School of Psychology
Ysgol Seicoleg

A Systematic Review of the Resiliency and Coping Factors that are Associated with Job Satisfaction and Professional Quality of Life in Mental Health Staff, and a Grounded Theory Study Exploring the Emotional Experiences of Staff Working within Adult Inpatient Mental Health Rehabilitation Services

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Thesis Preface

The current research focused on staff wellbeing and perceptions of their role within mental health services. Firstly, the systematic review aimed to examine existing research investigating the association between mental health staff's coping skills and/or resilience, and their reports of job satisfaction and/or professional quality of life. Both job satisfaction and professional quality of life (PQOL) capture employees' perceptions of their job and the positive and negative emotions they may hold about their work. This may include experiences of secondary traumatic stress, compassion fatigue, compassion satisfaction and burnout. Poor job satisfaction and PQOL have been linked to poor emotional wellbeing in staff, as well as service-related factors such as increased absenteeism and staff turnover. Staff may employ a range of coping strategies which can be described as helpful (adaptive) or unhelpful (maladaptive) to try and manage the challenges of their role and draw on personal resiliency factors. This review is the first to examine the relationship between these factors.

A systematic review of the literature was conducted, searching seven databases. Ten relevant papers were sourced and synthesised. Limited evidence was found for the relationship between resilience and job satisfaction. Resilience demonstrated a negative association with burnout but was not related to secondary traumatic stress or compassion fatigue. A positive association was reported between resilience and compassion satisfaction. There was limited evidence of a significant association between coping and job satisfaction. When considering PQOL, no significant association was found between most adaptive coping strategies and burnout and secondary traumatic stress. However, a positive association was found with experiences of compassion satisfaction. Maladaptive coping strategies were found to be positively associated with experiences of burnout, secondary traumatic stress, compassion fatigue, and a negatively associated with compassion satisfaction.

These findings should be held tentatively. Overall, there was limited research in this area and the research papers were of mixed quality. Several studies had substantial methodological flaws that should be addressed in future research, i.e. using valid and robust psychometrics and gaining

consistency in the measures used throughout this field. As such, it is difficult to draw firm conclusions about the relationship between the key variables.

Paper two describes a novel, qualitative research project, exploring the emotional experiences of staff working within adult inpatient mental health rehabilitation services (AIMHRS). Maintaining staff wellbeing poses a challenge across healthcare settings. Increases in service pressures and a reduction in resources have only intensified pressure on staff. Wellbeing is a particular challenge within mental health services, with research demonstrating high rates of stress and burnout. These experiences can impact on staff's health, their therapeutic relationships with service users and lead to staffing shortages. Despite research into other mental health specialities, there has been a lack of research within AIMHRS. The current research aimed to develop an understanding of staff's emotional experiences in this setting.

Nine members of staff, working across three health boards in south Wales agreed to participate. The author conducted semi-structured interviews and grounded theory was used to analysis transcripts. A theory was developed that described how staff's roles impact on them emotionally, how they negotiate challenges that arise and what supports them to keep going despite the challenges. Six primary categories emerged from the data: 1) enabling relational safety; 2) holding an explanatory framework; 3) reinvigorating staff; 4) systemic challenges; 5) challenges to relational safety and connection and 6) consequences of the 'perfect storm'. A dilemma was noted in how staff remain connected and authentic in a system that poses physical, emotion and systemic threats.

This research adds to the evidence base, expanding our understanding of staff psychological wellbeing and distress to an AIMHRS context. Clinical implications of the research, such as the importance of holding a clear model of care and relevant support structures for staff, are discussed. Future research may consider using this knowledge to tailor interventions for staff and address the specific challenges faced within this setting.

Paper 1. Understanding the resiliency and coping factors that are associated with job satisfaction and professional quality of life in mental health staff: A systematic review of the evidence

Lauren Stead

Word count of abstract: 204

Word count of the main body excluding abstract, table, figures and references: 7978

This manuscript was prepared in accordance with author guidelines for the International Journal of Psychiatry in Clinical Practice (appendix A). APA 7th edition reference style was used in line with The DClinPsy guidance. The DClinPsy word limited of 8,000 words for the main text and 250 words for the abstract was also used to ensure detailed information regarding the research process could be demonstrated. For ease of interpretation, a summary table of all abbreviations used within the paper can be found in appendix B. Tables and figures are imbedded within the text for the purposes of submission. These will be moved to the end of the document prior to submission for publication. A key points section was omitted to avoid repetition and will be added prior to submission for publication.

Abstract

Objective

Poor job satisfaction and professional quality of life (PQOL) have been associated with poor staff wellbeing, staff attrition, absence and poor service quality. An individual's coping skills and resilience have been found to buffer against experiences of stress. The current review aimed to systematically examine the evidence exploring the relationship between coping and/or resilience and job satisfaction and/or PQOL within mental health professionals.

Method

Seven databases were searched, and ten studies were included in the final review.

Results

Findings suggest that there is limited evidence supporting a relationship between resilience and job satisfaction, and no association with Secondary Traumatic Stress (STS) or Compassion Fatigue. Associations were found between resilience, and burnout and Compassion Satisfaction. Use of adaptive coping skills enhanced predictions of compassion satisfaction but not burnout. Higher rates of maladaptive coping strategies enhanced predictions of burnout, STS and were negatively associated with compassion satisfaction. There was preliminary evidence of an association between resilience, burnout and compassion satisfaction.

Conclusions

There is currently a lack of research examining the relationship between coping and/or resilience, and job satisfaction and/or PQOL for mental health staff. Future research would benefit from enhancing the quality of measures used and improving methodological rigor, to enhance the reliability of findings.

Key words

Job satisfaction, professional quality of life, coping, resilience, mental health, systematic review

Introduction

The wellbeing of healthcare workers has been described as 'an urgent global public health priority' (Søvold et al, 2021, pg. 1), with reduced resources, high stress and high service demands featuring as challenges across services (Søvold et al., 2021; The Kings Fund, 2022). These factors have intensified in the context of COVID-19, placing staff under considerable strain (Batra et al., 2020; Royal College of Nursing, 2021). Mental health staff face particular stressors within their roles such as exposure to violence (Jacobowitz, 2013), exposure to suicide risk (Lyra et al., 2021) and increased emotional labour (Mann & Cowburn, 2005), increasing their risk of negative physical and psychological consequences. This is reflected in the high rates of burnout, estimated between 21-67% (Morse et al., 2012) and Post Traumatic Stress Disorder (Jacobowitz, 2013) within this cohort. Conversely, research suggests that working within mental health services also provides opportunities for rewarding interactions with service users and team working (Reid et al., 1999). A complex interplay of all these experiences can influence how staff appraise their role and the extent that they feel professionally satisfied.

Job Satisfaction and Professional Quality of Life (PQOL)

Job satisfaction and PQOL are two concepts within the literature that attempt to capture staff's appraisal of their roles. Job satisfaction has been described as 'a pleasurable or positive emotional state resulting from the appraisal of one's job or job experience' (Locke, 1976, p. 1300) and is associated with an individual's sense of responsibility and commitment to their role. Job satisfaction is a 'multidimensional concept', incorporating a range of individual factors such as beliefs, values, attitudes and abilities (Ravari et al., 2012, p. 100). Evans et al (2006) found that 54% of mental health social workers in their sample (sourced from 145 councils) reported ambivalence or dissatisfaction with their work and 78% with their employer. Importantly, poor job satisfaction has been associated with a range of challenges within healthcare. Staff who are dissatisfied with their job roles (reflected

by high-demand and low decision-making autonomy) have been found to score significantly higher on the General Health Questionnaire-12 and emotional exhaustion, as measured using The Maslach Burnout Inventory (Evans et al., 2006; Maslach et al., 1986). A meta-analysis of 485 studies, has also demonstrated a significant, negative relationship between job satisfaction and increased anxiety, depression and burnout within the working population (Faragher et al., 2013). At a service level, low job satisfaction is associated with poor patient safety and care, including an increase in medication errors by nurses working in acute care hospitals (Rathert & May, 2007). A National Health Service (NHS) England report aimed to understand the relationship between patient satisfaction and staff's experience of their jobs (Dawson, 2018). Results found that greater work pressure, poor satisfaction with resources and poor satisfaction with the quality of patient care were associated with patients' dissatisfaction with their own care (Dawson, 2018).

Conversely, feeling valued by one's employer has been associated with greater job satisfaction (Evans et al., 2006), which is related to greater wellbeing. Team processes such as increased staff support, absence of conflict within the team, improved team collaboration and greater involvement in decision-making have been found to explain the highest variance in job satisfaction within mental health staff (Fleury et al., 2017). Research has also considered the intersect between individual and systemic factors within job satisfaction. Risman et al (2016) carried out research with registered nurses recruited from a midwestern hospital (N=753) and found that members of staff who felt their values were congruent with their organisation reported significantly greater job satisfaction.

As well as the influence of job characteristics such as autonomy, skill variety and opportunities for feedback (as detailed in the Job Characteristics model (Hackman & Oldham, 1975)), individual factors have also been associated with job satisfaction. The dispositional approach model of job satisfaction (Judge et al., 1998) suggests that individual factors, namely personality, contributed towards a person's reports of job satisfaction. Research has linked factors such as self-efficacy, emotional stability and locus of control to job satisfaction scores (Judge & Bono, 2001). Welbourne

et al (2007) assessed coping strategies employed by nurses working within a Veterans Affairs Medical Centre, and found that nurses' individual attribution style (i.e. the extent to which an individual viewed situations as external, temporary and specific, or internal, stable and global) mediated the relationship between coping strategies employed and reports of job satisfaction.

