaki et al., 2008 Balance: Rupert et al., 2015; Rupert et al., 2009; Lasalvia et al., 2009; Rupert et al., 2007; Papadomarkaki et al., 2008. Opportunities to learn: Hannigan et al., 2004 A ‘safe space’: Papadomakarki et al., 2008; Rupert et al., 2007; Rupert et al., 2005. Synthesis of work and personal life: Simionato et al., 2018-05-23
Inter-professional agents	Scriberras et al., 2018
Drive to improve staff wellbeing	Simionato et al., 2018; Rupert et al., 2015; Stevanovic et al., 2004

Table 8: Synthesis of current findings with previous research

2.5.ii Personal support

The importance of personal support was highlighted in the research, with particular reference to the moderating role support plays in making job demands feel more manageable. Rupert et al. (2007), suggested that social support acts as a moderator to managing distress in the workplace, a finding supported in the review by Hannigan et al. (2004). In their review Lee et al. (2011), proposed that personal support increases a

sense of personal accomplishment, which can act as a barrier to emotional exhaustion. Lasalvia et al. (2009), reported that a sense of shared responsibility and resources were helpful in maintaining the wellbeing of Practitioner Psychologists, similar to the findings in this study of support within clinical teams providing a sense of camaraderie. In addition to this, Beaumont et al. (2016), highlighted the negative impact of reduced opportunities to interact with colleagues, something frequently cited by participants in the current study. The literature surrounding the importance of support is often unclear as studies do not always account for the type of support provided and who is providing the support (Rupert et al., 2015). The present study highlights support as essential from colleagues, family and friends and clinical supervisors.

2.5.iii NHS Context

The difficult nature of the current NHS context was captured in the data in the present study. The difficulties cited by individuals are consistent with those reported in policy (Boorman, 2009) and in the available evidence base (Steel et al., 2015). The present study did not explore the differences in the prevalence of occupational wellbeing for clinicians working in the public or private sector. However, the identified themes of lack of control, pressure and difficulties balancing caseload have also been reported as key difficulties for clinicians working in the public health sector (Rupert et al., 2007).

Interestingly, the participants in the current study appeared to focus more on frustrations at an organisational level as opposed to with the client work itself. This is similar to recent findings by Scriberras et al., (2018), and is possibly indicative of the current NHS context (Hall et al., 2016).

2.5.iv Positive and negative job factors

The findings of this study were similar to those previously reported by Steel et al. (2015), and Lee et al. (2011), who found that higher levels of control and/or autonomy at work were perceived as enhancing practitioner wellbeing. In their national survey on staff morale, Johnson et al. (2011), concluded that feelings of control in the work place moderated experiences of stress, consistent to the results found in this study. Interestingly the current study did not highlight any differences between the impact of control on those who had been qualified for less time than those in higher banded roles, as highlighted by Rupert et al. (2015).

The present study also highlighted the importance of achieving ‘balance’ as a facilitator to a sense of positive wellbeing. This finding is consistent with Lasalvia et al. (2009), who highlighted variety as a key factor related to achieving a sense of positive wellbeing. In their research the authors suggest that individuals with a high clinical caseload experienced a reduced sense of wellbeing. Further research has suggested that emotive client work is draining for clinicians to work with (Sciberras et al., 2018; Bassett & Lloyd, 2001). This is in contrast to the findings of the presented study. Client presentation did not feature as a key theme within the data, however participants agreed that client work could become draining if the workload was high and ‘balance’ lost. Indeed, Rupert et al. (2015, 2009) highlighted higher levels of workload as a source of stress for Psychologists, claiming that a positive balance of clinical duties and paperwork is important to staff wellbeing. The review completed by Hannigan et al (2004), concluded that a sense of mastery was helpful in promoting health wellbeing at work, a finding echoed in the present study where participants valued the opportunity to learn and master new skills.

Given the importance placed on the physical environment in the present study, there is little research into the physical environment and its impact on the wellbeing of psychological practitioners (Rupert et al., 2007; 2005). Participants spoke about reduced access to resources such as desk space, possibly reflective of the current financial climate of the NHS (Hall et al., 2016), an important area for consideration in future research.

In the present study participants viewed their work life as being interconnected with their personal life. In their review of studies exploring personal risk factors impacting on burnout in psychotherapists, Simionato et al. (2018) similarly found that external demands of family life, may lead to work-life conflict as practitioners are required to manage conflicting responsibilities.

2.5.v Inter-professional job aspects

Interprofessional aspects such as understanding of differing professional roles held importance to participants. Some literature highlights the difficulties faced by Practitioner Psychologists when working in predominantly medically minded teams (Scriberras et al., 2018). In contrast to this, whilst some participants alluded to the dominance of the medical model in services, the principal focus of participants in this study was surrounding staff members' understanding their role as Practitioner Psychologists. Indeed, literature into staff morale concluded that clearly defined roles within teams support staff morale and enhance practitioner wellbeing (Rupert et al., 2015).

2.5.vi Drive to improve staff wellbeing

Participants expressed hope towards a solution, with participants expressing enthusiasm for the present research. In contrast to the research completed by Bearnse et al. (2013), who suggested that psychological practitioners felt too threatened to seek access to support, the suggestions for improvement provided by participants were predominantly related to increased levels of support for staff. This finding sits in line with suggestions made by Smith and Moss. (2009) that Practitioner Psychologists would accept additional support, but do not have the resources to do so.

2.5.vii Moderating factors

There is conflicting evidence on the prevalence of workplace stress and burnout in the psychology profession (Simionato et al., 2018). Practitioner Psychologists often report experiencing stress and burnout, yet still feeling satisfied (Hannigan et al., 2004). In the current study, participants spoke about the moderating roles of support provided from family and friends (Papadomarkaki et al., 2008), in supervision (Howard et al., 2008), opportunities to learn (Hannigan et al., 2004) and autonomy and control (Lee et al., 2011). It is possible that this profession has increased opportunities to access the above, which may act to prevent the development of burnout and preserve wellbeing.

2.5. viii: Contextualizing the current research with theoretical models

The themes identified in the present study can be linked with theoretical explanations of wellbeing in the workplace (Bakker et al., 2007; Hobfoll et al., 2002). In the Job-Demands Resources Model (Bakker et al.,2007), facilitators to wellbeing were considered to be gained through autonomy, support and supervision. In the present

study 'Personal support' in terms of supervision, colleague and family support were considered as a key factor to foster positive wellbeing at work. In addition to this, 'control and autonomy' were key facilitators to good wellbeing as highlighted in the superordinate theme 'Positive and negative job aspects'. Furthermore, this study also highlighted the importance in having adequate resources for clinicians to complete their work in terms of 'a safe space' and 'balance'. The model proposed by Hobfoll et al., 2002, that a 'threat' to resources services to increase distress amongst professionals, links to the identified theme of 'Traumatised systems- the NHS context' and 'positive and negative job aspects- a safe space' in that participants reported a lack of resources, or reduced resources leading to a reduced sense of wellbeing.

2.5.1 Strengths and Limitations of the study

This study was one of the first to qualitatively examine the perceptions of Practitioner Psychologist's wellbeing in relation to work (Sciberras et al., 2018; Papadomakaki et al., 2008; Hannigan et al., 2004). A key strength was the choice of methodology, thematic analysis, as the majority of studies surrounding the wellbeing of psychological practitioners have historically relied on survey data (Hannigan et al., 2004; New Savoy Partnership, 2016). This methodology allowed for in depth exploration of the data (Braun and Clarke, 2006). Whilst the sample size was small, it is considered to be optimal in the use of qualitative methodology (Braun & Clarke, 2013).

The sample was homogeneous, with participants primarily working as Clinical Psychologists. The recruitment of participants was generated through the Division of Clinical Psychology (DCP, BPS), which limited the sample to those subscribed to this division. This may account for the homogeneity of participants in terms of psychological profession. In addition to this the sample was not representative of professions working outside of the NHS context, and results would be difficult to generalise to other countries and those working privately. The research findings do however largely support and contribute to the expanding evidence base (Simionato et al., 2018; Rupert et al., 2015; Lee et al., 2011) and theoretical models of wellbeing (Bakker et al., 2007; Hobfoll et al., 2002).

Terminology around staff wellbeing was used inter-changeably, with burnout, stress and wellbeing all used to describe different poles of the same construct. Some research denotes that the above are separate constructs and should be considered independently to one another (Hall et al., 2016). There is a drive towards the use of positive psychology approaches to distress, with researchers recently promoting a more positive approach to assessing wellbeing (Rupert et al., 2015), and it is possible that the current study could have adopted a positive approach to questions. However, the purpose of this study was not to measure the prevalence of staff wellbeing. The terminology adopted in interviews was directed by the language used by the participants.

2.5.2. Implications for future research

Few studies have evaluated the efficacy of interventions to manage wellbeing for those working in psychological roles in the UK (Simionato et al., 2018; Rupert et al., 2015; Hannigan et al., 2004). Whilst this is an under-researched area, currently the literature is growing in the areas of interventions to support other healthcare professionals (Dreison et al., 2018). This study provides useful insights into the possible areas of intervention to target the wellbeing of psychological staff in terms of achieving adequate support, balanced caseloads, and a productive physical environment. As a starting point, it may be useful for organisations to adopt a positive psychology approach and to provide training to practitioners in noticing when wellbeing is compromised and then to provide further support in managing self-care and achieving balance between workload, other duties and personal needs (Simionato et al., 2018; Rupert et al., 2007).

2.5.2 Implications of the research for the profession

This piece of research contributes to the wider development of a quantitative psychological measure of staff wellbeing, a validated tool for practitioners. During the interviews a number of respondents highlighted the importance of the research in supporting the profession to monitor and manage the wellbeing of its staff. In combination, this literature will enable professional bodies such as the British Psychological Society to monitor staff wellbeing, leading to the future development of guidelines to manage and ameliorate the difficulties faced by practitioners.

2.5.4 Conclusions

In conclusion, this research contributes to the growing evidence base surrounding the wellbeing of mental health practitioners (Dreison et al., 2018), and more specifically, those working in a psychologically oriented role (Simionato et al., 2018; Rupert et al., 2015, Lee et al 2011; Lim et al., 2010; Papadomakaki et al., 2008; Hannigan et al., 2004). The results of the study provide timely insights given the current NHS context, and the results of the study fit well with current policy developments (Boorman, 2009) and the developing literature (Simionato et al., 2018).

2.6 References

- Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice, 19*(6), 624-631. doi:10.1037/0735-7028.19.6.624
- Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of managerial psychology, 22*(3), 309-328. doi: 10.1108/02683940
- Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology, 35*(3-4), 201-212 doi: 10.1007/s10464-005-3398-y
- Barnett, J. E., & Hillard, D. (2001). Psychologist distress and impairment: The availability, nature, and use of colleague assistance programs for psychologists. *Professional Psychology: Research And Practice, 32*, 205–210. doi: 10.1037/0735-7028.32.2.205
- Bassett, H., & Lloyd, C. (2001). Occupational therapy in mental health: Managing stress and burnout. *British Journal of Occupational Therapy, 64*(8), 406-411. doi:10.1177/030802260106400807
- Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157. doi:10.1037/a0031182
- Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: a quantitative survey. *Counselling and Psychotherapy Research, 16*(1), 15-23. doi: 10.1002/capr.12054
- Boorman, S. (2009) *NHS Health and Wellbeing Review London*: Department of Health.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. sage.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.
- British Psychological Society (BPS, 2018) Code of ethics and conduct. UK British psychological society. Accessed online in January 2018 at: <https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct>
- Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping, 23*(3), 319-339. doi:10.1080/10615800903085818

Crawford, E. R., LePine, J. A., & Rich, B. L. (2010). Linking job demands and resources to employee engagement and burnout: A theoretical extension and meta-analytic test. *Journal of Applied Psychology, 95*(5), 834-848. doi:10.1037/a0019364

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social science information, 45*(4), 483-499. doi:10.1177/0539018406069584

Department of Health (DH, 2011) 'Healthy staff better care for patients'. Accessed online in January 2018 at :
<http://www.nhshealthatwork.co.uk/dh-strategy.asp>

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology, 23*(1), 18-30. doi:10.1037/ocp0000047

Emery, S., Wade, T. D., & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in clinical psychologists. *Behaviour Change, 26*(2), 83-96. doi:10.1375/bech.26.2.83

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods, 5*(1), 80-92. doi:10.1177/160940690600500107

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4-5), 583-590. doi:10.1080/10503300902798375

Fisher, C. D. (2010). Happiness at work. *International journal of management reviews, 12*(4), 384-412. doi:10.1111/14682370

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand journal of psychiatry, 36*(6), 717-732. doi: 10.1046/j.1440-1614.2002.01100

Francis, R. (2015, February 11). *Freedom to Speak Up* - An independent review into creating an open and honest reporting culture in the NHS.

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology, 18*(6), 669-684. doi:10.1080/13645579.2015.1005453

Gallais, T. (2008). Wherever I go there I am: reflections on reflexivity and the research stance. *Reflective practice, 9*(2), 145-155. doi: 10.1080/14623940802005475

Galvin, J., Suominen, E., Morgan, C., O'Connell, E. J., & Smith, A. P. (2015). Mental health nursing students' experiences of stress during training: a thematic analysis of

qualitative interviews. *Journal of psychiatric and mental health nursing*, 22(10), 773-783. doi:10.1111/12273

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82. doi:10.1177/1525822X05279903

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS ONE*, 11(7), e0159015. doi:10.1371/.0159015

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health*, 13(3), 235-245. doi: 10.1080/09638230410001700871

Hobfoll, S. E., & Shirom, A. (2001). *Conservation of resources theory: Applications to stress and management in the workplace*. In Handbook of organizational behavior, 2nd ed., rev. ed. and exp. ed. (pp. 57-80). New York, NY, US: Marcel Dekker.

Howard, F. (2008). Managing stress or enhancing wellbeing? Positive psychology's contributions to clinical supervision. *Australian Psychologist*, 43(2), 105-113. doi: 10.1080/00050060801978647

Johnson S, Wood S, Paul M, Osborn DP, Wearn E, Lloyd-Evans B, Totman J, Araya R, Burton E, Sheehan B, Hundt G, Wellman N, Nolan F, Killaspy H: Inpatient Mental Health Staff Morale: A National Investigation. Final report. 2011, NIHR Service Delivery and Organisation programme, Accessed online in February 2018 at: [<http://www.sdo.nihr.ac.uk/files/project/142-final-report.pdf>]

Kaeding, A., Sougleris, C., Reid, C., Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of clinical psychology*, 73(12), 1782-1796. doi:10.1002/jclp.22485

Lasalvia, A., Bonetto, C., Bertani, M., Bissoli, S., Cristofalo, D., Marrella, G., ... & Marangon, V. (2009). Influence of perceived organisational factors on job burnout: survey of community mental health staff. *The British Journal of Psychiatry*, 195(6), 537-544. doi:10.1192/bjp.bp.108.060871

Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice*, 42, 252-258. doi:10.1037/a0023319

Leiter, M. P., & Stright, N. (2009). The social context of work life: Implications for burnout and work engagement. *International handbook of work and health psychology*, 25-47.

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling*, 47, 86-96 doi:10.1002/j.2161-1920.2010

Lizano, E. L. (2015). Examining the impact of job burnout on the health and well-being of human service workers: A systematic review and synthesis. *Human Service Organizations: Management, Leadership & Governance*, 39(3), 167-181. doi: 10.1080/23303131.2015.1014122

Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A., Murrells, T., & Morrow, E. (2012). Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. Southampton: NIHR Service Delivery and Organization Programme. Accessed online in March 2018 at: http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1819-213_V01.pdf

Maslach, C., & Jackson, S. E. (1984). *Burnout in organizational settings*. *Applied Social Psychology Annual*, 5, 133-153.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry*, 15(2), 103-111. doi:10.10022031

Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry*, 24(4), 331-336. doi: 10.1177/1039856215618523

Maslach, C. (2001). What have we learned about burnout and health?. *Psychology & health*, 16(5), 607-611. doi:10.1080/08870440

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. Sage.