PQOL and job satisfaction are overlapping concepts, both considering staff's perceptions and experience of their working lives. Several studies have considered the relationship between PQOL and job satisfaction and have consistently found a significant association between these factors (Faragher et al., 2013; Keshavarz et al., 2019; Rostami et al., 2021). The extent of this overlap is also evidenced by the inclusion of job satisfaction as a subscale within the Work Related Quality Of Life scale (Easton & Van Laar, 2018). As a result, research in this area frequently uses measures of both concepts.

PQOL describes the 'positive and negative emotions that an individual feels about [their] job as a helper' (Kim et al., 2015). Measures of PQOL include subscales such as burnout, compassion satisfaction secondary traumatic stress (STS), compassion fatigue (Stamm, 2010), job control, stress and home-work interface (Easton & Van Laar, 2018). Subscales of PQOL have been evaluated within healthcare professionals, who report variable experiences of compassion fatigue (Marshman et al., 2021) and moderate to high emotional exhaustion (O'Connor et al., 2018). During the COVID-19 pandemic, McFadden et al (2021) found 57.46% (N= 1,460/3425) of health and social care participants from the United Kingdom (UK) reported low or average work-related quality of life scores.

At a systems level, poor job satisfaction and PQOL have been associated with increased rates of staff turnover and absenteeism (Austin et al., 2017; Kozak et al., 2013), posing significant challenges for the sustainability of services. However, it is acknowledged that staff working within the same service may appraise their roles differently. As such, it is important to consider individual factors that may influence staff's experience of their work.

Staff Coping and Resilience

Healthcare professionals may draw on a range of coping strategies to manage the challenges of their work and attenuate the potential consequences of stress. Although a range of definitions exist within the literature, coping can be defined as 'the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful' (Folkman & Tedlie, 2004, p. 1). Coping can be considered along a continuum as well as interpreted dichotomously, such as adaptive or maladaptive coping. Adaptive coping strategies are considered helpful and efficacious ways of managing stressors, associated with increased psychological wellbeing and reduced rates of burnout (Maresca et al., 2022). Maladaptive coping strategies are considered unhelpful approaches that inadvertently increase stress in the long-term and are associated with higher rates of mental health difficulties (García et al., 2018; Meyer, 2001).

Resilience is a complex concept, described by the American Psychological Association (APA) as 'the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands' (APA, n.d.). Resilience encompasses a range of personal and contextual factors and rather than being a stable characteristic, may change over time in response to different experiences. Organisational and individual factors have been found to contribute to an individual's ability to build and sustain resilience. Mental health staff have been found to draw on self-efficacy factors such as self-reliance, emotional intelligence and positive thinking to manage the challenges of their work (Badu et al., 2020). Sull et al (2015) carried out cross-sectional research with NHS staff across a North England trust and found 'moderate' levels of resilience as measured by the Resilience Scale-25 (Wagnild, 2009). No relationship was found between rates of staff absence and resilience, when analysed by age, gender, length of service, specialty or banding. These results highlight that it may not simply be the case that increasing staff resilience will reduce absenteeism, and that other factors are likely to be contributing.

Aims of the review

Research suggests that systemic factors such as working conditions significantly explain the variance in mental health staff's self-reported job satisfaction (Barili et al., 2022). However, there has been no synthesis to date that has considered the association between coping and/or resilience and mental health staff's reports of job satisfaction and/or PQOL. This review aimed to systematically synthesise existing research exploring this relationship, including:

1. Understanding the experience of coping, resilience, job satisfaction and PQOL within this mental health professional sample.
2. Understanding the relationship between:
    a. Coping and job satisfaction and/or PQOL
    b. Resilience and job satisfaction and/or PQOL
3. Consider how these findings fit with existing research and advance the current literature.

The results of this synthesis are summarised and recommendations for further research are presented.

Method

The current review was written in line with updated Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidance (PRISMA; (Page, McKenzie, et al., 2021; Page, Moher, et al., 2021).

Search Strategy

Search terms and databases were decided through a literature search, consultation from a psychology subject librarian and discussion within the research team. The study protocol was

registered with the international database of prospectively registered systematic reviews in health and social care (PROSPERO – registration number CRD42022295762).

Seven databases relevant to the subject area were searched from their inception date until 30th January 2022; Medline, PsychInfo, Web of Science, Applied Social Sciences Index and Abstracts (ASSIA), International Bibliography of the Social Sciences (IBSS), SCOPUS and ProQuest Dissertations and Thesis. Search terms are outlined in Table 1. Grey literature was included in the review to reduce the impact of publication bias. The reference lists of included studies and relevant reviews were screened to scope for additional papers. No limits were placed on the date of publication, language or design type at the point of searching.

Search Group	Search Terms
Mental health staff	"Psychiatric nurs*" OR "psychiatric staff" OR "psychiatric hospital" OR "mental health staff" OR "mental health personnel" OR "mental health hospital" OR "forensic psychiatry*" OR "child and adolescent mental health staff" OR "FCAMHS" OR "CAMHS" OR "child psychiatry*" OR "adolescent psychiatry*"
	AND
Resilience and/or Coping	"resilienc*" OR "cop*" OR "positive adaptation" OR "protective" OR "engage*"
	AND
Job Satisfaction and/or Professional Quality of Life	"wellbeing" OR "well being" OR "satisfact*" OR "content*" OR "quality of life" OR "compassion satisfaction" OR "compassion fatigue"

Table 1. A table outlining the search terms and syntax used to search the databases.

Eligibility Criteria

The inclusion and exclusion criteria for the review can be found in table 2.

Inclusion & Exclusion Criteria	
Inclusion	• Participants who work within mental health services. • Quantitative studies that include measures of resilience/coping AND job satisfaction/PQOL. • Quantitative studies reporting on associations between any aspect of resilience/coping AND job satisfaction/PQOL. • Printed in the English language.
Exclusion	• Qualitative studies, case studies, editorials and reviews. • Studies published in languages other than English. • Studies that do not report specific measures and inferential statistics regarding resilience/coping AND job satisfaction/PQOL

Table 2. A table describing the inclusion and exclusion criteria used to select appropriate studies for the review.

Study Selection

All identified papers were exported to EndNote and duplicates removed. Titles and abstracts were screened and any papers that did not meet the inclusion criteria were removed. The full text of remaining papers were screened. Thirteen of the full text review papers were screened by an independent reviewer (κ=0.792 – substantial agreement). Any disputes regarding ratings were taken to the research team and resolved through discussion until 100% agreement was reached. This resulted in ten papers included within the final review. A PRISMA diagram summarising the selection process can be found in figure 1.

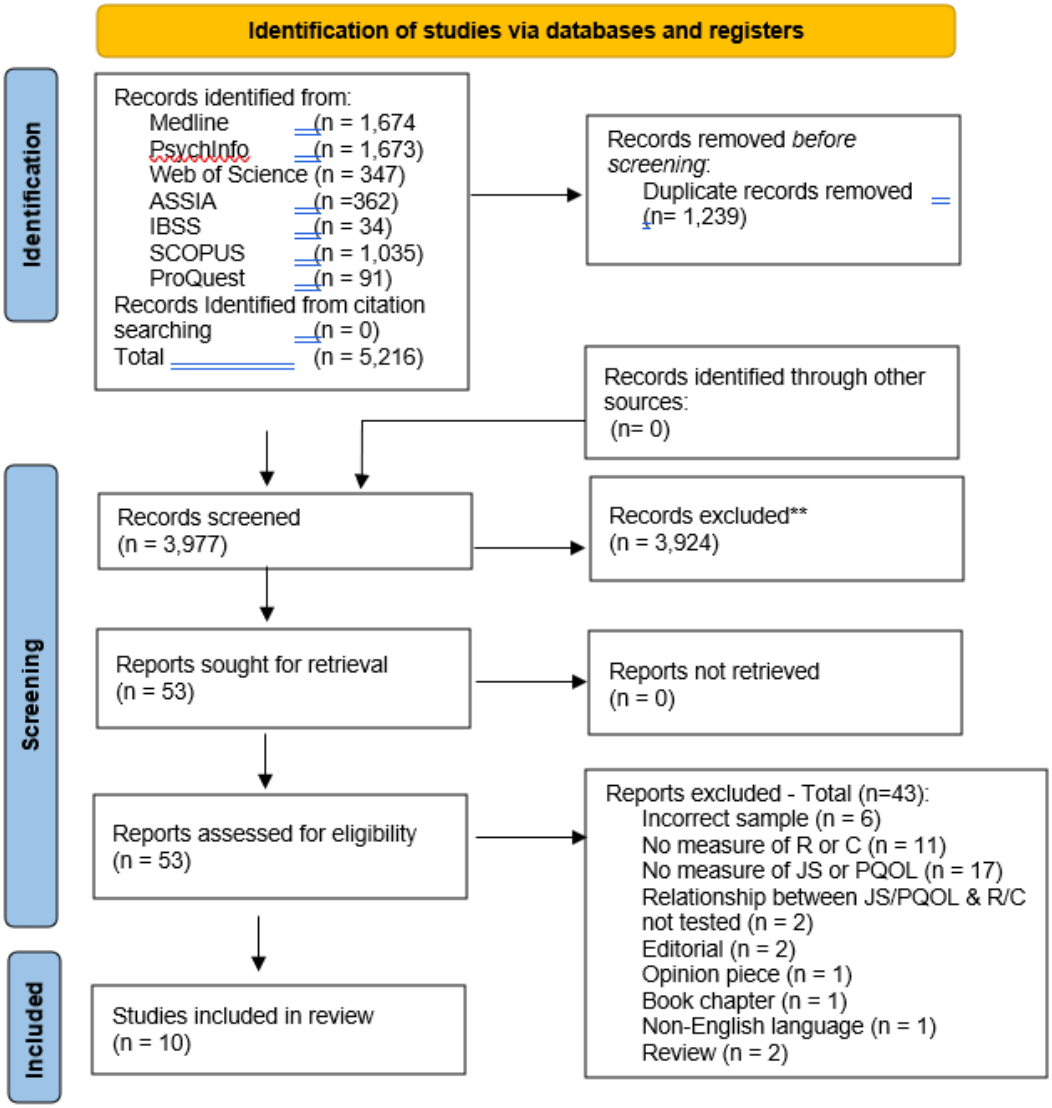

Figure 1. A PRISMA flowchart detailing the search process for the current review. R= Resilience. C= Coping. JS = Job Satisfaction. PQOL= Professional Quality of Life.