Mistry, H., Levack, W. M., & Johnson, S. (2015). Enabling people, not completing tasks: patient perspectives on relationships and staff morale in mental health wards in England. *BMC psychiatry*, 15(1), 307 doi: 10.1186/s1288-015-0690-8

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39(5), 341-352 doi: 10.1007/s10488-011-0352-1

New Savoy Partnership (NSP, 2016). Workforce wellbeing survey 2014-2016. Accessed online in January 2018 at: <https://www.newsavoypartnership.org/2017presentations/dosanjh-g-bhutani.pdf>

NHS (2014) Five year forward view. Accessed online in January 2018 at: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16(1), doi:10.1177/1609406917733847.

Papadomarkaki, E., & Lewis, Y. (2008a). Counselling psychologists' experiences of work stress. *Counselling Psychology Review*, 23(4), 39-51.

Picker institute, the (2015). Understanding staff wellbeing, its impact on patient experience and healthcare quality. Accessed online in January 2018 at: <http://www.picker.org/wp-content/uploads/2015/06/2015-06-10-StaffWellbeingBriefing.pdf>

Qu, H. Y., & Wang, C. M. (2015). Study on the relationships between nurses' job burnout and subjective well-being. *Chinese Nursing Research*, 2(2-3), 61-66. doi:10.1016/201509003

Priebe, S., Fakhoury, W. K., Hoffmann, K., & Powell, R. A. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social psychiatry and psychiatric epidemiology*, 40(3), 223-232 doi:10.1007/s00127-005-0880-7

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practice*, 38(1), 88-96. doi:10.1037/0735-7028.38.1.88

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice*, 46(3), 168-174. doi:10.1037/a0039297

Rupert, P. A., & Morgan, D. J. (2005). Work Setting and Burnout Among Professional Psychologists. *Professional Psychology: Research and Practice*, 36(5), 544-550. doi:10.1037/0735-7028.36.5.544

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: A meta-analysis. *Journal of general internal medicine*, 32(4), 475-482. doi:10.1007/1160601638869

Sciberras, A., & Pilkington, L. (2018). The lived experience of psychologists working in mental health services: An exhausting and exasperating journey. *Professional Psychology: Research and Practice*, 49(2), 151-158. doi:10.1037/pro0000184

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and education in professional psychology*, 1(2), 105. Doi:10.1037/1931-3918.1.2.105

Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, 22(1). Accessed online in January 2018 at: [file:///TheTheoreticalUnderpinningsofInterpretativePhenomenologicalAnalysisIPAShinebourne2011%20\(1\).pdf](file:///TheTheoreticalUnderpinningsofInterpretativePhenomenologicalAnalysisIPAShinebourne2011%20(1).pdf)

Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of clinical psychology*. Doi: 10.1002/jclp.22615

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it?. *Clinical Psychology: Science and Practice*, 16(1), 1-15. doi: 10.1111/j.1468-2850.2009.01137

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: burnout in therapists working within Improving Access to Psychological Therapy Services. *Journal of Mental Health*, 24(1), 33-37. doi:10.3109/09638237

Stevanovic, P., & Rupert, P. A. (2004). Career-Sustaining Behaviors, Satisfactions, and Stresses of Professional Psychologists. *Psychotherapy: Theory, Research, Practice, Training*, 41(3), 301-309. doi:10.1037/0033-3204.41.3.301

Walsh, R. (2011). Lifestyle and mental health. *American Psychologist*, 66(7), 579-592. doi:10.1037/a0021769

Warr, P. (2011). *Work, happiness, and unhappiness*. Psychology Press.

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead.

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, 43(5), 487-494. doi:10.1037/a0029446

3. Critical Review

Word count: 9444 excluding tables, figures, references and appendix.

3.1 Summary

This paper critically appraises the work completed in both the systematic review and empirical study. The appraisal will evaluate key stages of the research process and will highlight the issues raised throughout the work. The critical review will discuss the implications of both papers for clinical practice and research. Finally, this critical review will include a discussion of competency development and personal reflexivity on the process and nature of the research.

3.1.1 Overview of this project

This project aimed to firstly understand the current literature surrounding the relationship between staff wellbeing and/ or burnout and quality of care as perceived by clinicians and users of mental health services. Following this, the empirical study aimed to identify the domains affecting wellbeing in the workplace as perceived by Practitioner Psychologists.

3.1.2 The context of this research

An increasing body of literature details the importance of employee wellbeing in healthcare settings (Lizano et al., 2015). The importance of staff wellbeing is increasingly recognised in both policy and literature (Boorman, 2009; Francis, 2013). In the UK, financial pressures impact on staffing levels, leading to unmanageable workloads and subsequently impacting clinicians wellbeing and stress levels (Hall et al., 2016).

In his report ‘NHS health and wellbeing review’, commissioned by the department of health, Boorman. (2009), sets out and analysed the evidence surrounding staff wellbeing in our modern NHS.

The report found that staff wellbeing is not a current priority of services, and concluded that the NHS needs to commit to providing high quality services to support staff wellbeing. Furthermore, the results in Boorman. (2009), described links between staff wellbeing and service quality in terms of patient safety, satisfaction and quality of care.

The findings of the Boorman report. (2009), are reflected in the literature pertaining to the wellbeing of health care staff (Maben et al., 2012). The most commonly cited consequence of poor wellbeing in the workplace is the construct of ‘burnout’ (Maslach et al., 2016). Burnout is a syndrome that results from chronic stress at work, with consequences to workers wellbeing and health (Salvagioni et al., 2017). Within the UK it is estimated that up to 33% of individuals working across healthcare settings experience feelings of reduced wellbeing and burnout (Maben et al., 2012). It is estimated that up to 48% of individuals working in mental health settings experience burnout, leading to a reduced sense of wellbeing (Morse et al., 2012). For organisations, higher levels of burnout correlate with absenteeism and productivity at work (Maslach et al., 2016; Paris and Hoge, 2010; Maslach et al., 2001). There is a growing evidence base detailing the impact of poor staff wellbeing on consumer care (Salyers et al., 2017, Dewa et al., 2017).

In response to the developing evidence base surrounding the wellbeing of health care professionals (Salvagioni et al., 2017) and the implications of this for service delivery and individuals (Maslach et al., 2016) there has been a recent government drive to focus on improving staff wellbeing in healthcare services. The National Institute for Health and Care Excellence (NICE, 2015) have developed public health guidance titled ‘Workplace Health: Management Practices’, which calls for employers to do more to address the impact that the workplace has on peoples lives. The guidance calls for a focus on employee mental and physical wellbeing at work. Recommendations include providing higher levels of support, encouraging new ideas and providing opportunities for clinicians to learn whilst recognising the value of each employee. The recommendations also promote giving employees more control and flexibility over their own time. The ‘NHS health and wellbeing framework’ (Department of Health, DOH, 2011) sets standards for organisations on how to support staff in the workplace. The framework focuses around ‘organisational enablers’, such as structural change and leadership, and health interventions.

Despite the drive to improve wellbeing, research details continued distress amongst healthcare employees (Hall et al., 2016). There appears to be a dearth of research exploring the specific factors that lead to improved staff wellbeing, and therefore the literature surrounding interventions to support staff wellbeing are in its’ infancy (Dreison et al., 2018). Within mental healthcare there is a particular dearth of research (Dreison et al., 2018). Given the importance of staff wellbeing in health services, as evidenced in the report commissioned by the Department of Health (Boorman, 2009), it seems timely that further research be completed to understand the factors

contributing to staff wellbeing and the relationships of this with the people we work with within mental health services.

3.2 Systematic Review

Systematic reviews allow for synthesis of all available literature surrounding a certain topic (Boland, Cherry & Dickson 2013). This systematic review provided an opportunity to explore gaps in the current literature surrounding staff and client perceptions of the relationship between staff wellbeing and burnout with quality of care. The decisions taken in the design and execution of this systematic review are discussed below.

3.2.1 Rationale for the systematic review

Given the literature pertaining to the relationship between staff wellbeing, burnout and quality of care (Boorman et al., 2009), and the high levels of reported burnout in mental health settings (Morse et al., 2012) it seemed useful to explore the relationship between wellbeing and burnout with quality of care within the context of mental health services. The author hoped that the review would provide a rationale and context for further exploration of staff wellbeing in the empirical paper.

A number of reviews relating to the impact of practitioner wellbeing on quality of care were identified in initial scoping searches (Dewa et al., 2017; Salyers et al., 2017; Taris et al., 2016; Hall et al., 2016; Humpheries et al., 2014; Lee et al., 2013). However, none of the identified reviews focussed on mental health professionals as an

independent group. Over the past ten years a growing number of empirical papers have been published around this project area (Salyers et al., 2015). Until the review presented in this paper, no research had systematically reviewed the relationship between levels of burnout and wellbeing in mental health practitioners and the quality of care provided to clients as perceived by clinicians and service users.

As the previous reviews targeted different healthcare settings, the search strategies employed were different to those used in the present review. This review searched specifically for mental health professionals and different studies were identified in the search process to be included in the review. Some of the included studies had been reviewed in a previous meta-analytical review completed by Salyers et al. (2017), (Salyers et al., 2014, Van-Bogert et al., 2013, Garman et al., 2002), however the review completed by Salyers et al. (2017), focussed specifically on burnout in healthcare professionals and grouped professional roles together as a whole.

A key strength to the review completed as part of this thesis was that all articles pertaining to staff wellbeing or burnout and quality of care were included. Previous reviews have focussed more specifically on the construct of burnout (Salyers et al., 2017; Dewa et al., 2017), which may have excluded other studies relevant to staff experiences. Others focussed specifically on aspects of safety as a measure of quality of care (Hall et al., 2016). In addition to this, the present review was unique in that it encompassed and focussed around both patient and clinician perspectives of quality of care.

In summary, the decision was made to complete a systematic review in to the area of staff wellbeing, burnout and quality of care in mental health services as no other review has specifically aimed to understand this from the perspective of mental health services. The evidence base citing research pertaining to this has largely developed over the past ten years, and continues to grow. It seemed timely to systematically review the available research in order to ascertain the strengths and weaknesses of the current evidence base, with a view to providing a detailed account of the ways in which the quality of evidence can be improved, and the implications of the available literature for organisations and services.

3.2.2 The process of completing the review

3.2.2i Inclusion Criteria

Studies were included if they A) were published in English or had an English abstract available, B) Report data from mental health clinicians and/or service users on either burnout or wellbeing and quality of care, C) Contained research data that was either qualitative or quantitative in nature, or both. D) Studies were required to sample staff, clients or both E) Studies were required to be published in peer-reviewed journals. Studies were excluded if they did not include populations from a mental health setting or if the primary sample was recruited from generic healthcare professions, (i.e. Only a small portion of clinicians working in mental health).

The decision to include studies reporting data from mental health professionals was justified by previous reviews having already been completed in medical professionals

and other healthcare providers (Salyers et al., 2017; Dewa et al., 2017; Taris et al., 2016; Hall et al., 2016; Lee et al., 2013; Humpheries et al., 2014).

The authors decided to include all types of research design in order to ensure all possible information and research could be included in the review to support the generalizability and accuracy of the results. The decision was made to exclude articles that described a mental health sample within a wider healthcare sample. This decision was made due to the difficulty in separating sample groups within specific pieces of research.

The decision to exclude data that had not been published in a peer-reviewed journal was justified by the notion of ‘grey literature’ (e.g. doctoral thesis, conference presentations) being less likely to have been critically evaluated and therefore less likely to be of adequate quality. The inclusion of these studies may have added to the comprehensiveness of the present review. Whilst this exclusion may have led to a publication bias, the author in the present study felt that ascertaining good quality research was important in determining accurate results and reporting.

In addition to this, the author chose to include articles only written in English or if the author only had access to the abstract of the article. Studies were also excluded if they did not attempt to draw a link between staff wellbeing and/ or burnout and quality of care.

3.2.2ii Search Terms

The distinction between wellbeing and burnout

There has been conflict within the literature surrounding the relationship between wellbeing and burnout, with some literature alluding towards burnout and wellbeing as the same construct (Dreison et al., 2018; Maben et al., 2012; Warr et al., 2011), and others presenting the idea that burnout and wellbeing are separate constructs (Hall et al., 2016; Jahrami et al., 2013). Few studies have focussed on the relationship between burnout and worker wellbeing and the literature primarily focuses on how burnout affects job performance and organisational health as opposed to the relationship with subjective wellbeing (Lizano et al., 2015). A systematic review comparing studies measuring wellbeing and burnout concluded that burnout and wellbeing were independent, yet related constructs, and the nature and direction of the relationship is still to be definitively established (Lizano et al., 2015).

Burnout can be separated into the constructs of depersonalization, emotional exhaustion and personal accomplishment (Maslach et al., 2001). Whilst links have been drawn between emotional exhaustion and wellbeing, links between wellbeing and other constructs of burnout are still to be determined (Lizano et al., 2015). Wellbeing is generally considered and measured as a form of job satisfaction, and burnout has been linked to job dissatisfaction (Zangaro and Soeken., 2007), therefore the relationship between the two is sometimes viewed on a continuum (Maben et al., 2012). Some literature reports that staff can still be satisfied with work despite scoring high on constructs of burnout, which suggests that the two co-exist as opposed to sit on the same continuum (Salyers et al., 2017; Mandell et al., 2013).

Burnout is often treated as a substitute measure of wellbeing (Hall et al., 2016), possibly due to the difficulties with broad definitions of wellbeing as being an

umbrella term (Maben et al., 2012), which can lead to inconsistent quality of tools used in the measurement of wellbeing (Hall et al., 2016). Whilst some research promotes the use of a ‘catch all’ term, describing burnout and wellbeing as part of the same construct because it allows for multi-levelled analysis (Maben et al., 2012), others caution against it, as measurement of burnout does not capture the essence of wellbeing (Maslach et al., 2016). The available literature is unable to conclude links between all dimensions of burnout and wellbeing and therefore wellbeing and burnout need to be considered as separate constructs (Hall et al., 2016). For these reasons, the decision was made that burnout and wellbeing would be considered as different constructs in the present review. Previous systematic reviews into burnout, wellbeing and quality of care have chosen to separate the constructs of wellbeing and burnout (Hall et al., 2016) and thus it was deemed appropriate to do so in the present review.

3.2.2 iii Search process

The systematic review searched three databases: PSYCInfo, Web of Science, CINAHL. These databases were selected as they contain articles focused on psychological and healthcare research, and were likely to contain research relevant to this topic. In addition to the above PROSPERO was searched to ensure the current review was not already in development.

A list of search terms was devised based on the results of initial scoping searches and the search terms used in other reviews (Salyers et al., 2017). Additional components were added to search terms to encapsulate the context of a mental health setting. The terms pertaining to wellbeing, burnout and quality of care are used interchangeably in the literature (Maben et al., 2012). Initial screening of papers identified a number of

papers which had used additional or alternate terms to describe wellbeing, burnout and quality of care, and the search strategy was altered to include these terms.

The search strategy developed used three main concepts, ‘occupational wellbeing’, ‘outcomes’ and ‘mental health setting’. Each concept was developed individually, and additional terms explored. When completing searches, additional terms were included using Boolean operators ‘OR’ and concepts were then combined using ‘Occupational wellbeing AND outcomes AND mental health’. The centre of reviews and dissemination (CRD, 2008) advocates this method in order to ensure the data search is replicable when using clearly defined search terms.