Data Extraction and Synthesis

All extracted data was collated within a Microsoft Excel document. Data extracted from the full texts included:

- Study characteristics
- Inclusion/exclusion
- Participant characteristics

- Outcome measures

Method of Quality Assessment

As all included studies were cross-sectional in design, the Appraisal tool for Cross-Sectional Studies (AXIS) quality assessment tool was selected for this review (Downes et al., 2016). The AXIS tool is tailored to assess the common quality issues that can arise within observational, cross-sectional studies. The measure consists of a twenty-question checklist in which 'yes', 'no' or 'don't know' responses are given. The checklist is accompanied by a step-by-step guide to aid decision-making (Downes et al., 2016). Greater number of items endorsed indicates higher quality or more complete reporting within the paper. The AXIS tool recommends that scoring should be used to support the interpretation of the paper's quality and as such, does not provide categorical labels (e.g. good/bad quality).

The lead author assessed all included studies for their quality using the AXIS tool. 30% of these papers were randomly selected for quality assessment by an independent reviewer. Any disagreements were discussed with the research team until there was 100% agreement.

Results

Demographic Information

A total of ten papers were included in the final review involving 2,241 participants. Sample sizes varied considerably between studies, ranging from 35-726 participants. A full summary of the studies characteristics can be found in table 3.

Papers were published between 1990 and 2021. Four papers (English, 2021; Little, 2015; Sukut et al., 2022; Zheng et al., 2017) reported their data collection periods, which spanned nine days to eight

months. Most studies were conducted in America (N=6), with other studies coming from Turkey (N=1), Israel (N=1), United Kingdom (UK, N=1) and Singapore (N=1).

All participants worked within mental health services and were sourced from community services (homelessness services (N=1), crisis services (N=1), forensic clinics (N=1), mental health community services (N=3), including both national and private services) and inpatient services (acute (N=2), chronic inpatient settings (N=1) and other hospital settings (N=5)).

Percentages of female participants varied from 59.2% to 86.2%. Three out of ten studies reported the ethnicity of their sample. In two of these studies, participants most commonly identified as white Caucasian (Dearth, 2015; English, 2021), while the third reported African American to be the most frequently identified ethnicity (Matos et al., 2010). The most frequently selected professions were nursing, clinical social workers, and psychologists. Six studies reported response rates which ranged from 11.5% to 85.6% (Little, 2015, 2016; Matos et al., 2010; Oberlander, 1990; Sukut et al., 2022; Tyler & Cushway, 1998; Zheng et al., 2017).

Report Details	Participant Characteristics	Data Collection	Measure of resilience or coping	Measure of job satisfaction or PQOL	Analysis & Results
Dearth (2016) Thesis USA	**N=**157 **Recruitment site:** A homelessness shelter and community mental health organisation supporting the homeless community **Age**[2]**:** 18-23 N=8 (5.10%) 24-29 N=35 (22.29) 30-35 N=52 (33.12%) 36-45 N=36 (22.93) 46+ N=26 (16.56) **Gender** F= 106 (67.5%) M= 49 (31.21%) Transgender= 2 (1.27%) **Ethnicity:** White/Caucasian N=68 (43.31%) Latino/Hispanic N=35 (22.29%) Asian/Pacific Islander N=22 (14.01%) African American/Black N=13 (8.28%) Middle Eastern	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate:** NR **Power:** NR	The Brief Cope (Carver, 1997)	ProQOL scale V5 (Stamm, 2010b)	*Analysis:* Hierarchical regression *Descriptive Data:* Adaptive coping = 42.22[1] (SD =7.77) Maladaptive coping = 24.25[1] (SD=6.54). ProQOL: Compassion Satisfaction = 37.12[1] (SD= 6.83) Burnout = 24.52[1] (SD= 5.70) Secondary Traumatic Stress= 24.41[1] (SD= 6.16) *Relationship data:* Adaptive Coping & Burnout= F-change (1,153) = 0.34, p= .558 (NS) Adaptive Coping & Secondary Traumatic Stress= F-change (1,153) = 3.79, p = .053 (NS) Adaptive Coping & Compassion Satisfaction= F-change (1,153) = 6.86, p = .010 beta = .209, t = 2.62, p = .010 Maladaptive Coping & Burnout= F-change (1,153) = 82.55, p < .001.

	N=11 (7%) Other N=8 (5.10%) **Profession:** Mental health providers				β = .579, t = 9.09 Maladaptive Coping & Secondary Traumatic Stress= F-change (1,153) = 112.54, p = < .001 beta = .630, t = 10.61, p = < .001 Maladaptive Coping & Compassion Satisfaction= F-change (1,153) = 38.50, p = < .001 beta = -.443, t = -6.20, p = < .001
English (2021) Thesis USA	**N**= 109 **Recruitment site:** A hospital setting **Age[2]:** 25-34 = 38% 35-44= 40% **Gender:** F= 86.2% M= 13.8% **Ethnicity:** White (52%) Black (28%) Asian (2%) Native Hawaiian or Pacific Islander (1%) Multiple races (5%) Other (12%)	**Sampling method:** Non-probability, convenience sampling **Data Collection period:** March 2020- May 2020 (3 months) **Response Rate:** NR **Power:** NR	The Brief COPE Inventory (Carver, 1997)	ProQOL scale (version NR, Stamm, 2010b)	*Analysis:* Multiple linear regression. *Descriptive Data:* NR *Relationship:* Adaptive Coping: Active coping, planning, emotional support, positive reframe, Acceptance, Religion= NS Humour= P= .001 Maladaptive Coping: Self-distraction= r(107) = .34, p = .001 Venting= r(107) = .37, p = .000 Behavioural disengagement= r(107) = .37, p = .000 Self-blame= r(107) = .43, p = .000 β = .212, t(95) = 2.179

	Profession: Therapist (41%) Other (23%) Counsellors (14%) Psychologists (11%) Case managers (6%) Nurses (5%)				Denial= $r(107) = .12$, $p = .20$ (NS) Substance use= $r(107) = .24$, $p = .01$ (NS)
Little (2015) Thesis USA	**N=** 85 **Recruitment site:** Acute/crisis mental health settings **Age:** 43.08[1] (range= 25-70) **Gender:** F= 57 (67.1%) M= 28 (32.9%) **Ethnicity:** NR **Profession:** Active and licensed mental health professionals	**Sampling method:** Purposive sampling **Data Collection period:** May-September 2014 (5 months) **Response Rate:** 11.5% **Power:** G-Power Version 3.1.3 – n=84	The Resiliency Scale14 (RS-14, Wagnild & Young, 2011)	ProQOL V5 (Stamm, 2010).	*Analysis:* Multiple linear regression analysis *Descriptive Data:* RS-14= 83.61[1] (moderate, SD= NR, range 57-98) ProQOL: Scores on burnout: Average (81.2%), high (18.8%) Average score on STS (55.3%) Average score on CS (55.3%) *Relationship:* -Burnout: FOC & Resilience= ($F(2, 82) = 16.49$, $p = < .0001$, adj. $R2 = .27$). Resilience= Significant, negative predictor of burnout (adjusted $\beta = -.522$, $p = <0.001$, medium effect size) -Secondary Traumatic Stress FOC & Resilience= $F(2, 82) = 1.44$, $P = > .01$, adj. $R2 = .01$ (NS) -Compassion Satisfaction

					FOC & Resilience= F (2, 82) = 14.56, p = < .0001, adj. R2 = .24 Resilience= significant predictor of compassion satisfaction (adjusted β = .495, p<0.001 - small to medium effect size)
Matos et al (2010) Journal USA	**N=** 32 **Recruitment site:** Inpatient mental health units **Age[2]:** 40-60: 68.8% **Gender:** F= 81.2% M= 18.8% **Ethnicity:** African American= 46.9% Caucasian (28.1% Asian (12.5%) Hispanic/Latino (6.2%) Other (6.2%) **Profession:** Full time registered nurses	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate**: 32/42 =76% **Power**: Analysis for an effect size of 0.5. 0.80 power level N=27	The Resiliency Scale (Wagnild and Young, 1993)	The Index of Work Satisfaction (Stamps, 1997)	*Analysis:* Pearson's product-moment correlation coefficient *Descriptive Data:* Resiliency= 145[1] (High level, SD = NR, Range = 44-172) Job Satisfaction= 220[1] (SD = NR, Range = 101-282) *Relationship:* Resilience and job satisfaction= (r(30) = 0.33 (p = < 0.06, medium effect size) 10% of job satisfaction was explained by resilience (r2 = 0.11)