There are many constructs to describe ‘wellbeing’ ‘burnout’ and ‘quality of care’ and thus the search terms adopted were broad. This led to a large amount of search results. Whilst terms were overgeneralised and completing the search strategy was time consuming, the decision remained to have broad use of terms in order to capture all relevant data. When altering the search terms to attempt to reduce search result numbers the studies that had previously been identified in scoping searches did not appear in the new search results. Despite providing terms to capture research from mental health settings, a large number of studies cited in the search results related to medical professions only, and thus the search terms might have overly-generalised the search results.

The author checked for eligibility using abstracts and full text articles as a single reviewer. To ensure the review included all available research the researcher additionally scanned reference lists of included papers. Whilst the author aimed to

develop a search strategy that was easy to replicate, this element of the search strategy may be difficult to repeat.

The author found one study:

‘Luther et al., 2016’;

Luther, L., Miller, A.P., Hendrick, H.M., York, M., Firmin, R.L., Morse, G., Salyers, M.P. (2016). Client and provider perspectives on the impact of burnout on quality of care and client outcomes in community mental health. Journal of behavioural and social sciences, 3, 73-85.

The study appeared very relevant to the review, however the author was unable to access the paper. The author attempted to access the article through an Inter-library loans service. However, the service was unable to access the article.

In future reviews, it may be useful to have an additional researcher involved in the search process (Boland, Cherry and Dickson., 2013). This may reduce the possibility of accidental exclusion of papers. Also, it may be helpful to have another researcher replicate the search process, to ascertain whether the methodology was presented in a clear manner.

3.2.2 iv Data extraction

In order to minimise bias in quality assessment, data extraction was completed before the process of quality assessment commenced (Boland, Cherry, & Dickson, 2013). Data extraction was completed using guidelines on the development of data extraction forms (PICOS, Boland, Cherry and Dickson, 2013). The researcher chose to adopt

and develop their own protocol for the present study (Boland, Cherry and Dickson, 2013). The use of a standardized form can provide consistency in reporting and reduce bias (Boland, Cherry and Dickson, 2013). The validity of the process may have been improved by adopting a standardised form and using a second researcher to complete data extraction.

3.2.2v Quality rating assessment

When conducting a systematic review, included articles should be assessed for methodological quality using validated tools that enable the critical appraisal of findings (Boland, Cherry & Dickson 2013). A checklist approach for evaluating research has been recommended as part of a systematic review protocol as it allows for components of the research to be evaluated with a view to gauge bias and integrity (Jerosch-Herold, 2005).

Following the process of data extraction it became clear that the majority of included studies adopted a cross-sectional study design. After exploration of a recent article that reviewed quality assessment tools (Jarde et al., 2012), it became obvious that there was a lack of validated assessment tools to provide quality rating for cross-sectional studies. Quality frameworks have been developed for the use of intervention studies (Deeks et al., 2003), and subsequently many of the items reported were not applicable to the present systematic review.

The author decided to assess quality using the AXIS tool (Downes et al., 2016). The tool was developed for use with cross-sectional studies across disciplines. Other quality assessment tools developed for use with observational data focus on the

quality assessment of cohort studies as opposed to cross-sectional data (Downes et al., 2016). The AXIS tool also provides explicit information to interpret the quality of studies (Downes et al., 2016). An alternate tool, the STROBE guidance for observational cross-sectional studies was developed for use with cross sectional data (Von Elm et al., 2013) and could have been used as an alternative to the AXIS tool (Downes et al., 2016). However, the STROBE guidelines were not developed to be used for formal assessment of observational data (Von elm et al., 2007). Whilst the AXIS tool (Downes et al., 2016) is a relatively newly developed tool, and therefore has not been validated for use, the authors felt that the questions highlighted in the tool were more relevant than other more generic tools of observational data (CASP observational data tool, Critical Appraisal Skills Programme, 2013). The author would have been required to adapt this tool and would have lost fidelity to the tool, compromising validity. It is possible that using a tool specifically developed for cross-sectional research did not highlight some limitations to the nature of cross-sectional studies, and some factors were omitted from the scale such as the utility of psychological theory in the research.

As one of the papers included in the study was qualitative in design, the CASP tool was selected for measuring the quality of the study (Critical Appraisal Skills programme (CASP, 2013), which was developed specifically for qualitative research (Critical Appraisal Skills Programme, 2013). The CASP tool is a user-friendly measure with additional guidance to support the researcher. The CASP tool was selected as it is widely cited for use in other literature (Dixon-woods et al., 2007).

Some literature suggests approaching the use of appraisal tools with caution due to the possibility of over-simplifying results and biases of the quality of papers (Katrak et al., 2004). However, on reflection, the choice of the above quality assessment tools was the correct decision. The author felt that using different tools to assess the qualitative and cross-sectional research enabled a richer and more detailed analysis of individual studies.

One of the difficulties experienced by the researcher when using the CASP and AXIS tools was the lack of numerical value or scoring system to determine the overall quality of studies. The Cochrane collaboration cautions against the use of numerical rating scales as they often fail to identify bias (Higgins and Green, 2006) and other literature advocates for a domain based system in determining overall quality of studies (O'Connor et al., 2015). As a result of this, and through discussions with their research supervisor, the author chose to determine overall quality of included studies based on subjective interpretation and comparing the results of the quality indicators between studies. For example when viewing the quality assessment table it appeared that the study completed by Landrum et al. (2012), was of moderate quality. However, additional weighting was given to the lack of psychometric properties cited for the instruments used to measure wellbeing and quality of care, meaning that the paper was deemed overall as being of lower quality.

To assess bias in the quality assessment ratings, 2 of the 8 studies (20%) were rated by an independent rater. This is considered sufficient for ensuring reliability quality rating assessments (Boland, Cherry & Dickson, 2013).

3.2.3 Quality of the data

The extracted articles were predominantly cross-sectional, with one longitudinal and one qualitative in nature. The overall quality of studies was perceived to be moderate. This was partially due to the selection of a cross-sectional design in that the direction of relationships could not be determined and confounding variables could not be accounted for. The measures reported were largely self-report measures, which lend themselves towards self-selection and social desirability bias. In addition to this, there was variability in measures adopted to quantify wellbeing and a lack of validated measures used to determine quality of care. Furthermore, studies did not always cite the psychometric properties of measures used. This may have led to bias in the results of the studies as they were measuring inconsistent constructs. Whilst the results of this review provided further insights into the nature of the relationship between staff wellbeing, burnout and quality of care in mental health settings, conclusive results could not be determined due to the limitations of the included studies. It may have been useful to perform a review on intervention studies. However this evidence base is in its infancy at present (Salyers et al., 2011). The lack of intervention studies may reflect the overall quality of the literature available pertaining to staff burnout, wellbeing and their relationship with quality of care. Until definitive relationships between burnout, wellbeing and quality of care can be established, it is likely that intervention studies will remain under-researched.

3.2.4 Implications of the systematic review

3.2.4i Clinical implications

The systematic review offers a comprehensive overview of clinician wellbeing, burnout and the perceived relationship of this with quality of care in mental health settings. This knowledge is particularly relevant to those working in the mental health sector, and has implications for clients, practitioners and organisations.

Firstly, the review found a significant relationship between both measures of burnout and wellbeing with perceived quality of care. Whilst this review cannot establish poor wellbeing and burnout as an antecedent to quality of care, previous studies have expressed this as a likely direction of relationship (Maben et al., 2012). Given the likely impact of burnout and poor wellbeing, organisations should aim to engage with interventions to promote positive wellbeing in order to ensure the health of their employees and ensure the delivery of good quality of care. Indeed, whilst this is an important focus of NHS initiative (Maben et al., 2012), the importance of staff wellbeing has long been cited as overlooked in healthcare systems (Francis, 2013; Boorman, 2009).

The included studies highlighted the importance of a sense of personal accomplishment in their results (Salyers et al., 2014; Garman et al., 2002). Organisations should aim to enable staff to feel accomplished through providing staff with opportunities to control and input into their working environments (Landrum et al., 2012). Ownership and involvement and control were recommended to health staff in Maben et al.'s (2012), large-scale study of health practitioners, and are cited in

policy documents developed to enable organisations to promote healthy workplace wellbeing (NICE, 2015). The findings of this review provide further evidence to promote the utility of these policies.

The synthesis of studies found that reduced wellbeing was linked to poorer job satisfaction, poor ratings of work environments and higher levels of burnout in clinicians. Conversely, when exploring a positive construct for wellbeing through work engagement, Van-Bogeaert et al. (2013b), found that staff had more positive feelings and feelings of productivity when in a positive working environment, and this correlated with higher levels of self-reported quality of care ratings. Indeed, patients felt that staff working in a supportive team environment had a better sense of morale (Mistry et al., 2015). These findings suggest that workplaces should aim to provide a positive working environment for staff.

Some of the research cited in the data suggested that patient satisfaction increased as staff satisfaction increased (Rossberg et al., 2008). Introducing programmes into units aimed at improving the quality of staff- client relationships may serve to improve both staff morale and client experience (Mistry et al., 2015). Initiatives such as the ‘Productive mental health ward initiative’ (Van Bogeaert et al., 2017) have attempted to foster better staff- client relationships with promising results, and the present review provides support to continue developing the evidence base in this field.

3.2.4.ii Suggestions for further research

Out of the included studies, most research has been published in the past 10 years, highlighting the recent drive to determine the impact of clinician wellbeing on quality

of care. As the evidence base continues to develop it would be useful for studies to adopt longitudinal designs in order to ascertain the impact of clinician wellbeing on patient quality of care over time.

The review highlighted the nature of the developing evidence base as being restricted to studies adopting a cross-sectional design. The implications of this are that true causal relationships between quality of care and staff burnout and wellbeing cannot be established definitively at this time. In order to establish causality within the evidence base, further research into interventions aimed at reducing burnout and enhancing wellbeing and the impact of this on quality of care should be completed. Indeed, this suggestion is echoed in other reviews pertaining to staff burnout and quality of care in healthcare settings (Dewa et al., 2017; Salyers et al., 2017).

Some studies have attempted to quantify the impact of clinician burnout in mental health services through measuring rates of inpatient admissions (Priebe et al 2004). However, measurement remains difficult and tools should be continually developed and validated to ensure accurate measurement of constructs (Van-Bogeaert et al., 2013). Most of the studies included in the current review relied on self-report data. Interestingly, Salyers et al. (2015), noted that participants with higher levels of emotional exhaustion were less likely to report a relationship between reduced wellbeing and quality of care. This suggests that the use of self-report does not fully capture the relationship between wellbeing and care quality, as staff may not be able to see it themselves (Salyers et al., 2015). It is thus important to continue to develop the evidence base using a mixture of staff reports of burnout or wellbeing and client rated quality of care in order to ascertain the differences between the two.

The majority of studies included in the review measured wellbeing, burnout and quality of care at an individual level. Studies reporting team-based analysis (Van-Bogeaert et al., 2013; Garman et al., 2002) highlighted the nature of working in mental health services, with a team-led approach predominantly adopted when working in mental health settings. Some research suggests that burnout is ‘contagious’ within health care teams (Pettita et al., 2017). Future research should aim to explore and analyse the impact of reduced wellbeing and clinician burnout within a team as opposed to on an individual basis.

In combination, the findings from the current review confirm previous findings of the relationship between wellbeing and burnout (Lizano et al., 2015), with studies included in the current review drawing correlations between lower levels of job satisfaction and higher levels of burnout. Further research should be conducted to clarify the relationship between these two constructs in order to clarify definitions in the literature. This will in turn enable effective measurement of both constructs.

3.2.5 Conclusions

It is hoped that in contributing to the developing evidence base, this review will provide justification and scope for future, methodologically stringent research. Whilst the quality of the included studies was unreliable, this provides a valuable insight into the future directions and applications of this research, with implications for organisations, clients and individual practitioners.

3.3 Empirical Paper

The aim of this project was to identify the specific domains that are perceived as having an impact on the wellbeing of Practitioner Psychologists. This information was used to develop a psychometric measure to assess wellbeing of psychological practitioners.

3.1.1 Rationale for completing the empirical study

The current research also sets the agenda for a further project, which aimed to develop a validated measure of wellbeing for use with psychological practitioners. The decision was made to complete the empirical study into the perceived factors influencing the wellbeing of Practitioner Psychologists as there is a lack of qualitative research pertaining to this. (Scriberras et al., 2018). The majority of available evidence utilises survey data, and largely relies on non-validated forms of assessment. (Hannigan et al., 2004). Only two previous studies have used qualitative evaluation of the perceptions of Practitioner Psychologists on the factors influencing wellbeing in the workplace (Scribierras et al., 2018; Papadomarkaki et al., 2008), with only one completed in the United Kingdom (Papadomarkaki et al., 2008). This project consisted of a small sample size (n=7), focussed solely on counselling psychologists and was published over 10 years ago. Therefore it was pertinent to develop this evidence base to provide a context for the development of a validated scale. Further research on job burnout and distress are crucial for providers and clients (Dreison et al., 2018). Increasing awareness of the factors resulting in impairment of workplace wellbeing could also increase our understanding of the barriers Practitioner Psychologists face in accessing support (Smith and Moss, 2009).

3.3.2 Review of the selected methodology

3.3.2i Study design

Qualitative methodology is increasingly accepted as a legitimate means of inquiry (Braun and Clarke, 2013). This research focuses on the personal work experiences of Practitioner Psychologists. The current evidence base and understanding of the workplace factors associated with emotional wellbeing of Practitioner Psychologists is in its infancy and is currently reliant on survey information as opposed to in depth analysis (Hannigan et al., 2004). In addition to this, the current study formed part of a wider research agenda to develop a validated scale to assess the wellbeing of psychological practitioners.

Qualitative research is traditionally used to explore and understand perspectives, behaviours and contexts. It can be used to develop understanding in areas that are not yet well understood (Fossey et al., 2002). Qualitative research explores subjective experience and sense making (Willig, 2008), it requires interpretation from the researcher and is often used as an exploratory stage in the research process (Braun and Clarke, 2013). Given the lack of qualitative research pertaining to the experiences of wellbeing for people working in psychological roles (Scribberas et al., 2018., Papadomakaki et al., 2008., Hannigan et al., 2004), a qualitative methodology was selected for the present study.

As opposed to developing a specific hypothesis, qualitative research aims to aid understanding (Fossey et al., 2002). Given the aims of the present study, it seemed

that a qualitative approach would enable a thorough exploration of the factors impacting on the wellbeing of Practitioner Psychologists.

3.2.2ii Thematic analysis

Thematic analysis is one of the most widely used forms of qualitative data analysis (Nowell et al., 2017). Thematic analysis is a method used to identify and analyse patterns of meaning within a data set (Braun and Clarke, 2006) in a flexible and in-depth manner (Braun and Clarke, 2013). The advantages to using thematic analysis include its theoretical flexibility and suitability to conceptualizing the various perceptions of participants (Nowell et al., 2017).

The use of thematic analysis is also suitable for large data sets (Braun & Clarke, 2006). Small datasets are considered to be of around six participants in qualitative analysis, with sample sizes of 15 or higher representing larger datasets (Fugard et al., 2015). For this reason, thematic analysis was considered appropriate in the present study. In addition to this, the use of thematic analysis is generally deemed as accessible to general members of the public and policy makers (Braun and Clarke, 2006). When considering the dearth of literature available to inform practice in this area, it seemed appropriate to adopt this methodology to support interpretation of the results.