Oberlander (1990) Journal USA	**N=** 601 **Recruitment site:** Community mental health services **Age:** NR **Gender:** M= 240 F= 356 Unknown= 5 **Ethnicity:** NR **Profession:** Counsellors/technicians (N= 50) Educational, vocational and occupational therapists (N=8) Psychiatrics nurses (N=34) Psychologists (N=18) Social workers (N=155) Psychiatrists (N=13) Case managers (N=85) Administrators (N=53) Dual practitioners (N= 28) Dual administrator/practitioner titles (N= 18) Unknown (N= 139)	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate:** 1,799 surveys distributed – 601 returned (33.45% RR) **Power**: NR	Coping Items Scale (adapted – Lactack, 1986)	Minnesota Satisfaction Questionnaire	*Analysis:* Correlation *Descriptive Data:* Coping = 3.43[1] (moderate) Job satisfaction = 3.73[1] (moderate) *Relationship:* Coping and job satisfaction = r=.19 (weak)

Sukut et al (2021) Journal Turkey	**N=** 100 **Recruitment site:** Acute and chronic wards, adult and adolescent addiction clinics and forensic clinics **Age** 32.46[1] (SD= 8.60, range= 19-60) 19-32 (N = 60) 32-60 (N = 40) **Gender[3]:** F= 84 (82.4%) M= 18 (17.6%) **Ethnicity:** NR **Profession:** Psychiatric nurses	**Sampling method:** Purposive sampling **Data Collection period:** May –December 2019 (8 months) **Response Rate:** 100/142 (70.42% RR) **Power**: NR	Connor Davidson Resilience Scale (Connor & Davidson, 2003)	ProQOL R-IV (Stamm, 2010).	*Analysis:* Pearson's correlation analysis and linear regression *Descriptive data:* Resilience= 145[1] (SD = NR, Range= 44-172) ProQOL: Burnout= 17.46[1] (SD= 5.46, low range) Compassion Fatigue= 13.56 (SD= 7.89) Compassion Satisfaction= 32.54 (SD= 7.14) *Relationship:* Burnout and Resilience= r=-0.247 (weak, negative correlation) Compassion fatigue and resilience= NS Compassion Satisfaction and Resilience= r=0.424 (moderate positive correlation) Linear regression: Compassion satisfaction and Resilience= (β = 0.391, t = 3.831, p = 0.000)
Thomas-Sharksnas (2003) Thesis USA	**N=** 94 **Recruitment site:** A community mental health centre **Age:** 35[1] (SD= 10.87, range= 22-61)	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate:** NR	Adversity Response Profile (ARP, Stoltz, 1997) Providing a Adversity Quotient score	The Job Descriptive Index (JDI; Balzer, et al, 1997) including the Job in General Scale)	*Analysis:* Pearson product moment correlation analysis Simple regression Multiple regression *Descriptive Data:* Resilience = 137[1] (moderate, SD= 10.7, Range = 116-161)

	Gender: F= 62 (69%) M= 28 (31%) Unknown = 4 (3%) **Ethnicity:** NR **Profession:** Full and part time mental health employees	**Power**: n=86 to obtain 95% confidence level			Job satisfaction = 39[1] (37th percentile, SD = 11.1, Range = 9-54) *Relationship:* Resilience and job satisfaction= R=-.127, p= .224 (NS) JIG (job satisfaction) and total AQ score (resilience)= F (l, 92) = 74.317, p=.224 (NS) ARP CORE subscales (resilience) and JIG scores (job satisfaction) = (Control = r =-.155, p =.135 (NS), Ownership, r = -.124, p = .234 (NS), Reach = r = -.021, p = .841 (NS) and Endurance = r = .012, p =.909 (NS). Subscales on the ARP (resilience) and JIG scores (job satisfaction = (F(4, 89) = 75.189, p =.674 (NS).
Tyler & Cushway (1998) Journal UK	**N**= 155 (N= 83 mental health professionals) **Recruitment site:** Hospital mental health and surgical directorates **Age**: <30 N= 40 (26%)	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate:** N=155 represents 25% of target population	The coping scale of the Health and Daily Living Schedule (Moos & Billings, 1982) 7-point scale:	Job satisfaction measure unclear	*Analysis:* Hierarchical multiple regression *Descriptive Data:* Coping: Active cognitive coping = 1.90[1] (SD= 0.58) Active behavioural coping = 1.46[1] (SD= 0.46) Avoidant coping = 0.73[1] (SD = 0.44) Job satisfaction = 2.21[1] (1.02)

	30-50 N= 90 (58%) 50+ N= 18 (12%) Declined to respond N = 7 **Gender**: F = 112 (72%) M = 34 (22%) Declined to respond = 9 (6%) **Ethnicity**: NR **Profession:** Qualified nurses N = 82 (52.9%) Nursing or health care assistant N =25 (16.13%) Administrative/clerical staff N = 20 (12.9%) Clinical/medical staff N = 23 (14.84%) Not reported N = 5 (3.23%)	**Power**: NR	How confident are you with your ability to cope with stress at work		*Relationship:* Coping and job satisfaction = NS Avoidant (β = 0.05), behavioural (β = 0.14) and cognitive (β = -0.10)
Zeidner et al (2013) Journal Israel & USA	**N=** 182 (N=89 mental health professionals) **Recruitment Site:** 7 major hospitals and 6 private clinics **Age:** Mental health care group = 41.76[1] Medical care group = 47.95[1]	**Sampling method:** Volunteer sampling **Data Collection period:** NR **Response Rate:** NR	Coping inventory for stressful situations situation specific coping (CISS-SSC, Endler & Parker, 1990).	ProQOL R-III (Stamm, 2010).	*Analysis:* MANCOVA ANCOVA Hierarchical linear regression analysis *Descriptive Data:* Coping: -Problem/task focused:

Gender: Mental health care group F = 73% M or other = NR Medical care group F = 37% M or other = NR **Ethnicity:** NR **Profession (mental health professionals):** Clinical psychologists N = 25 Clinical social workers N = 55 Psychiatrists N = 9	**Power**: NR	Women = 3.85[1] (SD=0.72) Men = 3.87[1] (SD=0.51) -Emotion oriented Coping: Women = 2.39[1] (SD=0.75) Men = 2.19[1] (SD = 0.82) -Avoidance Oriented Coping: Women = 2.61[1] (SD = 0.73) Men = 2.36[1] (SD = 0.83) ProQOL: -Burnout Women = 22.06[1] (SD = 4.90) Men = 20.17[1] (SD = 5.77) -Secondary Traumatisation Women = 17.60[1] (SD = 6.76) Men = 13.38[1] (SD = 4.96) -Compassion Fatigue Women = 29.17[1] (SD = 10.42) Men = 33.54[1] (SD = 10.11) *Relationship:* Problem focused coping and all ProQOL scales = NS Emotion Focused Coping and Burnout = r = 48 (p<0.1), Emotion Focused Coping and Secondary Traumatic Stress= r = .39 (p = <.01), Emotion Focused Coping and Compassion Fatigue = r = .49 (p<.01), Avoidant Coping and Burnout = r = 26 (p = <.05) Avoidant Coping - Secondary Traumatic Stress = r =.23 (p<.05)

					Avoidant Coping and Compassion Fatigue = r = .30 (p<.01).
Zheng et al (2017) Journal Singapore	**N**= 726 **Recruitment site:** A mental health Institute **Age[2]:** 31–45: 38.5% **Gender:** F = 59.6% M = 37.2% **Ethnicity:** NR **Profession:** Registered nurses	**Sampling method:** Volunteer sampling **Data Collection period:** 16-24 December 2014 (9 days) **Response Rate:** 85.6% (874 distributed and 748 returned) **Power**: NR	The Resiliency Scale (Wagnild and Young, 1993)	The McCloskey and Mueller Satisfaction Scale (MMSS, Mueller & McCloskey 1990)	*Analysis:* Bivariate correlation analysis. Linear regression. *Descriptive Data:* Resilience = 127.99[1] (Moderately low levels, SD = 20.280, Range = 30-175) Job satisfaction = 96.31[1] (SD = 18.958, Range = 32-155) *Relationship:* Job satisfaction and resilience = β = 0.109, t = 2.953, P = 0.003 (effect size - negligible)

Table 3. A summary table of the characteristics of studies included in the final review.

NR= Not reported. NS= Non-Significant. SD= Standard Deviation. [1]= Mean score. [2]= Mean score not reported. **[3]** = data does is not equate to the total number of participants within the analysis. ProQOL= Professional Quality of Life scale. PQOL= Professional Quality Of Life. FOC= Frequency Of Contact. JIG= Job In General. ARP= Adversity Response Profile. AQ= Adversity Quotient. CORE= Control, Ownership, Reach and Endurance. F= Female. M= Male.

A summary of effect sizes can be found in Appendix C.

A range of psychometrics were used within the reviewed studies (table 4).

Topic	Measure	Papers
Resilience	The Resiliency Scale (Wagnild and Young, 1993)	Matos et al, 2010 Zheng et al, 2017
	The Resiliency Scale 14 (RS-14; Wagnild & Young, 2011)	Little, 2015
	Connor Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003)	Sukut et al, 2021
	The Adversity Response Profile (ARP; Stoltz, 2000)	Thomas-Sharknas, 2003
Coping	The Coping Items scale (adapted – Latack, 1986)	Oberland, 1990
	The Brief COPE Inventory (Carver, 1997)	Dearth, 2016 English, 2021
	Coping inventory for stressful situations - situation specific coping (CISS-SSC; (Endler & Parker, 1994)	Zeidner et al, 2013
	The coping scale of the Health and Daily Living Schedule- adapted (Moos & Billings, 1982)	Tyler & Cushway, 1998
	7-point scale: How confident are you with your ability to cope with stress at work?	Tyler & Cushway, 1998
Job Satisfaction	The McCloskey and Mueller Satisfaction Scale (MMSS, Mueller & McCloskey 1990)	Zheng et al, 2017
	The Index of Work Satisfaction (IWS) Part B, developed by Stamps (1997)	Matos et al, 2010
	Minnesota Satisfaction Questionnaire (MSQ, Weiss, Dawis, England, & Lofquist, 1967)	Oberland, 1990
	The Job Descriptive Index (JDI; Balzer, et al, 1997) including the Job in General Scale	Thomas-Sharknas, 2003
	Job satisfaction measure unclear	Tyler & Cushway, 1998
Professional Quality of Life	Professional Quality of Life Measure (ProQOL; (Stamm, 2010) *Version of the ProQOL used is indicated next to the author details.*	Little, 2015 *(V5)* Sukut et al, 2021 *(R-IV)* Dearth, 2016 *(V5)* English, 2021 *(NR)* Zeidner et al, 2013 *(RIII*)*

Table 4. A table summarising the quantitative, self-report psychometrics used by each paper included within the current review. A brief description of each of these measures can also be found in Appendix D. NR = not reported. *Zeidner et al (2013) employed the STS and BO subscales and linearly combined these to form a compassion fatigue score.

Quality Assessment and Risk of Bias

A summary of the final quality assessment scores can be found in appendix E. All papers were cross sectional and so it is not possible to draw conclusions regarding the causal direction of the relationship between variables. All participants were recruited using volunteer sampling, which may create bias within the findings. Four papers did not report response rates (Dearth, 2015; English, 2021; Thomas-Sharksnas, 2003; Zeidner et al., 2013), so it is unclear to what extent the responses gathered represent the experiences of the cohort. Two papers included both mental health staff and staff from physical health settings in their relationship analysis (Tyler & Cushway, 1998; Zeidner et al., 2013).

Papers varied significantly in their quality, with endorsed items on the AXIS tool ranging from eight to seventeen out of twenty. This is likely to impact on the replicability of studies and the validity of their results. There was much variability in the number of participants and only three studies conducted power analysis to justify their sample size (Little, 2015; Matos et al., 2010; Thomas-Sharksnas, 2003). Four studies were published more than ten years ago (Matos et al., 2010; Oberlander, 1990; Thomas-Sharksnas, 2003; Tyler & Cushway, 1998).

Quality of Psychometrics

Seventeen different psychometrics were used across all papers in this review (including different iterations of the ProQOL, table 4). Psychometrics varied considerably in their validity and reliability, impacting on the quality of the current review. A brief description of all measures in the review is provided in appendix D. One paper used a bespoke, unvalidated measure (Tyler & Cushway, 1998). Two papers indicated that measures were adapted, however, the nature of these adaptations were unclear (Oberlander, 1990; Tyler & Cushway, 1998). One paper did not clearly describe the measure of job satisfaction used (Tyler & Cushway, 1998). The scoring of the coping scale of the Health and

Daily Living Schedule was also unclear (Tyler & Cushway, 1998). Although the Minnesota Questionnaire has been validated (Purohit et al., 2016), this has not been carried out with healthcare staff. All papers exploring PQOL used iterations of the ProQOL (Stamm, 2010). Concerns have also been raised regarding the validity of the burnout and STS subscales within this measure (Geoffrion et al., 2019; Hagan, 2019; Hemsworth et al., 2018).

Experience of Key Variables within this Sample

Coping

Five papers (Dearth, 2015; English, 2021; Oberlander, 1990; Tyler & Cushway, 1998; Zeidner et al., 2013) used measures of coping. Two papers utilised the Brief COPE (Dearth, 2015; English, 2021) however, the later paper did not provide descriptive statistics. Dearth (2015) found a mean adaptive coping score of 42.22 (SD=7.77, max score= 64) and mean maladaptive coping 24.25 (SD=6.54, max score= 48). Higher scores on both scales indicated a greater tendency to use the corresponding coping strategy. However, cut off scores were not provided to aid interpretation of these results.

Oberlander (1990) used an adapted version of The Coping Items Scale (Latack, 1986) however, the nature of the adaptation was not specified. This measure captures active and passive coping, but results were not categorised in this way. Oberlander (1990) reported total mean scores that suggested participants used coping strategies in the work setting to a moderate degree (3.43 – possible scores range from 1-5). The authors provided no further interpretation.

Tyler & Cushway (1998) reported mean scores on the Coping Scale for the Health and Daily Living Schedule (Moos & Billings, 1982) for staff working within a mental health directorate within a hospital in England. Coping was broken down into active cognitive coping ('efforts to manage the appraisal of the stressfulness of the event', mean=1.90, SD= 0.58), active behavioural coping ('overt behavioural attempts to deal directly with the problem', mean=1.46, SD= 0.46) and avoidant coping

('attempts to avoid confronting the problem or to indirectly reduce tension by behaviours such as eating or smoking more', mean=0.73, SD= 0.44 (Holahan & Moos, 1987)). These findings suggest that participants were most likely to employ active behavioural strategies to manage challenges. The authors also asked participants how confident they felt in their ability to cope with work stress. Participants answered on a 0-7 scale. Mean responses were 5.43 (SD= 1.23). However, this was a bespoke measure and so the reliability is considered poor.

Zeidner et al (2013) used the CISS-SSC (Endler & Parker, 1994) to assess coping within this sample. Table 5 summarises the key findings from this paper.

Coping scores as reported in Zeidner et al (2013) using the CISS-SSC (Endler & Parker, 1994)		
Sub-Scales	Men	Women
Problem/Task Oriented Coping	3.87 (SD=0.51)	3.85 (SD=0.72)
Emotion oriented Coping	2.19 (SD=0.82)	2.39 (SD=0.75)
Avoidance Oriented Coping	2.36 (SD= 0.83)	2.61 (SD= 0.73)

Table 5. A table displaying the mean coping scores and standard deviations, as detailed within Zeidner et al (2013) using the CISS-SSC (Endler & Parker, 1994).

Across all studies, results were presented as continuous data and the measures did not provide cut-off scores or norms. Both men and women were most likely to use problem-focused coping strategies. Participants reported using adaptive coping and active cognitive coping strategies to a greater extent that maladaptive, emotion oriented, avoidant and active behavioural coping strategies.

Resilience

Five papers used measures of resilience (Little, 2015; Matos et al., 2010; Sukut et al., 2022; Thomas-Sharksnas, 2003; Zheng et al., 2017).

Summary of Resilience Findings				
Paper	**Scale**	**Norms and Cut Off Scores**	**Observed Score**	**Interpretation** *based on cut-off scores provided by the psychometrics*
Little (2015)	The Resiliency Scale-14 (RS-14 - Wagnild & Young, 2011)	Total score range: 14-98. Cut off scores: Very low (14-56) Low (57-64) 'On the low end' (56-73) Moderate (74-81) Moderately high (82-90) High (91-98) Mean within the general population = 76.17 (SD = 13.9 - Wagnild & Young, 2011)	Mean = 83.61 SD = NR Range = 57-98	Moderately high levels of resilience
Matos et al (2010)	The Resiliency Scale (Wagnild & Young, 1993)	Total score range: 25-175 Cut off scores: 25-100= very low 101-115= low 116-130= moderately low 131-145= moderately high 145-160= high 161-175= very high	Mean = 145 SD = NR Range = 44-172	High level of resilience
Sukut et al (2022)	Conor Davidson - Resilience Scale (25 item scale - CD-RISC - Connor & Davidson, 2003)	Total score range: 0-100 Greater scores = greater resilience Mean score within the general population = 80.4, SD=12.8 (Connor & Davidson, 2003).	Mean = 67.33 SD = 12.96 Range = 17-99	More than one SD below the norm.
Thomas-Sharksnas (2003)	Adversity Response Profile (Stoltz, 2000)	Provides an Adversity Quotient (AQ) score Total score range: 40-200	Mean = 137 SD = 10.7 Range = 116-161	Moderate level of resilience

		Cut off scores: Low (40-117) Moderately low (118-134) Moderate (135-160) Moderately High (161-177) High (178-200) Mean international scores = 147.5		
Zheng et al (2017)	The Resiliency Scale (Wagnild & Young, 1993)	Total score range: 25-175 Cut off scores: Very low (25-100) Low (101-115) Moderately low (116-130) Moderately high (131-145) High (145-160) Very high (161-175)	Mean = 127.99 SD = 20.280 Range = 30-175	Moderately low levels of resilience

Table 6. A table summarising resiliency scores across papers included within the synthesis. NR= Not Reported. SD= Standard Deviation.

Of the five studies included, three papers reported that staff exhibited moderate to high levels of resiliency (Little, 2015; Matos et al., 2010; Thomas-Sharksnas, 2003; Zheng et al., 2017). One study found that staff scored one standard deviation below the mean for resiliency (Sukut et al., 2022) and the final study found moderately low levels of resilience (Zheng et al., 2017).

Professional Quality of Life (PQOL)

Five papers (Dearth, 2015; English, 2021; Little, 2015; Sukut et al., 2022; Zeidner et al., 2013) used iterations of the ProQOL (Stamm, 2010). One measure did not provide means scores for key variables (English, 2021).

Burnout

Mean burnout scores ranged from 17.46, falling within the low range (Sukut et al, 2022) to 24.52 (SD=5.7), falling within the average range (Dearth, 2015) across three papers (Dearth, 2015; Sukut et al., 2022; Zeidner et al., 2013). Zeidner et al (2013) analysed their findings by gender and reported

mean scores for men 20.17 (SD 5.77) and women 22.06 (SD 4.90) which are within the average range. One study (Little, 2015) considering staff working within acute and crisis settings, found 18.8% experienced high levels of burnout (scoring 57+) and 81.2% experiencing average levels (scoring 18-56). In summary, these results demonstrate considerable variability in staff's experience of burnout (ranging from low to high), with most staff reporting average levels of burnout across studies.