Within thematic analysis, data can be identified from an inductive or theoretical perspective (Braun and Clarke, 2013). An inductive method reviews the data in a 'bottom up' way, meaning that themes are linked strongly to the data (Fereday et al., 2006). The author chose to approach the data inductively to ensure all possible themes

related to the research could be identified. The use of inductive thematic analysis allows for themes to be identified that are not in response to the initial research question (Fereday et al., 2006). In the present study, this method led to a valuable conclusion when the theme ‘Drive to improve staff wellbeing’ was identified. In addition to this, the ‘bottom up’ nature of inductive thematic analysis ensures that data is not derived based on the researchers theoretical interest or relationship with the research topic because the results are driven by the data (Braun and Clarke., 2013). Given the ‘insider’ (Galais, 2008) position of the researcher when completing the interviews with individuals in the same profession, inductive thematic analysis was used to attempt to account for and reduce this bias.

Thematic analysis has received criticism for a lack of focus on rigour in the process of analysis, which can detract from the overall credibility of the research process (Nowell et al., 2017), however, Braun and Clarke, (2006) developed and defined a process to analysing data and deriving themes (Appendix K). This method is widely cited in literature surrounding thematic analysis (Braun and Clarke, 2013) and the author chose to follow these guidelines to enhance the quality of the data analysis. Whilst there are different approaches to analysing qualitative data, it is the individuals’ personal responsibility to ensure rigour and trustworthiness of analysis (Nowell et al., 2017). The use of a structured format for data analysis (Braun and Clarke, 2006) allowed for a systematic and transparent approach to data collection, ensuring a higher quality of interpretation.

3.2.2iii Alternate approaches to qualitative analysis

Other forms of methodology are cited for analysing qualitative data including interpretive phenomenological analysis (IPA, Smith, 2004) and grounded theory (Braun and Clarke, 2013). The key difference between thematic analysis and both IPA and grounded theory is that both IPA and grounded theory are theoretically driven (Braun and Clarke., 2013). In IPA, the experience of participants is of primary importance, with extremely in depth analysis of the experiences of participants in developing an understanding of the topic area (McLeod., 2011). Grounded theory aims to develop a useful theory driven and developed by the data collected (McLeod., 2011).

The methodology of thematic analysis was selected over interpretive phenomenological analysis (IPA) as there has been little research in the presenting topic area and the depth of interpretation was not required at this stage. In addition to this, IPA is wedded to a theoretical epistemology (Shinebourne et al., 2011), and the present study aimed to take a bottom- up, data-driven approach to analysis to ensure that themes were strongly linked to data (Fereday et al., 2006).

The present study was inductive in nature, and the author made interpretations of the data similar to the approach used in Grounded theory. However, it was not the original intention of the researcher to develop a theoretical model (McLeod et al., 2011), and thus grounded theory was not seen as an applicable methodology for the present study.

3.3.3 The research process

3.3.3i Recruitment

Participants were eligible to participate in the research providing they met the following criteria;

- Adults of a working age (18 years +) from the following professions: clinical psychologist, cognitive behaviour therapist, counselling psychologist, counsellor, psychoanalyst, psychological therapist, psychological wellbeing practitioner, psychotherapist, and psychiatrist.

Participants were excluded from participation if they were below the age of 18. The author was surprised at the scale of the response to the recruitment process. Over 100 practitioners responded to the call for participants. In order to manage the scale of the response the author recruited individuals on a first-come-first-served basis providing they inclusion criteria were met. Following the initial call for participants, potential participants contacted the researcher via email. Consent to make contact was assumed on receiving emails from prospective participants and the researcher contacted the respondent to arrange further contact and to ensure participants sat within the inclusion criteria.

The participants were recruited via convenience sampling through two avenues; the Division of Clinical Psychology (DCP) and Psychological Professions Network (PPN). Whilst this method of recruitment allowed a broad sample from different geographical areas and in different services, the sample was homogeneous to practitioners largely working in the field of clinical psychology. The nature of the DCP and PPN mean that it is likely that clinical psychology professionals would have access to these networks and would have received the invitation to participate.

However, other professions such as psychiatry would not hold membership to these networks and thus would not receive the invitation to participate. Because of this the sample of participants was biased towards those working in a clinical psychology role meaning results must not be generalised to all professionals working in ‘psychological practitioner’ roles.

3.3.3ii Sample size

A total of 16 participants were recruited to take part in the study. One of the recordings did not work sufficiently and therefore data could not be transcribed. Because of this 15 interviews were transcribed for analysis.

There are no clear guidelines for how many participants are sufficient for qualitative research, however some authors have suggested that between 10- 20 interviews are optimum when completing ‘medium sized research’ (Braun and Clarke, 2013), which the authors deemed appropriate for doctoral level work. The author endeavoured to complete up to 20 interviews and review the dataset in relation to theoretical saturation (Fugard et al.,2015). Theoretical saturation refers to the notion of completing interviews until no further themes are identified during interviews (Fugard et al., 2015). During the process of collecting the research, it became clear that particular themes were prominent during data collection. Thus the author made the decision after 16 interviews that ‘theoretical saturation’ had been met. This is consistent with previous research that found saturation typically occurs after around 12 interviews when sampled participants are relatively homogenous (Guest et al., 2006).

3.3.3iii Development of the interview schedule

Participants in the study completed a semi-structured interview. Semi-structured interviews are one of the most frequently used interview techniques in qualitative research (DiCiccoBloom and Crabtree, 2006) and are considered an appropriate way of collecting data for use in thematic analysis (Braun and Clarke, 2006). Interviews were completed between February and July 2016.

A semi structured interview schedule was developed to elicit the participants' experiences of wellbeing. The interview schedule was developed using the results of previous staff surveys completed by the 'New Savoy Partnership, 2016'. Questions pertained to areas of social, personal and workplace wellbeing. The current project was completed in conjunction with New Savoy Partnership to develop a validated measure of staff wellbeing to replace previously used surveys, and it seemed appropriate to follow guidance from the survey data previously collected.

An initial illustrative interview schedule was reviewed and authenticated by a group of four local clinical psychologists and consisted of open ended questions, which began with more general questions and led to more specific and personal questions (Appendix J). During the interviews, the schedule was used flexibly and adapted around the data presented by interviewees. This allowed rapport to be built throughout the interview (Willig, 2008). As the questions were open ended, this allowed the author to explore the responses in more detail (Dearnley, 2005).

3.3.3iv Credibility of the research process

Qualitative research requires the researcher to disclose their theoretical perspective and assumptions to enhance the validity of the analysis (Braun & Clarke, 2013). The author maintained a reflective journal throughout the research process in order to maintain reflexivity (Fossey et al., 2002). Within this the author noted their 'insider' position (Gallais, 2008) as a clinical psychologist in training. Using a reflective journal and supervision from both peers and research supervisors, the author was able to 'bracket' (Fischer, 2009) their assumptions to help ensure that the data collection was not led by preconceived ideas about the factors that would have an impact on practitioner functioning.

Credibility checks ensure that that interpretation and analysis of qualitative data is valid (Barker and Pistrang, 2005). In order to enhance the validity of the themes identified, subsequent peer review of the transcript and proposed themes was sought. Initially, the author had intended to collect data and hold a focus group with initial participants to determine authenticity of themes. Unfortunately during the recruitment process it became clear that holding a focus group would be difficult as participants varied in terms of location and it would not be possible to bring participants together in one place, therefore the decision was made to authenticate themes within a local service and to email participants detailing the themes and ask for feedback should participants wish to comment. The identified themes discussed within the local service were completed with six clinical psychologists working in one particular specialty. The author did not receive responses from all emailed participants, possibly because of the gap in time between data collection and final theme development (1 year). Nevertheless, participant responders (n=4) and staff working in local services responded to the themes with enthusiasm and commented on the relevance of the

identified themes. However, they were surprised that the nature and emotional impact of client work had not been identified as a theme within the research. This led to the researcher re-reviewing transcripts to ensure there was not an additional theme around the nature of clinical work. Whilst participants mentioned this on occasion, it did not develop into a theme in the data.

3.3.4 Ethical considerations and professional issues

Consideration was given to ethics throughout the research process and the author was mindful of the distinction between being a clinician and being a researcher during the interviews. Practitioners often spoke about feelings of distress during the interviews. It was necessary to ensure that individuals were provided with the resources to seek support should they wish, and support avenues were suggested in debrief forms and discussed during interviews as needed. However, the author felt some discomfort when needing to detach from difficulties in maintaining their positioning as a researcher in this context.

It was also important for the author to consider the professional climate during the interviews. The impact of the current context of austerity (Hall et al., 2016) was clear during the interviews, and in addition to this there is growing uncertainty within the profession surrounding the future of the British Psychological Society and included professions (DCP, 2017). At the time of completing this research challenges with professional bodies had led to the development of the '*UK Association For Clinical Psychologists*' (ACP-UK). In November 2017 the BPS issued a statement '*The future of clinical psychology in the society*' (BPS, 2017), where they claimed:

'We wish to emphasise that first and foremost, the Division of Clinical Psychology is a valued Member Network of the British Psychological Society and as a home for our clinical psychologist members it will continue to play an integral part in the Society's future.' (BPS, 2017).

The author felt it important to hold in mind the current professional context of psychologists in conducting the research, and wondered whether the presenting context may mean that the current climate of uncertainty could have impacted on the participants taking part in the study, and therefore impacted on the results. Whilst this may have impacted on the results of the study, and given the uncertainty of the future of the profession, it seemed timely and important to conduct research pertaining to the fostering the wellbeing of this profession.

3.3.5 Implications of the empirical paper

In summary, given the dearth of qualitative research exploring the wellbeing of Practitioner Psychologists (Hannigan et al., 2004) this piece of research provides novel and useful insights in to the perceived factors impacting on the subjective wellbeing of Practitioner Psychologists. The implications of this for research and the profession are discussed below.

3.3.5i Implications for research

When considering the sample of participants included in the study, it appears that the sample was homogeneous to those working as clinical psychologists. Whilst the results of this study cannot be generalised to all practitioners working across different

types of psychological role, it provides a framework for future research to differentiate between professions. It would be useful for the literature to articulate salient differences in the perceived wellbeing of people working in other roles such as psychiatry when compared with practitioner psychologists.

The results of the present study were utilised in the development of a validated measure of wellbeing, specifically tailored to those working in psychological roles, and based on the emergent themes found in this study. This is the first validated tool for use specifically with psychological practitioners (New Savoy Partnership, NSP 2016). The development of this tool will enable measurement of the wellbeing of psychologists over time and provide valuable longitudinal data to expand the current evidence base. It is hoped that doing this will lead to the development of future interventions to support the wellbeing of psychological practitioners.

Few studies have evaluated the efficacy of interventions to manage levels of stress for those working in psychological roles in the UK and future research should aim to address this (Simionato et al., 2018; Hannigan et al., 2004). Whilst this is an under-researched area, currently the literature is growing in the areas of interventions to support other healthcare professionals (Dreison et al., 2018). This study provides useful insights into the possible areas of intervention to target the wellbeing of psychological staff in terms of achieving adequate support, balanced caseloads, self-care, and a productive physical environment. As a starting point, it may be useful for organisations to adopt a positive psychology approach and to provide training to practitioners in noticing when their wellbeing is compromised. They then need to provide further support in managing self-care and achieving balance between

workload, other duties and personal needs (Simionato et al., 2018; Rupert et al., 2007).

3.3.5 ii Implications for the profession

The New Savoy Partnership (NSP) in combination with the British Psychological Society (BPS) created the ‘Charter of Wellbeing and Resilience’ (Rao et al., 2016) following completion of annual staff surveys on the wellbeing of psychological practitioners (NSP, 2016). The Charter called for a greater focus on staff wellbeing and support for staff wellbeing to ensure effective service delivery. One aim of this research was to contribute to the wider development of a quantitative psychological measure of staff wellbeing, a validated tool for practitioners. The validated tool will be utilised by the ‘Charter for wellbeing and resilience’ moving forward.

During the interviews a number of respondents highlighted the importance of the research in supporting the profession to monitor and manage the wellbeing of its staff. In combination, this literature will enable professional bodies such as the British Psychological Society (BPS) to monitor staff wellbeing, leading to the future development of guidelines to manage and ameliorate the difficulties faced by practitioners. The development of this measure will provide services and organisations with a practical tool to understand the steps required to improve and build on staff wellbeing.

During the interviews, participants spoke about the impact of the current context on the wellbeing of their colleagues. Practitioner Psychologists have skills in reflective proactive, leadership, supervision, formulation and working with teams (BPS, 2010). Practitioner Psychologists therefore have the necessary skills required to impact on organisational delivery and foster workplace promotion in the wellbeing of their staff (BPS, 2010). According to Rao et al., (2016), we must ‘reset the balance on the front line so that success can be achieved sustainably’. It will therefore be an important role for Practitioner Psychologists to work with organisations to promote the importance of, and to deliver, interventions to enhance wellbeing in the workplace.

3.3.6 Conclusions

In conclusion, this research contributes to the growing evidence base surrounding the wellbeing of mental health practitioners (Dreison et al., 2018), and more specifically, those working in a psychologically oriented role (Simionato et al., 2018; Lee et al 2011; Papadomakaki et al., 2008; Hannigan et al., 2004). The results of the study provide timely insights given the current NHS context, and fit well with current policy developments (Boorman, 2009) and the developing literature (Rao et al., 2016).

3.4 Competency development

The process of completing this piece of research has enabled the author to develop competencies that will better prepare them for future working as a qualified clinical

psychologist. The researcher considered the areas of competency development in relation to the 'standards for the accreditation in doctoral programs in clinical psychology' (BPS, 2016). The following sections detail the key ways in which the author has achieved competency development during the process of conducting the research.

3.4.1 Research skills

Across both papers the authors developed their skills in conducting and critiquing research. The author was required to understand the current evidence base, design, and conduct an original piece of research to contribute to the knowledge base of the discipline. The author was required to utilise skills in considering ethical issues, choosing appropriate research methods and analysis, reporting outcomes and identifying appropriate pathways for dissemination.

3.4.2 Communication

The researcher was required to quickly build a good level of rapport with participants in order to make people feel comfortable and better equipped to talk about their experiences, which were often negative. Participants sometimes felt reticent about speaking about their place of work, and spoke about the fear of ramifications if colleagues were aware. The author was grateful towards people who chose to speak about their personal experiences of wellbeing. This experience helped the author to develop their communication skills and ability to engage with others. Due to the 'insider bias' (Gallais, 2008), it was sometimes difficult for the author to avoid

biasing results by over-privileging and attaching too much importance to comments that resonated with them personally. The nature of completing semi-structured interviews fit well with systemic principles of neutrality and curiosity (Dallos and Draper, 2010), and the author found it helpful to consider this when completing interviews in a neutral yet curious way.

3.4.3 Organisational and systemic influence and leadership

In completing this piece of research the author hopes to demonstrate leadership skills by contributing to the development of a measure to be used by organisations in measuring staff levels of wellbeing. It is hoped that this will influence decision-making processes within the British Psychological Society and lead to a more prominent focus on the importance of measuring and monitoring wellbeing in the profession. The interviews and recruitment process demonstrated that this is perceived as a valuable avenue of research to many people working in psychological roles, and the development of a validated questionnaire based on this study may eventually lead to more evidence-based research into interventions to support staff working in psychological roles. On a personal level, the author endeavors to use the knowledge gained during this process to develop and foster good working alliances within the workplace and to promote and develop initiatives which focus on building positive levels of staff wellbeing.

3.4.4 Professional and personal issues

The author developed their skills in self-awareness and personal reflexivity during the research process. Within qualitative research, it is recognized that good quality research requires reflexivity and consideration to the epistemological position of the researcher (Braun and Clarke, 2006). The epistemological positioning of the researcher shapes the nature and direction of the research process (Dowling, 2006).

The author maintained a reflective journal throughout the research process in order to maintain reflexivity (Fossey et al., 2002). During this process the researcher was closely aligned with the participants in the study, as they were from the same profession with experiential knowledge of the research topic area. Having taken an ‘insider’ (Gallais, 2008) position, it was important for the author to reflect on the process of decision making and understanding throughout the process (Berger, 2015).

Using a reflective journal and supervision from both peers and research supervisors, the author was able to ‘bracket’ (Fischer, 2009) their assumptions to help ensure that the data collection was not led by preconceived ideas about the factors that would have an impact on practitioner functioning.

3.4.5 Reflections

3.4.5i Reflections on completing the empirical study

Reflections highlighted in the reflective journal and through the process of bracketing are detailed below:

Personal Reflexivity

'I have found that I sometimes become very interested in the topics people have presented to me, and I wonder whether some of these may be more personally relevant and interesting as opposed to answering the research question. I think I need to be very aware and cautious not to seek too much information about things that hold personal relevance to me.'

'A number of participants are reporting the difficulties they experience in work. This makes me worry about the future of the profession I am only just embarking on. The sense of hopelessness and lack of control seems contagious and it makes me want to avoid re-reading the transcripts. I wonder if this reflects the nature of burnout on a wider scale within services, it seems contagious amongst teams. In my literature search I have read about the discrepancies between expectations vs. reality when starting qualified life and I wonder if this is what people experience as newly qualified'

'The things people are talking about in interviews are very interesting. People are talking a lot about the physical environments that they work in and not having the right resources to complete their work activities. I feel that I have a sense of this as a trainee, constantly feeling like I am 'fitting' with the physical work environment, with limited desk space and less opportunities to see clients. For me I think this links with my sense of being valued, however this hasn't come up in interviews yet. I will endeavor to be careful to 'bracket' this assumption to avoid leading participants into saying this.'

Table 9: Extracts from reflective journal

As the process of data collection developed the author began to reflect on their own experiences of wellbeing in the workplace. The author was able to understand their insider position, whilst also understanding a degree of separation. Whilst the author is completing their clinical training course they are provided with enhanced levels of supervision. This provides a reflective space and a level of containment that was not described by many of the participants during the interviews. This appears to have provided the trainee with a certain level of ‘protection’ from the difficulties experienced by many of the clinicians, which may have made it difficult to relate to some of the described difficulties. There were however, particular themes derived from the interviews that resonated with the trainee personally. This included the positive impact of personal support as well as inter-professional agents including other’s understanding of the role of being a trainee clinical psychologist. The trainee shared some of the frustrations described by participants when faced with clinicians who may not understand their role or who may minimize their previous experiences.

The nature of training to be a clinical psychologist often requires uncertainty and difficulty finding a balance between work and personal life, and this resonated with the findings from the interviews, particularly with ‘Positive and negative job aspects’. The author reflected on experiencing a struggle to find ‘balance’ between clinical, academic and their personal life. However experiences of feeling ‘valued’ in work and experiencing some ‘autonomy’ alongside ‘having opportunities to learn’ have provided some protection to the pressures of training and working within this profession.

The trainee found the theme ‘drive to improve staff wellbeing’ particularly inspiring, and felt that this theme changed the trainee’s perspective of their role as a Clinical Psychologist. The subthemes of hope and drive described by practitioners led to the author now viewing the profession of Clinical Psychology as holding a level of responsibility in advocating for staff wellbeing within organisations. Throughout the interviews there seemed to be varying perceptions as to who holds responsibility for supporting staff and their wellbeing within organisations. It seemed to the author that the profession of clinical psychology holds a unique position and understanding of such difficulties and this profession has the resources to support and enhance staff wellbeing. In addition to this on a personal level the author was struck by the response rate to the call for participants, which initially led the trainee to experience the same feelings of drive to improve staff wellbeing as described by participants.

3.4.5ii Reflections on completing the systematic review

Whilst the process of completing the systematic review proved to be a challenge for the researcher, the process driven nature of completing systematic reviews and having a structured approach felt containing. This level of rigour required when completing the systematic review enhanced the expertise of the author in terms of critical evaluation and feelings of being a ‘scientist practitioner’.

Initially the author viewed the systematic review as something that was not as ‘novel’ as when completing empirical research. However, the author came to understand the value of systematic reviews. The process helped the author to reflect on the quality of studies often included in peer-reviewed journals. The author previously held the view that articles published in ‘peer-reviewed’ journals would be of good quality.

However, the studies included in this review were of lower quality. This made completion of the systematic review feel important in that it enables overall understanding of a body of research, as opposed to relying on small pieces of research to draw conclusions.

3.4.5iii Reflections on the research topic

The topic of the research felt important to the author, and the author found it motivating to complete work that felt valuable. The lack of research in this area came as a surprise. Whilst it came as no surprise that a lot of research had been completed on occupational wellbeing and the relationship between wellbeing, burnout and quality of care in healthcare settings, the author felt that the lack of research conducted in mental health settings reflected the nature of privilege given to medical settings over mental health settings, and demonstrated a lack of parity of esteem.

The researcher found it useful to reflect on the distinction between ‘wellbeing’ and ‘burnout’ as documented in the systematic review. During data collection for the empirical study participants did not appear to be dissatisfied with their jobs or career, however a number of participants alluded to experiencing feelings of burnout.

3.5 Dissemination

The results of the empirical study formed part of a wider research agenda aimed at developing a validated measure to assess the wellbeing of psychological practitioners. The results of the study were disseminated to the sister project in July 2017.

Following completion of the measure it will be disseminated to the British Psychological Society and New Savoy Partnership to form part of an annual measure of staff wellbeing used by ‘The Charter for Wellbeing and Resilience’ (BPS, NSP 2016).

The results of the empirical study discussed in chapter two have been presented at the ‘DCP-Annual Conference 2018- Being Bold in Changing Times’ as part of ‘The New Savoy Partnership and BPS wellbeing survey - The development of a validated measure’.

3.5.1 Selection of journal for publication

The systematic review in chapter one and empirical paper in chapter two have been formatted for submission to ‘The Journal of Occupational Health Psychology’. This journal was chosen due to its relevance to the topic area, readership, and impact factor (2.67). The journal is concerned with the application of psychology to improving the quality of work life and promoting the wellbeing of workers. The journal holds particular interest in how work-related factors play a role in the aetiology of occupational wellbeing and the implications of this for organisations.

3.6 Concluding Statement

This thesis aimed to investigate wellbeing and burnout in mental health settings. The systematic review provided novel insights in to the relationship between burnout, wellbeing and quality of care in mental health settings, and in particular highlighted the importance of service user involvement in the measurement of quality of care. The

empirical paper highlighted specific domains which Practitioner Psychologists felt affected their wellbeing. The results of this study highlighted the significance of organisational structure and processes. The author has developed both professionally and personally during the development of the project, and this was highlighted in the critical review paper. The author would like to thank all the people who contributed to the development of this project and provided support throughout the process.

3.7 References

Barker, C., & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology*, 35(3-4), 201-212 doi:10.1007/s0464-005-3398-y

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, 15(2), 219-234. doi:10.1177/1468794112468475

Boland, A., Cherry, G., & Dickson, R. (Eds.). (2013). *Doing a systematic review: A student's guide*. Sage.

Boorman, S. (2009) *NHS Health and Wellbeing Review* London: Department of Health.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.

British Psychological Society (BPS, 2017) The future of clinical psychology in the society. BPS . Accessed online in March 2018 at: <https://www.bps.org.uk/news-and-policy/future-clinical-psychology-society>

British Psychological Society. (2016). *The Standards for the accreditation of Doctoral programmes in clinical psychology*. London: British Psychological Society.

British Psychological Society. (2010). *The Clinical Psychology Leadership Development Framework*. London: British Psychological Society.

CASP (2013) Critical appraisal skills program: making sense of evidence. Oxford: CASP UK (www.casp-uk.net) Accessed online in January 2018 at: <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist.pdf>

Centre for Reviews and Dissemination (2008) Systematic reviews: CRD's guidance for undertaking reviews in health care. University of York. Accessed online in March 2018 at: https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf

Dallos, R., & Draper, R. (2010). *An introduction to family therapy: Systemic theory and practice*. McGraw-Hill Education (UK).

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher* (through 2013), 13(1), 19. doi:10.7748/nr2005.07.13.1.19.c5997

Deeks, J., Dinnes, J. D'Amico, R., Sowden, A., Sakarovitch, C., Song, F. (2003) Evaluating non-randomised intervention studies. *Health technology assessment*, 7(27): 1-173.

Department of Health (DOH, 2011) 'NHS health and wellbeing improvement framework. '. DOH. Accessed online in February 2018 at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216380/dh_128813.pdf

Dewa, C. S., Loong, D., Bonato, S., & Trojanowski, L. (2017). The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ open*, 7(6), doi:10.1136/bmjopen-2016-015141

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, 40(4), 314-321. doi:10.1111/j.1365-2929.2006.02418.x

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., ... & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of health services research & policy*, 12(1), 42-47. doi:10.1258/135581907779497486

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3), 7. doi:10.7748/nr2006.04.12.3.7.c5975

Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ open*, 6(12), e011458. doi:10.1136/bmjopen-2016-011458

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology*, 23(1), 18-30. doi:10.1037/ocp0000047

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, 5(1), 80-92. doi:10.1177/160940690600500107

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19(4-5), 583-590. doi: 10.1080/10503300902798375

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand journal of psychiatry*, 36(6), 717-732. doi: 10.1046/j.1440-1614.2002.01100

Francis, R. (2015). *Freedom to Speak Up - An independent review into creating an open and honest reporting culture in the NHS.*

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology*, 18(6), 669-684. doi:10.1080/13645579.2015.1005453

- Gallais, T. (2008). Wherever I go there I am: reflections on reflexivity and the research stance. *Reflective practice*, 9(2), 145-155. doi: 10.1080/14623940802005475
- Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology*, 7(3), 235. doi:10.1037/1076-8998.7.3.235
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82. doi:10.1177/1525822X05279903
- Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS ONE*, 11(7), e0159015. doi:10.1371/.0159015
- Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health*, 13(3), 235-245. doi: 10.1080/09638230410001700871
- Higgins, J., & Green, S. (2006). Cochrane handbook for systematic reviews of interventions 4.2.6. The Cochrane Library, Issue 4. Chichester, UK: John Wiley & Sons, Ltd. Accessed online in January 2018 at: <https://pdfs.semanticscholar.org/4b43/91c08c45ebfcd046a53106c97ca09fcd9fa.pdf>
- Humpheries, N., Morgan, K., Conry, MC., McGowan, Y. (2014) Quality of care and health professional burnout: narrative literature review. *International Journal of Health Care Quality Assurance*. 27:293– 307. doi:10.1108/IJHCQA-08-2012-0087.
- Jahrami, H., Thomas, A., Saif, Z., Peralta, F., Hubail, S., Panchasharam, G., & AlTajer, M. (2013). The relationship between burnout and job satisfaction among mental health workers in the psychiatric hospital, Bahrain. *The Arab Journal of Psychiatry*, 24, 69-76. Doi:10.12816/0000101
- Jarde, A., Losilla, J. M., & Vives, J. (2012). Methodological quality assessment tools of non-experimental studies: a systematic review. *Anales de Psicología/Annals of Psychology*, 28(2), 617-628. doi:10.6018/analesps.28.2.148911
- Jerosch-Herold, C. (2005). An evidence-based approach to choosing outcome measures: a checklist for the critical appraisal of validity, reliability and responsiveness studies. *British Journal of Occupational Therapy*, 68(8), 347-353. doi: 10.1177/030802260506800803
- Katrak, P., Bialocerkowski, A. E., Massy-Westropp, N., Kumar, V. S., & Grimmer, K. A. (2004). A systematic review of the content of critical appraisal tools. *BMC medical research methodology*, 4(1), 22. doi:10.1186/1471-2288-4-22
- Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of substance abuse treatment*, 42(2), 222-230. doi: 10.1016/j.jsat.2011.10.011

Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice, 42*, 252–258. doi:10.1037/a0023319

Lee, R. T., Seo, B., Hladkyj, S., Lovell, B. L., & Schwartzmann, L. (2013). Correlates of physician burnout across regions and specialties: a meta-analysis. *Human resources for health, 11*(1), 48. doi:10.1186/1478-4491-11-48

Lizano, E. L. (2015). Examining the impact of job burnout on the health and well-being of human service workers: A systematic review and synthesis. *Human Service Organizations: Management, Leadership & Governance, 39*(3), 167-181. doi: 10.1080/23303131.2015.1014122

Maben, J., Peccei, R., Adams, M., Robert, G., Richardson, A., Murrells, T., & Morrow, E. (2012). Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. Southampton: NIHR Service Delivery and Organization Programme. Accessed online in March 2018 at:
http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1819-213_V01.pdf

Mandell, D., Stalker, C., de Zeeuw Wright, M., Frensch, K., & Harvey, C. (2013). Sinking, swimming and sailing: experiences of job satisfaction and emotional exhaustion in child welfare employees. *Child & Family Social Work, 18*(4), 383-393. doi:10. 1111/j.1365-2206.2012.00857.x

Maslach, C. (2001). What have we learned about burnout and health?. *Psychology & health, 16*(5), 607-611. doi:10.1080/08870440

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111. doi:10.10022031

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. Sage.

Mistry, H., Levack, W. M., & Johnson, S. (2015). Enabling people, not completing tasks: patient perspectives on relationships and staff morale in mental health wards in England. *BMC psychiatry, 15*(1), 307 doi: 10.1186/s1288-015-0690-8

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341-352 doi: 10.1007/s10488-011-0352-1

National Institute for Health and Clinical Excellence (2015) Workplace health management practices. NICE guideline NG13. Accessed online in February 2018 at: <https://www.nice.org.uk/guidance/ng13>

New Savoy Partnership (NSP, 2016). Workforce wellbeing survey 2014-2016. Accessed online in January 2018 at: <https://www.newsavoypartnership.org/2017presentations/dosanjh-g-bhutani.pdf>

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16(1), doi:10.1177/1609406917733847.

O'Connor, S. R., Tully, M. A., Ryan, B., Bradley, J. M., Baxter, G. D., & McDonough, S. M. (2015). Failure of a numerical quality assessment scale to identify potential risk of bias in a systematic review: a comparison study. *BMC research notes*, 8(1), 224. doi:10.1186/s13104-015-1181-1

Papadomarkaki, E., & Lewis, Y. (2008a). Counselling psychologists' experiences of work stress. *Counselling Psychology Review*, 23(4), 39-51.