Secondary Traumatic Stress (STS)

The majority (55.3%) of staff working within acute and crisis care settings scored within the average range for STS (Little, 2015). Other studies (Dearth, 2015; Sukut et al., 2022; Zeidner et al., 2013) found that staff reported low rates of STS. Overall, despite working in high emotional labour environments, participants appeared to experience low levels of STS.

Compassion Satisfaction

55.3% of staff working within acute and crisis care scored within the average range for compassion satisfaction (Little, 2015). Other studies (Dearth, 2015; Sukut et al., 2022) reported mean compassion satisfaction score within the low range. Overall, staff reported experiencing diverging experiences of compassion satisfaction, ranging from low to average sense of compassion satisfaction.

Compassion Fatigue

Zeidner et al (2013) separated compassion fatigue scores by gender, with a mean score of 33.54 (SD = 10.11) for men and 39.17 (SD = 10.42) for women, which were both within the high range. However, authors combined scores from the STS and burnout sub-scales to create a compassion fatigue composite score. There is some suggestion within the literature that this method of analysis may increase the validity of the results (Geoffrion et al., 2019) however, it is also unclear if standardised cut-off scores are applicable due to the creation of composite scores. Sukut et al (2022)

reported mean compassion fatigue scores of 32.54 (SD = 7.14), which again falls within the high range.

Job Satisfaction

Four papers used measures of job satisfaction (Zheng et al, 2017; Matos et al, 2010; Oberland, 1990 and Thomas-Sharksnas, 2003). Each paper used a different questionnaire to assess this factor. A summary of these findings can be found in table 7.

Job Satisfaction Outcomes					
	The Minnesota Satisfaction Questionnaire (MSQ) Mean scores range from 1-5	The Index of Work Satisfaction (IWS) Part B (Stamps, 1997) Total score range = 44-308	The Job in General Score (Balzer et al, 1997)	Job satisfaction measure unclear	The McCloskey and Mueller Satisfaction Scale (Mueller & McCloskey 1990) Total score range = 31-155
Oberlander (1990)	Mean = 3.73 Interpretation: Moderate levels of satisfaction				
Matos et al (2010)		Mean = 220* SD = NR Range = 101-282 Higher scores = higher satisfaction at work.			
Thomas-Sharksnas (2003)			Mean = 39* SD = 11.1 Range = 9-54		
Tyler & Cushway (1998)				Mean= 2.21* SD= 1.02	
Zheng et al (2017)					Mean = 96.31* SD = 18.958 Range = 32-155 Interpretation: 'The majority of participants were

					satisfied with their jobs'

Table 7. Mean job satisfaction scores. *No cut off scores or categories provided. NR= Not Reported.

Oberlander (1990) and Zheng et al (2017) provide evidence of moderate levels of job satisfaction within mental health staff. However, the range of job satisfaction measures used, as well as the lack of cut-off scores used by some of the measures posed challenges when synthesising the data.

The Relationship between Resilience and Job Satisfaction/PQOL

Resilience and Job Satisfaction

The relationship between resilience and job satisfaction was reported within three papers (Matos et al., 2010; Thomas-Sharksnas, 2003; Zheng et al., 2017). This captured a total of 855 participants. Studies used different scales to evaluate key variables (summary in table 4).

Within a sample of 35 participants working within inpatient units, Matos et al (2010) reported a correlation coefficient of $r(30) = 0.33$ ($P < 0.06$) between job satisfaction and resilience, representing a medium effect size. Authors concluded that in this sample, 10% of nurses' job satisfaction was explained by their resilience scores. Zheng et al (2017) considered this relationship within a mental health institute in Singapore (n=726 nurses). Bivariate correlations revealed a positive association between job satisfaction and resilience ($\beta = 0.109$, $t = 2.953$, $P = 0.003$). Using regression analysis, Thomas-Sharksnas (2003) found no significant correlations between resilience and job satisfaction on any of the subscales used.

All papers demonstrated good quality (15-16 out of 20 on the AXIS quality coding scale). Two studies report having sufficient power to increase confidence in their results (Matos et al., 2010; Thomas-Sharksnas, 2003). Despite the lack of power analysis used by Zheng et al (2017), their sample size was considerably larger than the other studies. In summary, there is some, limited evidence suggesting an association between job satisfaction and resilience within this population.

Resilience and Professional Quality of Life (PQOL)

Two studies (n=185) looked at the relationship between resilience and PQOL (Little, 2015; Sukut et al., 2022). Both studies found a relationship between resilience and burnout. Sukut et al (2022) found a weak negative correlation between burnout and resilience (r=-0.247). Little et al (2015) found that frequency of contact with clients admitted due to suicidality and resiliency accounted for 27% of the variance for scores on burnout ($F (2, 82) = 16.49$, $p < .0001$, adj. $R2 = .27$). Resilience was found to be a unique predictor of burnout (adjusted $\beta = -.522$, $p = <0.001$) demonstrating a significant, negative association, with a medium effect size. This means that reduced resilience predicted greater scores on measures of burnout.

Little et al (2015) evaluated the relationship between resilience and STS. STS was not predicted by frequency of contact with clients who expressed suicidality, or staff resilience. Sukut et al (2021) found no significant associations between compassion fatigue and resilience.

Both Little et al (2015) and Sukut et al (2021) found a positive association between staff resilience and experiences of compassion satisfaction. Sukut et al (2021) found a moderate positive correlation between compassion satisfaction and resilience (r=0.424). Little (2015) found that resilience scores accounted for 24% of the variance in compassion satisfaction scores. Resilience was a unique predictor of increased compassion satisfaction and produced a small effect size.

In summary, these results provide preliminary evidence of a negative association between resilience and burnout and a positive association between compassion satisfaction and resilience. There is no evidence of a relationship between resilience and STS. Both studies demonstrated good quality, fulfilling 15 and 16 quality criteria on the AXIS coding system, respectively.

The Relationship between Coping, Job Satisfaction and/or Professional Quality of Life

Coping and Job Satisfaction

Two studies (n=756) reported on the relationship between coping and job satisfaction (Oberlander, 1990; Tyler & Cushway, 1998).

Oberlander (1990) found a weak positive correlation between job satisfaction and available coping mechanisms. Tyler & Cushway (1998) carried out a hierarchical regression considering the impact of coping on predictions of job satisfaction for staff working within mental health and surgical directorates. The inclusion of coping strategies (including avoidant, behavioural and cognitive coping) into the hierarchical regression resulted in a small addition to the variance predicting job satisfaction. Avoidant, behavioural and cognitive coping strategies were non-significant. Instead, work stressors were a major contributor and were significantly associated to staff's reports of poor job satisfaction (29%, $p = <0.0001$).

These results suggest limited evidence of an association between coping and job satisfaction. The quality of both papers were poor. Despite the substantial sample size within the Oberlander (1990) paper, neither reported the use of power analyses. The measures used in these studies were weak, with a bespoke and undisclosed measures used. Two scales were also adapted. Tyler & Cushway (1998) included both physical health and mental health staff within their analysis. The reliability and replicability of these findings are therefore unclear.

Coping and Professional Quality of Life (PQOL)

Three papers (n=448) investigated the relationship between coping and PQOL (Dearth, 2015; English, 2021; Zeidner et al., 2013). All papers used an iteration of the ProQOL (Stamm, 2010). English (2021) only reported on the relationship between the impact of staff coping and burnout. Both Dearth (2016) and English (2021) used the brief COPE (Carver, 1997) to measure staff coping, with Zeidner

et al (2013) using the Coping inventory for stressful situations situation-specific coping (CISS-SSC - Endler & Parker, 1990).

Coping and Burnout

Key findings are summarised in table 8.

Paper	Adaptive / Maladaptive Coping	Specific Coping Style	Result	Interpretation
Dearth (2015)	Adaptive	Religion Active Coping Planning Acceptance Positive reframing Instrumental support Emotional support Humour	F-change (1,153) = 0.34, p = .558	Non-significant
English (2021)	Adaptive	Active coping Planning Emotional support Positive reframe Acceptance Religion Humour	r(107) = .07, p = .491 r(107) = .07, p = .50 r(107) = .001, p = .99 r(107) = -.01, p = .96 r(107) = .15, p = .13 r(107) = .07, p = .49 NR	Non-significant P = .001
Zeidner et al (2013)	Adaptive (problem focused coping)	Problem focused coping & Burnout	r=-.12	Non-significant
Dearth (2015)	Maladaptive	Self-blame, self-distraction, venting, behavioural disengagement, denial and substance misuse Maladaptive coping	F-change (1,153) = 82.55, p < .001. β = .579, t = 9.09	Significant P = < .001 Significant and unique predictors of burnout p = < .001
English (2021)	Maladaptive	Self-distraction Venting Behavioural disengagement Self-blame	r(107) = .34, p = .001 r(107) = .37, p = .000 r(107) = .37, p = .000 r(107) = .43, p = .000	Significant p = .000 and p = .001

		Denial Substance use Self-blame	*r*(107) = .12, *p* = .20 *r*(107) = .24, *p* = .01 β = .212, t(95) = 2.179	Non-significant Significant and unique predictor of burnout p = < .032
Zeidner et al (2013)	Maladaptive (emotion focused coping)	Emotion Focused Coping & Burnout	r=48	p = <.01
Zeidner et al (2013)	Avoidant Coping	Avoidant Coping & Burnout	r=26	p = <.05

Table 8. A table summarising papers examining the association between coping and burnout scores.