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The journal of behavioral health services & research*, 37(4), 519-528. doi:10.1007/s11414-009-9202-2

Petitta, L., Jiang, L., & Härtel, C. E. (2017). Emotional contagion and burnout among nurses and doctors: Do joy and anger from different sources of stakeholders matter?. *Stress and Health*, 33(4), 358-369. doi: 10.1002/smi.2724

Priebe, S., Fakhoury, W. K., Hoffmann, K., & Powell, R. A. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social psychiatry and psychiatric epidemiology*, 40(3), 223-232 doi:10.1007/s00127-005-0880-7

Rao, A. Bhutani, G. Clarke, J. Dosanjh, N. Sanjivan, P. (2016) *The case for a charter for psychological wellbeing and resilience in the NHS*. BPS and New Savoy Conference (Discussion paper). Accessed online in November 2017 at: https://www1.bps.org.uk/system/files/user-files/DCP%20Leadership%20and%20Management%20Faculty/public/final_draft_case_for_a_charter_for_psychological_wellbeing_and_resilience_copy.pdf

Rosberg, J. I., Melle, I., Opjordsmoen, S., & Friis, S. (2008). The relationship between staff members' working conditions and patients' perceptions of the treatment environment. *International Journal of Social Psychiatry*, 54(5), 437-446. doi:10.1177/0020764008090689

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practice*, 38(1), 88-96. doi:10.1037/0735-7028.38.1.88

Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & de Andrade, S. M. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PloS one*, 12(10), e0185781. doi: 10.1371/journal.pone.0185781

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality

and safety in healthcare: A meta-analysis. *Journal of general internal medicine*, 32(4), 475-482. doi:10.1007/1160601638869

Salyers, M. P., Fukui, S., Rollins, A. L., Firmin, R. L., Gearhart, T., Noll, J. P., Williams, S., & Davis, C.J. (2014). Burnout and Self-Reported Quality of Care in Community Mental Health. *Administration and Policy in Mental Health and Mental Health Services Research*. Doi: 10.1007/s10488-014-0544-6

Sciberras, A., & Pilkington, L. (2018). The lived experience of psychologists working in mental health services: An exhausting and exasperating journey. *Professional Psychology: Research and Practice*, 49(2), 151-158. doi:10.1037/pro0000184

Shinebourne, P. (2011). The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, 22(1). Accessed online in January 2018 at: file:///TheTheoreticalUnderpinningsofInterpretativePhenomenologicalAnalysisIPAShinebourne2011%20(1).pdf

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology*, 1(1), 39-54. doi:10.1191/1478088704qp0040a

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it?. *Clinical Psychology: Science and Practice*, 16(1), 1-15. doi: 10.1111/j.1468-2850.2009.01137

Taris, T. W. (2006). Is there a relationship between burnout and objective performance? A critical review of 16 studies. *Work & Stress*, 20(4), 316-334. doi:10.1080/02678370601065893

a. Van Bogaert, P., Kowalski, C., Weeks, S. M., & Clarke, S. P. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and quality of nursing care: a cross-sectional survey. *International journal of nursing studies*, 50(12), 1667-1677. doi: 10.1016/ijnurstu.2013.05.010

Van Bogaert, P., Verspuy, M., Wouters, K., Slootmans, S., Van der Straeten, J., Van Aken, P., & White, M. (2017). The Productive Ward Program™: A Two-year Implementation Impact Review Using a Longitudinal Multilevel Study. *Canadian Journal of Nursing Research*, 49(1), 28-38. doi:10.1177/0844562116686491

b. Van Bogaert, P., Wouters, K., Willems, R., Mondelaers, M., & Clarke, S. (2013). Work engagement supports nurse workforce stability and quality of care: nursing team-level analysis in psychiatric hospitals. *Journal of Psychiatric and Mental Health Nursing*, 20(8), 679-686. doi:10.1111/jpm.12004

Von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., Vandenbroucke, J. P., & STROBE Initiative. (2007). The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement: guidelines for reporting observational studies. *PLoS medicine*, 4(10), doi:10.1371/0040296

Warr, P. (2011). *Work, happiness, and unhappiness*. Psychology Press.

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead.

Zangaro, G. A., & Soeken, K. L. (2007). A meta-analysis of studies of nurses' job satisfaction. *Research in nursing & health*, 30(4), 445-458. doi:10. 1002/nur.20202

Appendix A: Journal submission information

Journal of Occupational Health Psychology®



- [Pricing and Access](#)

Editor: [Peter Y. Chen](#)

ISSN: 1076-8998

eISSN: 1939-1307

Published: quarterly, beginning in January

Impact Factor: 2.679

Psychology - Applied: 16 of 80

5-Year Impact Factor: 4.534

The Journal of Occupational Health Psychology® publishes theory, research, and public policy articles in occupational health psychology, an interdisciplinary field representing a broad range of backgrounds, interests, and specializations. Occupational health psychology concerns the application of psychology to improving the quality of work life and to protecting and promoting the safety, health, and well-being of workers.

The Journal has a threefold focus, including organization of work, individual psychological attributes, and work-nonwork interface in relation to employee health, safety, or well-being.

The Journal seeks scholarly articles, from both researchers and practitioners, concerning psychological factors in relationship to all aspects of occupational safety, health, and wellbeing.

Included in this broad domain of interest are

- articles in which work-related and nonwork-related psychological factors play a role in the etiology of occupational safety, health, and wellbeing
- articles examining the dynamics of occupational safety, health, and wellbeing
- articles concerned with the use of psychological approaches to improve occupational safety, health, and wellbeing

Special attention is given to articles with a prevention and a promotion emphasis.

Authors should consider the financial costs and economic benefits of prevention and promotion programs they evaluate.

Manuscripts dealing with issues of contemporary relevance to the workplace, especially with regard to unique challenges of occupational safety, health, and well-being experienced by minority, cultural, or occupationally underrepresented groups, or topics at the interface of work and non-work, are encouraged.

Each article should represent an addition to knowledge and understanding of occupational health psychology.

Journal of Occupational Health Psychology[®] is a registered trademark of [American Psychological Association](#)

Submission Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Department of Psychology
226 Thach Hall
Auburn University
Auburn, AL 36849 USA

Email

General correspondence may be directed to the [Editor's Office](#).

Manuscripts submitted for publication consideration in the *Journal of Occupational Health Psychology* are evaluated according to the following general criteria:

- Mastery of the relevant literature
- Theoretical/conceptual framework
- Measures of key constructs
- Research design
- Data analysis
- Interpretations and conclusions
- Writing style (clarity)
- Appropriateness of topic for *Journal of Occupational Health Psychology*
- Theoretical contribution to occupational health psychology
- Practical implications for occupational health psychology

Length of Submission

Standard manuscripts may not exceed 40 double-spaced pages (excluding figures, tables, references, and appendices). Research Note (also known as Kevin's Corner) manuscripts may not exceed 20 double-spaced pages (excluding figures, tables, references, and appendices).

Additional materials, if needed, can be placed in a supplemental materials file.

Submission letters should include a statement regarding any possible conflict of interest in conducting or reporting of the research and a statement of compliance with APA ethical standards. Authors can (but are not required to) suggest up to five reviewers who are especially qualified to review their work and who would not have a conflict of interest in serving as a reviewer.

Masked Review Policy

The journal accepts submissions in masked review format only.

Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript.

Furthermore, author identification notes should be typed on the title page. Authors

should make every effort to see that the manuscript itself contains no clues to their identities.

Manuscripts not in masked format will not be reviewed.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Prepare manuscripts according to the [Publication Manual of the American Psychological Association \(6th edition\)](#). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's [Checklist for Manuscript Submission](#) before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Additional guidance on APA Style is available on the [APA Style website](#).

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit [Supplementing Your Article With Online Material](#).

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several [vendors that offer discounts to APA authors](#).

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see [Supplementing Your Article With Online Material](#) for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order using APA Style. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151. <http://dx.doi.org/10.1037/a0028566>
- **Authored Book:**
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Appendix B: The AXIS tool for quality assessment of cross-sectional studies

		Yes	No	Do not know/comment
<i>Introduction</i>				
1	Were the aims/objectives of the study clear?			
<i>Methods</i>				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determine statistical significance and/or precision estimates? (eg, p values, CIs)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			

		Yes	No	Do not know/comment
<i>Results</i>				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results for the analyses described in the methods, presented?			
<i>Discussion</i>				
17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
<i>Other</i>				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

Appendix C: The CASP tool for assessing quality

Screening Questions

1. Was there a clear statement of the aims of the research?

Consider:

- What the goal of the research was
- Why is it important
- Its relevance

2. Is a qualitative methodology appropriate?

Consider:

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants

Detailed questions

3. Was the research design appropriate to address the aims of the research?

Consider:

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

Consider:

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. **Were the data collected in a way that addressed the research issue?**

Consider:

- *If the setting for data collection was justified*
- *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)*
- *If the researcher has justified the methods chosen*
- *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?*
- *If methods were modified during the study. If so, has the researcher explained how and why?*
- *If the form of data is clear (e.g. tape recordings, video material, notes etc.)*
- *If the researcher has discussed saturation of data*

6. **Has the relationship between researcher and participants been adequately considered?**

Consider:

- *If the researcher critically examined their own role, potential bias and influence during:*
 - *Formulation of the research questions*
 - *Data collection, including sample recruitment and choice of location*
- *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*

7. **Have ethical issues been taken into consideration?**

Consider:

- *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained*
- *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)*
- *If approval has been sought from the ethics committee*

8. Was the data analysis sufficiently rigorous?

Consider:

- *If there is an in-depth description of the analysis process*
- *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?*
- *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process*
- *If sufficient data are presented to support the findings*
- *To what extent contradictory data are taken into account*
- *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*

9. Is there a clear statement of findings?

Consider:

- *If the findings are explicit*
- *If there is adequate discussion of the evidence both for and against the researcher's arguments*
- *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)*
- *If the findings are discussed in relation to the original research question*

10. How valuable is the research?

Consider:

- *If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature?*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix D- Ethical approval

Ethics Feedback - EC.16.11.08.4753R

P

psychethics

Reply all |

Mon 05/12/2016, 11:23

Cathy McLellan;

Elisabeth Summers;

Reginald Morris

Dear Cathy & Elisabeth

The Ethics Committee has considered your revised project proposal: The development of a psychometric measure to assess the wellbeing of psychological practitioners (EC.16.11.08.4753R).

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Mark Jones

Ethical approval-participant recruitment

ECT/fmc

26 October 2016

Dr Esther Cohen-Tovée
BPS Division of Clinical Psychology UK Chair
Clinical Director, Psychological Services
Northumberland, Tyne and Wear NHS FT

Ethics Committee
School of Psychology



The British
Psychological Society
Promoting excellence in psychology

Cardiff
Tower Building
70 Park Place
Cardiff CF10 3AT

University

To whom it may concern:

Project Title: The Development of a Psychometric Measure to Assess the Wellbeing of Psychological Practitioners

On behalf of the British Psychological Society's Division of Clinical Psychology (DCP), I am happy to support this project by providing access to participants and requesting their contribution to focus groups/interviews as well as responses to questionnaires. The request can go out via direct email to all DCP members. Members would opt-in according to their own preferences.

The DCP promotes the interests of Clinical Psychology and Clinical Psychologists in the UK. It has approximately 12,000 members including qualified clinical psychologists, trainee clinical psychologists and affiliate members.

Please contact me if you require further information. For further information about the BPS and the DCP, see our website www.bps.org.uk

Yours faithfully

Dr Esther Cohen-Tovée

**BPS Division of Clinical Psychology UK Chair
Clinical Director, Psychological Services
Northumberland, Tyne and Wear NHS Foundation Trust**

Address for Correspondence

Dr Esther Cohen-Tovée
Clinical Director Psychological Services
St Nicholas House
St Nicholas Hospital
Jubilee Road
Newcastle upon Tyne NE3 3XT

Tel: 0191 2456618

Mobile: 07795 476 494

Email: DCPUKChairDrEstherCohen-Tovee@ntw.nhs.uk

Appendix E : Call for participants



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK

www.psych.cf.ac.uk

Prifysgol Caerdydd
Adeilad y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

Invitation to Participate in Research

Title of Project: The development of a psychometric measure to assess the wellbeing of psychological practitioners. Phase I: Identifying the domains that influence wellbeing.

My name is Cathy McLellan, I am a Trainee Clinical Psychologist. I am researching factors that impact on the wellbeing of Psychological Practitioners with a view to develop a psychometric measure to assess the wellbeing of Psychological Practitioners. This project is linked to work being undertaken by the Division of Clinical Psychology. There is a participant information sheet enclosed in the email sent to you by the Division of Clinical Psychology (DCP) or Psychological Professions Network (PPN).

You are invited to be part of this study if you are currently employed as a Psychological Practitioner in the role of: Clinical psychologist, cognitive behavior therapist, counselling psychologist, counsellor, psychoanalyst, psychological therapist, psychological wellbeing practitioner or psychotherapist.

If after reading through the information sheet you decide that you would like to partake in the research, please contact me on: McLellanC@cardiff.ac.uk.

If you have any questions, please contact me as above. If you decide to partake you will be invited to read through the information sheet again and will be able to ask any further questions before the interview.

If you do not wish to partake, you do not need to do anything.

Many thanks for your time,

Cathy McLellan

Appendix F: Participant information sheet



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK

www.psych.cf.ac.uk

Prifysgol Caerdydd
Adelad y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

Participant Information Sheet

The development of a psychometric measure to assess the wellbeing of psychological practitioners.

Phase I: Identifying the domains that influence wellbeing.

Introduction

You have been invited to take part in a research project that aims to explore factors that impact on the wellbeing of Psychological Practitioners, with a view to develop a psychometric measure to assess this. Please take the time to read this information sheet before you decide whether you would like to give consent to take part in the study. The following information outlines why the research is being carried out and what it will involve.

The researchers

My name is Cathy McLellan and I am a Trainee Clinical Psychologist on the South Wales Doctoral Programme in Clinical Psychology. I am carrying out this study as part my training. The research is being supervised by Professor Reginald Morris (Course Director and Clinical Psychologist, South Wales Programme in Clinical Psychology) and Gita Bhutani (Chair of the Psychological Professions Network North West)

What is the purpose of the research?

This study aims to identify specific domains of the different factors that have an impact on the subjective wellbeing of Psychological Practitioners. Previous research has indicated that Psychological Practitioners are reporting reduced levels of wellbeing, however there is not currently a validated scale to measure this. The domains generated by this study will be used to develop a validated psychometric scale to assess the wellbeing of psychological practitioners. It is expected that this measure will support in developing the evidence base surrounding the wellbeing of psychological practitioners.

Why have I been invited to take part in the study?

I am recruiting 20 participants to be interviewed on a one to one basis. Following this I will invite between 6 and 8 of the initial interview participants to complete a focus group. The inclusion criteria includes adults aged over 18 who are working as Psychological Practitioners in the following roles: Clinical psychologist, cognitive behavior therapist, counselling psychologist, counsellor, psychoanalyst, psychological therapist, psychological wellbeing practitioner or psychotherapist.

Do I have to take part?

You are under no obligation to take part in the research. Even if you do agree to take part you may change your mind at any time, without having to give a reason. Participation is entirely voluntary. If you have any doubts about taking part in this research please feel free to take as much time as you need to consider it further.

Consent to take part in the study

Consent to take part in the interview

If you decide that you would like to take part in the research, please email me at **McLellanC@cardiff.ac.uk**. Based on your initial contact, I will assume that you consent to being contacted. I will then contact you on the email or number provided in your response. You can ask me any questions that you may have. If you would still like to take part we can arrange a time to complete a Skype interview or meet at your place of work.

When we first meet I will re-read this information sheet with you and answer any further questions. I will then ask you to read and sign the consent form to show that you agree to take part in the research. If you are completing the interview through Skype, I will send you the consent form in the post with a stamped addressed envelope enclosed to return back to me.

I will then ask you some questions about your profession and age. This is so that I have some basic information about the people who take part in the research.

Consent to complete the focus group

During the initial interview you may consent to being invited to complete a focus group following the interview. If you consent to being contacted, I will contact you using the details provided for the initial interviews. You can ask me any questions that you may have about completing the focus group. If you would like to take part we can arrange a time to complete a Skype interview or meet at Cardiff University (dependant on location of participants and availability). If you choose to participate in the focus group and it is hosted through Skype, I will send you the consent form in the post with a stamped addressed envelope enclosed to return back to me.

What will I be asked in the interview?

The interview will take between 60 to 90 minutes. I will ask you questions based on different domains relating to psychological wellbeing. You do not have to answer any questions that you do not want to. I will audio-record the interview so that the information can be written out after the interview. Following the interview you will have the opportunity to ask any questions or discuss any concerns that you may have about taking part in the research.

After the interview, if you consent to complete the focus group, you will be invited to discuss the broad themes that are highlighted at the interview stage. This will last between 60 and 90 minutes and will be held either over Skype or at Cardiff University (dependant on the location of participants). Following the focus group you will have the opportunity to ask any questions or discuss any concerns that you may have.

What will happen to my information?

After the interviews, spoken word will be typed up so that I can use the information gathered in more detail. I aim to look at themes that may come from the interviews to see whether people share any similar experiences and opinions, or if people have different views on their subjective wellbeing. Similarly, following the focus group, spoken word will be typed in order to determine themes arising from this.

All audio recordings and typed transcripts will remain anonymous; your name or details will not be linked to your interview record. All copies of the interview and audio recordings will be kept in a secure storage facility such as a locked filing cabinet for up to five years.

My supervisors will read anonymised sections of the interview record to support me in the process of writing my report, which is part of my training. Any sections of interview I quote within the report will be also be anonymised. A full anonymised record of your interview will be included at the back of my report.

In the future, I hope to publish my research in an academic journal, and present my findings at relevant conferences. Anonymised quotes will also be used in these journals and presentations.

At the end of the research interview I will ask you if you would like a summary of the findings once I have written up the research. You may also read my full research report when it is completed.

What are the possible disadvantages and risks of taking part?

During the interview and if you choose to complete the focus group, you will be asked about different domains that have an impact on your wellbeing. This may be a difficult and emotional experience for you. If at any point during the interview you feel you need to stop and take a break you will be able to. There will also be an opportunity to talk at the end of the interview about the things we have discussed, and I will be providing you with an information sheet about people you can talk to afterwards if you wish to have further support.

Taking part in the research will not result in payment. No travel expenses will be included as the research will take place in your work base.

What are the potential benefits of taking part?

The information gathered at interviews will highlight specific areas of wellbeing which will be used to develop a psychometric measure to assess the wellbeing of Psychological Practitioners. This will be the first validated measure specifically targeted at measuring the wellbeing of Psychological Practitioners.

The development of this tool will support in enhancing the available evidence base surrounding the wellbeing of Psychological Practitioners. In the future this may lead to specific intervention to support the profession, and may in turn improve care for clients.

What will happen if I don't want to carry on with the study?

If at any point during the study you wish to withdraw please contact me by telephone, email or post. Even if you have completed the interview you can still withdraw your information. I will ask you what you would like me to do with the information you have provided by that point. If you would like me to destroy the information at any stage, this is absolutely fine.

What if there is a problem?

If you have any concerns about any aspect of this research you can contact me or my research supervisor Professor Reg Morris (both contact details are found below).

Will my taking part in this study be kept confidential?

All of the information you provide to this study will be kept confidential. The only time I cannot guarantee confidentiality is if I believe you are at risk of harm to yourself or to someone else. In these instances I will have to break confidentiality. However I will, where possible, talk to you about this first if I did need to break confidentiality.

Who is monitoring this study?

This study has been reviewed by an independent group of people who sit on a Research Ethics Committee. This process is to protect your rights, safety and dignity. This study was reviewed and approved by the South Wales Research Ethics Committee on (05/12/2016) It is also being regularly monitored by my supervisors to ensure quality, standards and above all safety is being maintained.

**THANK YOU FOR TAKING THE TIME TO READ THIS
INFORMATION!**

Contact Details:

Cathy McLellan (Trainee Clinical Psychologist)

McLellanC@cardiff.ac.uk

Telephone number: 07716011674(Mon-Fri 9am-5pm)

Professor Reginald Morris (Clinical Psychologist)

Course Director and Project Supervisor, South Wales Doctoral Programme in
Clinical Psychology

reg.morris@wales.nhs.uk

Telephone number: 02920870582

This study has been reviewed by Cardiff University School of Psychology
Research Ethics Committee (reference EC.16.11.08.4753R)

If you have any concerns or complaints, please contact:

Email address: psychethics@cardiff.ac.uk

Address: School of Psychology Research Ethics Committee, Cardiff
University, Tower Building, 70 Park Place, Cardiff, CF10 3AT

**The data controller is Cardiff University and the Data Protection Officer is
Matt Cooper CooperM1@cardiff.ac.uk . The lawful basis for the processing
of the data you provide is consent.**

Appendix G: Participant consent form



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK

www.psych.cf.ac.uk

Prifysgol Caerdydd
Adelid y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

CONSENT FORM

PARTICIPANT

Title of Project:

The development of a psychometric measure to assess the wellbeing of psychological practitioners. Phase I: identifying the domains that influence wellbeing.

Name of Researcher: **Cathy McLellan**

Please initial all boxes you agree with:

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that participation will involve my interview being audio-

recorded, with possible use of anonymised word for word quotation in the research report.

4. I understand that my information will be stored securely in a filing cabinet for up to five years, and the information I provide will be anonymised for use in the study.

5. I agree to take part in the above study.

6. I agree to the researcher contacting me following the interview to invite me to participate in a focus group.

Name of Participant (PLEASE PRINT)	Date	Signature

Name of Person Taking Consent (PLEASE PRINT)	Date	Signature

Please sign and return this consent form in the addressed envelope provided

Appendix H: Demographic questionnaire

DEMOGRAPHIC QUESTIONNAIRE

We would like to know a little bit about you so that we can compare the experiences of different types of staff. Please complete the following questionnaire.

1) Gender

- Male
- Female
- Transgender
- Prefer not to say

2) Please state your ethnic background:

- Asian or Asian British (Bangladeshi / Indian / Pakistani / Any other Asian Background)
- Black or Black British (African / Caribbean / Any other Black background)
- Mixed (White & Asian / White & Black African / White & Black Caribbean / Any other mixed background)
- White (British / Irish / Any other White background)
- Other Ethnic Group (Chinese / Any other ethnic group)
- I do not wish to disclose this

3) What is your religion?

- Atheism
- Buddhism

- Christianity
- Hinduism
- Islam
- Jainism
- Judaism
- Sikhism
- I do not wish to disclose this

4) How old are you?

- 18-24
- 25-34
- 35- 44
- 45-54
- 55-64
- 65-74
- 75 or over

**5) Do you currently have any long standing health conditions or disability?
(lasting at least 12 months)**

- Yes
- No

If you feel able to say what it is please comeplete here:.....

.....

6) If you answer to question 5 was 'YES', has your employer made adequate adjustments to enable you to carry out your work?

- Yes
- No
- No adjustment required
- N/A

7) Please state your current job title:

.....

8) In which speciality do you mainly work?

- Adult
- Children and young people
- Older people
- Physical health
- Forensic
- Learning disabilities
- Neuropsychology
- Academia
- Other (please specify)

9) How long have you been in your current post for?

- < 5 years
- 5-10 years
- 11-20 years
- Over 20 years

10) How many hours are you contracted to work per week?

- Full time hours (37.5)
- Part time (please specify contracted hours)

11) On average, how many additional hours do you work a week over and above your contracted hours?

- 0 hours
- Up to 5 hours
- 6- 11 hours
- 11+ hours

12) What AfC banding best describes your wages?

- 4
- 5
- 6
- 7
- 8a
- 8b
- 9

13) Who do you work for?

- NHS
- Third Sector
- Social Enterprise
- Private Provider

- Private Practice
- University
- Mixed (please say which with hours in each):

.....

Other

14) What is your main work area (tick all that apply) ?

- Prevention/ Public health
- IAPT/Primary Care
- Secondary Care
- 3rd Sector/Social Enterprise
- Specialist/Tertiary Care
- Private Practice

Other

15) Which of the following duties apply to your current role (tick all that apply and estimate percentage of time in each):

- Clinical (____%)
- Organisational consultancy (____%)
- Managerial (____%)
- Medical/Legal (____%)
- Training (____%)
- Service Development (____%)
- Policy development (____%)

Academic/ Research (____%)

Other(____%)

Thankyou for completing this questionnaire. Please send the questionnaire back in the prepaid envelope provided.

Appendix I: Debrief sheet



NHS
WALES
GIG
CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK

www.psych.cf.ac.uk

Prifysgol Caerdydd
Adeilad y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

The development of a psychometric measure to assess the wellbeing of psychological practitioners.

Phase I: Identifying the domains that influence wellbeing.

Debriefing Information Sheet

Thank you very much for taking part in this study. The study aimed to explore the wellbeing of people who work as Psychological Practitioners. I was interested in identifying specific domains that may influence wellbeing, with the intention of using this information to develop a psychometric measure of psychological practitioner's wellbeing.

Studies have recognised that Psychological Practitioners report reduced feelings of wellbeing and increased distress compared to other occupational groups. There have been particular calls for more research in the area of the wellbeing of psychological practitioners. This study aimed to contribute to the development of a validated measure of the wellbeing of psychological practitioners.

Further Support

Talking about your experiences of wellbeing may have been a difficult conversation for you. This is understandable and you may feel vulnerable after taking part in this interview. If you do feel upset here are some suggested sources of support you may want to consider calling upon:

- Your friends and family may be able to provide you with immediate support.

- Your GP is also a potential source of support if you feel upset about what has been discussed for a longer than you feel comfortable with.

If you have any further questions in relation to this study please contact me on the details below.

Contact details:

Name: Cathy McLellan

Email: McLellanC@cardiff.ac.uk

Telephone number: 07716011674 (Mon-Fri 9am-5pm)

Address: Doctorate in Clinical Psychology, 11th Floor, Tower Building, School of Psychology, 70 Park Place, Cardiff, CF10 3AT

Contact details:

Name: Professor Reginald Morris

Email address: reg.morris@wales.nhs.uk

Telephone number: 02920870582

Address: Doctorate in Clinical Psychology, 11th Floor, Tower Building, School of Psychology, 70 Park Place, Cardiff, CF10 3AT.

This study has been reviewed by Cardiff University School of Psychology Research Ethics Committee (reference: EC.16.11.08.4753R)

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk . The lawful basis for the processing of the data you provide is consent.

If you have any concerns or complaints, please contact:

Email address: psychethics@cardiff.ac.uk

Address: School of Psychology Research Ethics Committee, Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT

Thank you again for taking the time to participate in this study.

Appendix J: Illustrative interview schedule

Illustrative Interview Schedule

Interview

The following illustrative interview schedule has been developed as a guide for the interview process of phase 1. The questions are to be based around themes pertinent to wellbeing as identified in the 'Staff Wellbeing Questionnaire' developed by the BPS & the New Savoy Conference. Specific open-ended questions will be developed prior to completing the interviews and domain themes on which questions will be based have been highlighted in this schedule.

Participants will be provided with an information sheet prior to meeting to complete the interview (See participant information sheet phase 1)

Initial introductions

Information about the study:

This study aims to identify specific domains of the different factors that have an impact on the subjective wellbeing of Psychological Practitioners.

The domains generated by this study will be used to develop a validated psychometric scale to assess the wellbeing of psychological practitioners. It is expected that this measure will support in developing the evidence base surrounding the wellbeing of psychological practitioners.

The interview will take between 60 to 90 minutes. I will ask you questions based on different domains relating to psychological wellbeing. You do not have to answer any questions that you do not want to and you are free to withdraw from the interview at any point. I will audio-record the interview so that the information can be written out after the interview. Following the interview you will have the opportunity to ask any questions or discuss any concerns that you may have about taking part in the research.

After the interview I may contact you again to invite you to invite you to complete a focus group to generate feedback on the themes I find in the interviews.

Additional Information to be provided before starting interview:

*Are you happy to take part in the interview today?
Fill in and sign consent form (See consent form: Phase 1)
Do you have any questions before we start?*

Background

*-Briefly outline your job title and role?
- How long have you been in your current role?*

- Do you consider yourself to have any long-term difficulties that may impact on your psychological wellbeing?

Broad question domains:

1.Experiences of psychological wellbeing

- What does psychological wellbeing mean to you?
- Description of psychological wellbeing to be provided

2.Personal Wellbeing

Could you tell me a little bit about your experiences of personal wellbeing? This may be related to experiences both in and outside of the workplace.

Sample probing questions:

Could you tell me a little bit about your experiences of emotional wellbeing?

What do you consider to be positive functioning?

What do you find helpful to your self-esteem?

In what ways do you consider yourself to be resilient?

3.Social Wellbeing

Could you tell me a little bit about your experiences of social wellbeing? This may be related to experiences both in and outside of the workplace.

Sample probing questions

What do you consider to be supportive relationships?

Who do you feel provides you with supportive relationships?

What do you feel that you get out of your relationships with others?

4.Wellbeing at work

How do you feel you experience wellbeing in the workplace?

What factors do you feel have an influence over your wellbeing in the workplace?

Sample probing questions:

How would you describe the level of satisfaction you experience from your work?

What kinds of emotional experiences do you have at work?

How would you describe your working conditions?

What is your experience of organisational pressures or demands?

What would you consider to be the most important factors contributing to your wellbeing at work?

5.Synthesis of personal wellbeing, social wellbeing and wellbeing at work

-Do you feel that personal wellbeing, social wellbeing and wellbeing at work relate to one another?

Endings

- Thank you very much for participating in this research.*
- *Do you have any questions or would you like to add anything else to your responses?*
- Check contact details*
- Provide debrief sheet (See debrief sheet: Phase 1)*

Appendix K: The process of thematic analysis (Braun and Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Step one: Familiarising yourself with the data

Data was transcribed, read and re-read. Notes on key messages were written next to extracts to help with familiarisation.

there in different offices and things like that so having a base somewhere where you can kind of check in with the team and have people go around I think is really important for me as well so I know I can always give them a phone call or I can just check in and my manager regularly will just phone me just to check in if they hadn't seen me for a few weeks just to see how things are going and it's a really nice supportive atmosphere. Yeah.

I: Sounds nice!

R: Yeah, come and work for us!

E: Okay so are there any key factors that you think enhance wellbeing in the workplace? I know you might have just answered that question I guess.

R: Yeah, um, yeah I think it's having a supportive team is really big so having those connections and even if it's just people to talk to. I think humour can be really big within the team as well and I'm just thinking about, I mean this doesn't quite fit in with this but a lot of the residential care teams that I work with, the ones that work best are often the ones where there is some humour and they've got shared jokes, they go through things together but then they are really supportive of each other and they know each other quite well and I think that really works when you've got that within your team, I think you've got that support behind you so you can almost go off and do things. I think...sorry was it wellbeing within the team did you say or in the workplace?

I: In the workplace, yeah.

R: ...um, yeah, knowing that you can make a mistake or you can be struggling with something or find something hard and being able to have someone you can talk to about that without the fear of being judged or criticised or feeling that you have no one to raise that with. I think being able to have a say over your workload to a certain extent and being able to say no and have that listened to, I think is quite important so you can manage that yourself really and have a say in what you are doing or when it's getting too much, you can say no. Yeah like I was saying before, having that support and supervision in place that you know someone is at the end of the phone or you know that you've got those supervision slots where you can go and meet with a supervisor and kind of talk through what is happening in work, even if it's not that regular just knowing that it's there is really important. Opportunities for development I think being a big one and I think therefore not feeling stuck in a role so there might be things that you want to work on so, for example, I've just done my DDP training and I'm working towards accreditation so that's something that keeps me going and I quite enjoy and it's learning more all the time so even if, some people might just have time to be able to do a lit review, Google some stuff, read a book that's important to your practice, attend a group with other people that are doing something similar so I go to a CFT Group near me so something where you meet other practitioners who are doing a similar thing or you've got kind of the access to further development which, again, is going to enhance your role and what you want to be doing so you're working towards something. Yeah.