The majority of studies reported non-significant associations between adaptive coping and burnout. Humour was the only strategy demonstrating a significant positive correlation with burnout. Dearth (2015) found that adaptive coping (religion, active coping, planning, acceptance, positive reframing, instrumental support, emotional support and humour) did not significantly enhance predictions of burnout, over control variables (history of trauma and frequency of self-care - F-change (1,153) = 0.34, p = .558). In summary, these results suggest that the majority of adaptive coping strategies used by staff were not sufficient to significantly and independently predict their experience of burnout.

Most maladaptive coping strategies measured were significantly, positively associated with burnout. Dearth (2015) found that history of trauma, frequency of self-care and maladaptive coping explained 42.1% of the variance of experiences of burnout. Frequency of self-care and emotion focused/maladaptive coping were found to be unique predictors of burnout. Using multiple regression analyses, a linear combination of self-blame, substance use, behavioural disengagement, denial, average daily caseload, STS, childhood trauma, educational level and gender predicted burnout and accounted for 47% of the variance in burnout scores. Self-blame was found to uniquely

predict burnout scores, β = .212, t(95) = 2.179, p < .032 (English, 2021). The only strategies where this relationship was not maintained were denial and substance misuse (English, 2021). These results suggest staff who used more maladaptive coping strategies were significantly more likely to experience burnout.

Coping, and Secondary Traumatic Stress (STS) and Compassion Fatigue

Adaptive coping did not significantly enhance the prediction STS, over above frequency of self-care and history of trauma (Dearth, 2015). Zeidner et al (2013) also found no significant associations between problem-focused coping and STS.

Maladaptive coping significantly enhanced predictions of STS over and above control variables. Emotion-focused/maladaptive coping, frequency of self-care and history of trauma predicted 49.7% of the variance in staff experiences of STS. History of trauma and emotional focused/maladaptive coping were unique predictors of STS (Dearth, 2015). Zeidner et al (2013) found a significant relationship between emotion-focused coping and STS, and avoidant coping and STS. Zeidner et al (2013) also found a significant positive association between emotion-focused coping and compassion fatigue (r = .49, p<.01), and avoidant coping and compassion fatigue (r=.30, p<.01).

In summary, evidence from this review demonstrates a positive association between maladaptive coping (including emotion focused and avoidant coping) and experiences of STS, but no relationship between adaptive coping (including problem focused coping) and STS. There is evidence of a positive association between maladaptive coping (including emotion focused and avoidant coping) and compassion fatigue.

Coping and Compassion Satisfaction

In a study by Dearth (2015), adaptive coping was found to significantly enhance the prediction of experiences of compassion satisfaction, over control variables. Years of mental health experience, frequency of self-care and adaptive coping explained 11.4% of the variance in predicting compassion satisfaction. Frequency of self-care and adaptive coping strategies were unique predictors of compassion satisfaction.

Using regression analysis, maladaptive coping significantly enhanced predictions of compassion satisfaction over and above control variables (history of trauma and frequency of self), with greater use of maladaptive coping associated with reduced compassion satisfaction (Dearth, 2015). Maladaptive coping negatively predicted compassion satisfaction.

Dearth's (2015) paper provides preliminary evidence that use of maladaptive coping may be related to experiences of burnout and STS, and that the use of adaptive and maladaptive coping uniquely predicts staff's scores on compassion satisfaction. This paper adequately described their methodological process and findings, enabling ease of replication in future research. Despite concerns regarding the validity of the ProQOL in the literature, there is some evidence that the compassion satisfaction subscale is subject to fewer of the validity flaws compared to the other subscales (Hemsworth et al., 2018), which may offer weight to these findings.

Discussion

The current review aimed to synthesise the existing research investigating the associations between coping and/or resilience, and job satisfaction and/or PQOL for staff working within mental health services. The review uniquely contributes to the evidence base as it is the first to consolidate the research within this field.

Summary of the Main Findings

Resilience and Adaptive Coping

When considering the relationship between resilience and job satisfaction, despite an overall substantial sample size (N=855) and appropriate power analysis conducted by two out of three of the papers (Matos et al., 2010; Thomas-Sharksnas, 2003), there is currently limited evidence to suggest a relationship between resilience and job satisfaction (Matos et al., 2010; Thomas-Sharksnas, 2003; Zheng et al., 2017). Non-significant relationships and negligible effect sizes were reported (Thomas-Sharksnas, 2003; Zheng et al., 2017). However, Matos et al (2010) provided initial evidence of a moderate effect size, with resilience accounting for 10% of the variation in job satisfaction scores for mental health staff. Matos et al's (2010) findings are consistent with more recent research with nurses working within acute care hospitals (Brown et al., 2018), which found a positive association between job satisfaction and resilience. However, it is noted that this study maintains similar limitations to Matos et al (2010), including the lack of investigation into the temporal relationship between factors due to the study design. Existing research has found job satisfaction to be positively associated with organizational culture commitment for Korean American registered nurses (Kim et al., 2017). Organisational commitment has been found to be a key factor underpinning turnover rates of staff. This research highlights the importance of pursuing further research in this field.

Oberlander (1990) reported positive associations between coping and job satisfaction. However, the interpretation did not specify whether coping strategies were considered adaptive or maladaptive. Tyler & Cushway (1998) found that coping skills provided a small but non-significant addition to predictions of job satisfaction. Measures of coping were adapted by researchers within both studies and the nature of the adaptations were unclear, potentially impacting the validity of the findings. Given the low quality of this research, results should be held tentatively. Despite these limitations, the latter paper fits with existing research within a physical health settings, reporting non-significant

associations between subscales on The Ways of Coping Questionnaire (Folkman & Lazarus, 1980), measures of humour and job satisfaction within nurses (Healy & McKay, 2000).

There is evidence to suggest a negative association between resilience and burnout (Little, 2015, 2016; Sukut et al., 2022), with resilience emerging as a unique predictor of burnout (medium effect size, (Little, 2015). These finding are consistent with research examining burnout in physicians and the general population (N= 5,445), suggesting a negative relationship between resilience and burnout (West et al., 2020). However, within this review, only two papers analysed this relationship and queries have been raised about the use of the ProQOL (Stamm, 2010) as an appropriate measure. Future research may consider using measures that are appropriately validated for the sample under investigation.

Across three high quality studies, no significant relationships were found between increased use of adaptive coping strategies and burnout (Dearth, 2015; English, 2021; Zeidner et al., 2013). Adaptive coping skills such as religion, active coping, planning, acceptance, positive reframing, instrumental support, emotional support and humour did not significantly and independently add to predictions of burnout (Dearth, 2015; English, 2021). Given the definitions of resilience and coping previously described (Folkman & Tedlie, 2004; Kim et al., 2015; Stamm, 2010) future research would benefit from considering the potential mediating or moderating impact of adaptive coping on the relationship between resilience and burnout, i.e. does adaptive coping provide a mechanism through which staff may increase their resilience, which may in turn impact on experiences of burnout. Evidence of this relationship is tentatively predicted by (De la Fuente et al., 2021) within a sample of students. However, additional research is needed to consider other factors that may influence this relationship.

There is currently no evidence to suggest a relationship between resilience or adaptive coping and STS within mental health staff (Dearth, 2015; Little, 2015). This is contrary to research with emergency medical service participants and counsellors, which found greater experiences of

resilience was associated with reduced experiences of STS (Austin et al., 2017; Temitope & Williams, 2015). Similarly, there is currently no evidence of a relationship between resilience and adaptive coping and compassion fatigue within this cohort (Sukut et al., 2022). However, research with trauma responders had found a significant negative correlation between compassion fatigue and resilience (Burnett Jr & Wahl, 2015). For both STS and compassion fatigue, challenges arise in distinguishing whether this heterogeneity in findings is accounted for by the selection of the sample and the inherent differences in occupational demands or the different measures used within these studies.

Three studies considered good quality assessed the relationship between compassion satisfaction and resilience, all of which found a significant positive relationship between these factors, with small to moderate effect sizes (Dearth, 2015; Little, 2015; Sukut et al., 2022). Little (2015) found that resilience uniquely predicted greater scores of compassion satisfaction and accounted for 24% of the variance in compassion satisfaction scores. Adaptive coping was found to uniquely predict compassion satisfaction (Dearth, 2015). This finding is consistent with research carried out with trauma nurses, which found that adaptive coping strategies such as access to support networks, exercise and meditation were associated with greater compassion satisfaction scores (Hinderer et al., 2014).

Overall, these findings suggest that for mental health professionals, there is limited evidence of a relationship between resilience and job satisfaction, and no evidence of a relationship between resilience, STS or compassion fatigue. Resilience and adaptive coping strategies appear to be associated with compassion satisfaction in mental health staff. While negative associations have been found between resilience and burnout, adaptive coping strategies have demonstrated no association with burnout. However, measures of adaptive coping may be limited by the quantitative measures used, which may miss out the nuances of coping strategies used by staff, such as the

efficacy of strategies employed and the adequacy of external sources of support (Oakland & Ostell, 1996).