Handwritten notes and annotations:

- base
- support
- check in
- Supportive team
- Connection
- humour
- Shared experience
- permission
- support-judgemental
- Choice
- Control
- regularity
- Balance
- opportunities to learn
- learning
- working towards something
- breathing enhances your role.

Step two: Generating Initial Codes: sample extract from coding table.

Data extracted from transcript was organised in to sentence by sentence coding. Focussed codes were then derived to create possible themes.

Verbatim: Interview transcript extract	Initial coding- Sentence by sentence.	Focussed coding
<p>I: I think that relates to something else you mentioned which was the demands of the job? Could you tell me a bit about that?</p> <p>R: Yeah. Like I said, it just feels like it's... it is demanding, [inaudible 00:20:52] in the service, I'm meaning by that, that the service I feel is just demanding of you personally and that that can yeah, just be really exhausting. how that affects me or...?</p> <p>I: Yeah.</p> <p>R: Yeah, I think it just... it feels like... I think how it has affected me is that I've realised I had to kind of just look after myself and that I couldn't meet the demand, so I had to just kind of draw a boundary for myself and for me, that was going part time so that I didn't have... a better work-life balance. So, yeah, I think I learned that it's just never going to end so I've kind of had to develop ways to make that be okay for me without it having an effect on me 'cause I think that that's just the way that the system is, that it is just really</p>	<p>Services are demanding. Demands effect you personally. It is exhausting.</p> <p>It has affected me. Have to look after myself. Developed boundaries to have work-life balance. You can't meet all demands. The system is just that way. If you engage it leads to burnout. Have to find your own way to cope through boundaries.</p>	<p>Emotional impact of demands</p> <p>Balance Acceptance Boundaries</p>

<p>demanding, and I think I realised that if I was to be part of that, it would just burn me out. It does just seem to burn people out, so yeah, I have to find my own way to cope with that, just to create clearer boundaries for myself with my work.</p> <p>I: Okay, thank you. And when you say demands of the service, is there anything in that about targets?</p> <p>R: Yeah.</p> <p>I: Okay.</p> <p>R: Yeah, so we've got... we're just constantly reminded of targets, you know, and it's... you know, weekly updates and you know, just constantly being asked to do more and do more even though we were told that we're actually working beyond the capacity of the service but then we're still getting asked to do more, so that... you know, that just... to me, it sounds like... a demand that can't really be met, that can't... that will never be satisfied. So that's [inaudible 00:23:11] you know, what it feels like. It's the kind of service, the] targets to meet and yeah, we've been told that that we're... you know, the financial kind of demands all the time, that... but also, we can't kind of do any more than what we're doing so yeah, it just feels like you're getting squeezed and squeezed and squeezed and told everything else to do, and yeah... yeah, I don't buy into that, I don't really think you can kind of survive with buying into that kind of model of just asking more and more and more but not really being able to do that. Yeah, so it's just... it feels impossible, I guess, being in that.</p>	<p>Targets always there constantly. Told to do more. Already doing too much but asked to do more. The demands can't be met. You can never satisfy the demands. Can't do any more. I choose to separate myself. It becomes impossible to remain working in that way.</p>	<p>Targets Unrealistic demands Pressure Hopelessness</p>
--	---	--

--	--	--

Step three: Corresponding codes were then collated together to form possible themes.



Step four: Extract of thematic data extraction table.

The entire dataset was organised in to the themes derived from earlier coding stages and reviewed for consistency. This led to the development of the thematic map (step 5).

Personal Support	‘Traumatised Systems’ The NHS context	Positive and Negative job aspects	Inter-professional agents	Drive to improve staff wellbeing
<p><i>‘I’m very lucky to have someone who is compassionate, understanding you know, He’s really psychologically minded, and he just gets it. If I didn’t have that, god, I don’t know- I’d struggle massively.’</i></p> <p><i>Um, there are people I can trust, who actually I can talk to without being judged, who will support me. Sometimes they might have information that’s useful, so I have a lot of friends who work in different specialist areas, which is really useful. I sometimes think I don’t want social, I just want someone to listen and empathise</i></p> <p><i>‘It’s about connecting and it’s about understanding each other and that person listening to you and giving them attention and their time, that makes you feel important and like your problems are worth listening to somehow’</i></p> <p><i>I suppose the big thing is a sense</i></p>	<p><i>I think that that’s just the way that the system is, that it is just really demanding, and I think I realised that if I was to be part of that, it would just burn me out. It does just seem to burn people out, so yeah, I have to find my own way to cope with that, just to create clearer boundaries for myself with my work.</i></p> <p><i>For the LD team, the outcome measures don’t actually.. they’re not relevant to what we are doing, so we don’t see any progress really in the measures that we’ve been told we have to do by NHS England, so that’s scary... that’s a huge impact on stress I’d say.</i></p> <p><i>It’s always lurking in the background, it doesn’t really feel like it goes away, but the culture they’re trying to preserve is one of psychology and patients first and I think that is really nice, that is good to work in.</i></p>	<p><i>Control and autonomy</i></p> <p><i>I think that it feels good to have a sense of autonomy and choice and that feels taken away if you’ve got a very strict target about who you need to see how and when you need to see them</i></p> <p><i>It helps when you can lay your caseload out as you want it, you wouldn’t put two trauma cases beside each other, you’d give yourself a little bit of a space. But because everything is booked in on our system for you by admin, you have no control over that, so it’s just done for you, so you might have three interpreters in one day. So um, a lot of decision makers take that out of your hands as well, so the control is taken away from you, and it has a big impact on emotions, I think. On morale, on energy, and just all kind of feelings of, I can’t give any more, you know. Emotional exhaustion. And that’s</i></p>	<p><i>Yeah, I think it impacts my wellbeing. I think my experience of supervision are generally not particularly positive. As a qualified psychologist, it seems like it’s more of a... something that we have to do rather than something that’s kind of used in a positive and productive way. I’ve always been supervised by my manager which is I think quite problematic. So it’s often seen as not really a space for me to... or it’s just [inaudible 00:12:30] space to be able to explore what’s going on and to develop my kind of abilities or my practice. Yeah, so it’s not particularly use... I’ve not really found it particularly useful aspect of my work but I would like it to be. I think it should be, and I think it could be, but it’s something that I’ve experienced.</i></p> <p><i>But I do feel that your clinical supervisor should be someone you can trust and you can say, look, I’m</i></p>	<p><i>I do think things like exactly the thing you’re doing...having some kind of measure of staff wellbeing and for that to be used within teams and then addressed so if I or one of my colleagues wasn’t managing very well or something in particular wasn’t going well for that to be addressed in supervision or something like that. I think we do that informally already, I think generally we do that but I think it can be useful to actually have that measure and to be able to compare things over time</i></p> <p><i>I think just having a different mindset, you know like really encouraging self-care and encouraging sort of wellbeing and making that something that’s actually talked about...</i></p> <p><i>What would need to happen for change to be made is that it would need to be proven that there would be a financial benefit in it for services, which I think there would</i></p>

<p><i>of connection, a sense of belonging, I think it depends on the relationship so, for example, my relationship with my partner is obviously massively important to me as someone who I think we have a strong connection bond and we rely on each other for lots of things and for kind of emotional support</i></p> <p><i>When you have got people in the team that are feeling equally overloaded, stressed, overwhelmed, I think it has, it can have a huge impact. It has done on me</i></p> <p><i>P9: we have a reasonably good sense of team identity and always being marginalised so knowing that I think they're actually quite supportive to each other and chat about how's your life, how was your weekend, what you doing the weekend so all that sort of stuff... I think that's just knowing each other, support each other, being interested in each other helps all of our psychological wellbeing.</i></p> <p><i>I think if there is a culture of understanding within different groups, and that there's a culture of supporting one another when things get stressful, so that you feel less alone, if time is made to share lunch together in a communal area, I think they can all be</i></p>	<p><i>I think there's such an emphasis on contacts and meeting targets that the staff emotional wellbeing is just really, time isn't allocated for that.</i></p> <p><i>Balancing workplace demands because I think in a time of austerity in the NHS, more and more is being asked of people, with fewer and fewer supports, and although there's room for improvement, I think there's only so much you can ask of people. So I think, demands being realistic.</i></p> <p><i>Because it's all targets and there's no space for reflection, and I think other than targets, I think that can translate into very stressed clinicians and therefore less than ideal on service delivery. So it impacts on everyone really.</i></p> <p><i>Just constantly being asked to do more and do more even though we were told that we're actually working beyond the capacity of the service but then we're still getting asked to do more, so that... you know, that just... to me, it sounds like... a demand that can't really be met, It just feels like you're getting squeezed and squeezed and squeezed.... I don't think you can kind of survive buying into that kind of model of just asking more and more and more but not really being able to</i></p>	<p><i>where the burn-out comes from. That lack of control over your environment,</i></p> <p><i>I think being able to have a say over your workload to a certain extent and being able to say no and have that listened to, I think is quite important so you can manage that yourself really and have a say in what you are doing or when it's getting too much, you can say no</i></p> <p><i>P4: Being able to have some control of where your career is going or even how your time in work is spent and having some say in your role.. you feel that at east you are doing something that is of interest to you and that you find stimulating.</i></p> <p><i>I manage my own diary ad I manage my own time. And so today, I went in a bit late and I left a bit late and that's all ok and that fits quite well for me. I'd find it quite hard if I was kind of stuck to a certain time limit each day, so that's.. I guess fitting work around your life is important, having the flexibility to do that.</i></p> <p><i>I do have that ability to, to manage my diary in a way that suits me, not only the demands of the job, but optimises my efficacy, because I know if I'm doing too much of one</i></p>	<p><i>really struggling with this individual, or the way that was handled made me feel really bad, and they can help you think about what can you do differently, and also, what can they escalate for kind of a top down approach, but if that person is your performance manager, then that becomes exceptionally difficult, whereas they might press you then on performance issues which takes away from your time to discuss more emotional and social issues</i></p> <p><i>I've had supervisors that have been, you know, commissioners in the past, I've had ex-nurses, um, and they've been quite hard-lined, um, it's been more case management, any risk [inaudible 6[00:25:23]] great, you know, that's it. Um, and that was awful for me, um, because I felt like their aims, um, in terms of giving [inaudible [00:25:37]] was really to make sure that numbers - well, it was about numbers being met and targets being met. Um, so I didn't feel a supportive space. I kept feeling like um my questions weren't being answered and that ii'm not really learning much.</i></p> <p><i>The types of environments that I work in particularly as well have quite traumatised systems quite a</i></p>	<p><i>be. You know, I think we would probably look at reduced sickness and increased productivity. I really hope that they look into this.</i></p> <p><i>Because I think the physical and social environment are so important to the personal and professional well-being, I think, um, paying more attention to, to the physical, the physical environment would make a huge difference to well-being.</i></p> <p><i>I think, yeah opportunities for kind of more support networks where people can talk and get together, I know often one of the challenges with that is time as well and someone to organise that kind of thing.</i></p> <p><i>So I think there'd have to be a lot more education of people who commission services about the limitations of what we do, and the impact of, of this kind of work on clinicians.</i></p> <p><i>If there was more of a positive psychology approach rather than, wait till you're sick, then go off and seek support, if there were staff support groups, if there were mindfulness groups that went on regularly, if there was some drop-in sessions that staff could access if they're feeling stressed, then I think that would reduce burn-out,</i></p>
---	---	---	---	---

<p>positive events.</p> <p><i>'I think feeling understood and feeling a part of things, that also feels really important and I guess in terms of social identity as well, having just some really kind of fixed friendship groups that I am in including at work just really helps that sense of who I am and what I want and what we have in common, that kind of almost in-group feeling but without there being an out-group'</i></p> <p><i>I think if the team isn't feeling cohesive and supportive, that is most likely to have an effect on me. I think I could cope with even being horribly busy, with the world's worse patients in a horrible environment if I had the support of the people around me but if not, even if the work itself was nice but the people weren't great, I would find that really really difficult, I think that would have a big impact on both my kind of mental health but my physical health as well so I think that is the biggest one.</i></p> <p><i>Your peers make a difference. If they are managing, or if they come and check I with you, just like, you know, make a cup of tea, something like that, makes a difference. It makes you feel like people understand what you are</i></p>	<p><i>do that. Yeah, so it's just... it feels impossible, I guess being in that.'</i></p> <p><i>Sometimes it can be absolutely overwhelming and you can go home feeling absolutely burnt out, mentally exhausted if you try and get it all done and it can lead to people thinking 'this just isn't fitting with my values' and feel 'what am I doing as a clinician?' and I feel that it can also lead to people wanting to cut off and just it becoming so, so much that they put their heads down and say 'I can't do anymore'</i></p> <p><i>I think people can know that they're trying very hard and still not achieving goals, even though they know they're kind of unobtainable goals. The fact that you're constantly reminded, every week, that you're not achieving goals can be very demoralising. You feel very criticised. And that can just take a toll on people's self-confidence and on their, um, on their, their morale really. People just feel very low</i></p> <p><i>I think when you're dealing with a client, it can feel very frustrating when you feel you need a bit more to offer, and you're not allowed to do that, and clients will often express their frustration and hold you kind of personally responsible. So if you, it can kind of feel like a</i></p>	<p><i>thing - whether it's too much admin or too much client work, then, um, the quality of my work will naturally decline</i></p> <p>Valued</p> <p><i>A place that's interesting in you as an individual and in my development and not just interested in me professionally but interested in me personally as well and knowing that I'm okay and doesn't have ridiculous expectations at the amount of work that I will do</i></p> <p><i>A sense of recognition, things like office parties or Christmas parties or things. Some sense that we do something as valuable as other sectors but we don't get any perks for it. It would be nice to have some sense of validation I reckon</i></p> <p><i>Feeling respected and listened to and that what I do makes a difference in the workplace. Having my work recognised by people and by management I guess, and having positive feedback from colleagues</i></p> <p><i>Not being recognised, either the work that you're doing not being recognised or the stresses that you are under not recognised.</i></p>	<p><i>lot of the time so often my managers are also quite highly stressed so sometimes I've gone for supervision and it's felt more like me supervising them</i></p> <p><i>Something about having boundaries and shared group supervision I guess, with people who have a similar background to you and similar levels of training, that's the key bit I think.</i></p> <p><i>I think I struggled at times where there might be people from different backgrounds; mental health practitioners who might have a nursing background or they might not have done much additional [inaudible 00:14:30] training and so when I am stuck and feeling like struggling with a case and somebody's not recovering, or not ready to you know struggling. A young person with an eating disorder, I feel like...I feel like somehow I...somehow, I do feel like I get some support from my colleagues because they are lovely people but the again I know that if it's colleagues that have got a similar training to me and background, somehow...it, it sounds awful but it means more, something more helpful about their supervision and their ideas they might be suggesting</i></p>	<p><i>increase productivity and make the workplace a more enjoyable workplace.</i></p> <p><i>I think what you're doing is great. I think it should, if it could be measured and included in reporting that would be really useful rather than the only statistic being leaving and I'm not even sure if that's collected actually but it would be interesting to see because they're always going on about they need to train more therapists and why is that. I think it would be nice, it would feel very validating to have staff wellbeing put on the agenda properly and measured and be something that organisations have to account for</i></p>
---	--	---	---	--

<i>experiencing. And you also see them experiencing something similar, so you're not on your own with that.</i>	<i>tug-of-war between service needs and client needs, that you're trying to weasel an extra moment or two for a client</i>	<i>Everybody is in a stressful environment but you know, if that's kind of minimized or normalised, I think that can be really harmful.</i>		
---	--	---	--	--