Maladaptive Coping

Maladaptive coping strategies such as self-blame, self-distraction, venting, behavioural disengagement, denial and substance misuse significantly enhanced predictions of burnout in mental health staff (Dearth, 2015; English, 2021). Emotion focused/maladaptive coping and avoidant coping strategies were also significantly, positively associated with burnout scores (Dearth, 2015; Zeidner et al., 2013) and self-blame (English, 2021). These findings are consistent with the broader evidence base, including research with NHS doctors, which found maladaptive coping strategies (behavioural disengagement, self-blame and substance use) were associated with experiences of burnout (McCain et al., 2018). Research suggests that experiential avoidance strategies are ineffective in managing stressors and are linked to a range of psychopathologies including substance misuse, anxiety and distress relating to trauma experiences (Chawla & Ostafin, 2007). Thought suppression strategies such as distraction have been found to increase the frequency of difficult thoughts and the distress caused by them, in comparison to strategies such as acceptance (Marcks & Woods, 2005). It is possible that this may lead staff to be more susceptible to experiences of burnout. Previous research has also found that self-distraction was the most frequently used strategies amongst doctors (McKinley et al., 2020) and 26.3% of frontline health care workers used alcohol to manage the stress of the COVID-19 pandemic (Smallwood et al., 2021). Given the frequent use of these strategies within healthcare staff and the impact on burnout, this highlights a key area for exploration and intervention. Future research may benefit from considering the utility of interventions focused on supporting staff to use alternative coping strategies, to buffer against experiences of burnout.

Emotion focused, maladaptive coping strategies were found to be associated with increased rates of STS (Dearth, 2015; Zeidner et al., 2013). These findings fit with research from a UK sample of staff working within child exploitation services (Bourke & Craun, 2014) who found that denial and substance use (including an increase in alcohol and tobacco consumption) were predictive of STS. However, cross-sectional design and challenges in establishing clarity regarding the response rate within this study should be considered in the interpretation.

The current review also found maladaptive coping to be positively associated with compassion fatigue (Zeidner et al., 2013) and negatively associated with compassion satisfaction (Dearth, 2015). Alharbi et al (2020) assessed the impact of coping (using the Coping Strategy Questionnaire) on ProQOL-5 scores within a sample of critical care nurses. Results demonstrated no significant relationship between coping and STS, burnout and compassion satisfaction. These finding differ from those within the current review. This may relate to the differences in the sample (hospital staff, those working with the homeless population and nurses within critical care).

Future research would benefit from a review of existing measures to reach a consensus regarding those which are considered gold standard for clinical and research use. In addition, understanding the impact of coping on job satisfaction and PQOL was limited by the definitions of coping captured within the psychometric measures. It is possible that staff use other coping strategies that were not captured within these measures. Future research to understand the full breadth of coping strategies utilised by mental health staff may be beneficial.

Methodological Considerations

There were a number of methodological considerations that impact on the interpretation of the findings from this review. All participants were recruited using volunteer sampling, which may create bias within the findings. For example, those who would have scored lower on measures of coping,

resiliency, job satisfaction or PQOL, may have been absent. Although sampling is a challenge within cross-sectional designs, good practice recommends that attempts are made to quantify levels of engagement with the project (Downes et al., 2016). Samples were also drawn from a range of mental health settings, making it difficult to interpret the discrepancy in results. The inclusion of both mental health and physical health staff in some studies meant it was not possible to ascertain the unique relationship within mental health staff. Four papers were published more than ten years ago. Given the changing nature of mental health services, increases in service pressures and a reduction in resources (Royal College of Nursing, 2021), the generalisability to modern services is unclear.

The lack of consistency in measures used posed challenges to synthesising key findings. This challenge has previously been raised in the literature (Endler & Parker, 1994; Greenaway et al., 2015). It is therefore difficult to conclude whether findings were representative of the relationship between factors or whether methodological concerns, such as the different specificity and sensitivity of these psychometrics, impacted upon outcomes.

Within the relationship analysis, most papers presented variables as continuous data, which was appropriate given the sample sizes and analyses used. However, this posed challenges when interpreting the experience of key variables, with many measures not providing comparative or cut off scores. Measures of coping also differed in terms of whether they categorised coping strategies as adaptive and maladaptive or simply ways an individual may cope (continuous variable). For those that provided limited interpretative guidance regarding whether strategies are considered positive or adaptive coping (such as the CISS-SSC), this posed challenges to the analysis. However, it is also acknowledged that particular coping skills may not necessarily be good or bad. The ability to utilise a range of coping strategies that best fit the situation may be the most adaptive approach.

Strengths and Limitations of the Current Research

Previous reviews have considered prevalence of burnout (O'Connor et al., 2018), STS (Baum, 2016) and compassion fatigue (Cavanagh et al., 2020) in health care professionals. The literature also, appropriately, has focused on systemic influences that may impact on staff's experiences at work (Fleury et al., 2017; Scanlan & Still, 2019). However, despite an acknowledgment of differing levels of job satisfaction and PQOL across staff and a range of interventions focused on increasing staff's adaptive skills, there has been limited understanding of these factors and their impact on job satisfaction and PQOL. Poor job satisfaction and PQOL have been found to negatively impact staff wellbeing (Faragher et al., 2013; Gurková et al., 2012; Rothmann, 2008), increase staff turnover intention and absence (Jafar Jalal et al., 2014; Saeed et al., 2014) and negatively on patient care (Rathert & May, 2007). This review was the first to synthesise the existing evidence regarding mental health staff's coping and/or resilience, and its association with job satisfaction and/or PQOL.

A strength of this review is the inclusion of unpublished literature (4 out of 10 papers; (Dearth, 2015; English, 2021; Little, 2015, 2016; Thomas-Sharksnas, 2003)). Three of these unpublished theses found non-significant results for all subscales for measures of adaptive coping. Their inclusion in the review reduced the potential impact of publication bias. However, there may be limited by a lack of peer review. Quality reviews were completed for every paper to offer transparency regarding their reliability. The review set no time limits on the date of publication, with the view to increase the sensitivity of the scoping. However, available research in this area was limited.

A limitation is found in the exclusion of papers that were not published in English. Although the scope of the literature search remained broad, the final review only included mental health staff from adult services. As such, results may not be generalisable to other services. The findings from this review were also significantly impacted by the methodological considerations regarding the included articles.

The AXIS quality assessment tool (Downes et al., 2016) was used to support this review. However, domains within the assessment tool are scored 'yes', 'no' or 'don't know'. This scoring system failed to capture the nuances of the methodological considerations of each paper. For example, several papers used widely cited measures however, these were not necessarily valid measures. As such, AXIS scores may appear inappropriately inflated.

Due to the lack of research in this area, the sensitivity of the literature scoping was broadened to include all mental health staff. However, it is possible that staff within different mental health settings experience different pressures that may impact on job satisfaction and PQOL. This is supported by O'Connor et al's (2018) systematic review of burnout within mental health professionals, which described staff's differing experiences of emotional exhaustion, burnout and personal accomplishment across different mental health settings. Further research is needed to understand staff experiences across the breadth of mental health services.

All papers used cross sectional designs which provide a snapshot of the key variables under study at one time point. This study design and the resulting analyses (correlation, ANOVA and regression) do not allow causation to be inferred. In addition, correlational studies prevented the consideration of potential confounding variables which may impact on key relationships. The methodology and analysis used also did not allow for mediating variables (factors that elucidate the mechanism through which the dependent variable and independent variable are related) and moderating variables (factors that impact upon the relationship between independent and dependent variables) to be considered. It is therefore possible that key mechanism for change were not captured within the review. Future research would benefit from utilising intervention studies to evaluate the impact of changing or enhancing staff's coping and/or resilience skills and assessing the impact upon PQOL and/or job satisfaction scores over time.

Clinical Implications

Given the changing nature of mental health services, increases in service pressures and a reduction in resources (Royal College of Nursing, 2021), more up to date research is needed to help understand the current picture of job satisfaction and PQOL for staff. This is particularly pertinent as the impact of the Covid-19 pandemic is likely to have impacted upon the factors under investigation.

Evidence from this review suggests that interventions may be best placed supporting staff to replace maladaptive coping strategies or improve resilience within staff teams. This may attenuate the impact of negative consequences for staff such as burnout. Findings from the reviewed studies suggest that interventions that offer staff space to connect with others and process the challenges of their work may be beneficial as these may counter maladaptive coping strategies such as avoidance and distraction. Examples of such interventions may include opportunities for reflective practice or Swartz Rounds (Allen et al., 2020; Fragkos, 2016; Rodham et al., 2020).

Supporting staff to enhance adaptive coping strategies may support the maintenance of compassion satisfaction and job satisfaction. However, solely focusing on the development of adaptive coping may not be sufficient to overcome the range of challenges faced by staff. This review suggests that resilience is negatively associated with factors such as burnout, but adaptive coping is not. Research would benefit from considering what may contribute to this difference in findings, as this may lead to avenues for intervention. One hypothesis considered was whether the concept of psychological flexibility within the definition of resilience may have provided a key difference. Psychological flexibility is defined as 'the tendency to respond to situations in ways that facilitate valued goal pursuits' and is used to negotiate challenging situations (Doorley et al., 2020, p. 1). It is possible that positive outcomes may be more closely related to staff's ability to flexibly adapt their coping style to meet the needs of the situation, rather than possessing specific skills. A recent meta-analysis found a small but significant association between healthcare workers' psychological flexibility and compassion satisfaction, and a medium negative association between psychological flexibility and

compassion fatigue; key factors in PQOL (Garner & Golijani-Moghaddam, 2021). Acceptance and Commitment Based Therapies (ACT) specifically target experiential avoidance by enhancing an individual's psychological flexibility. A meta-analysis has found that ACT interventions reduced levels of distress in direct care mental health and learning disabilities staff, for those who reported increased distress at baseline. However, this intervention did not specifically impact on burnout or psychological flexibility and so the mechanism for this change is unclear (Reeve et al., 2018).

This review also suggests that supporting a change to staff's coping or resilience may not be sufficient to mitigate against poor job satisfaction and PQOL. The presence of increased job stressors as well as the context in which the stressors occur may be more closely linked to staff perceptions of their role, than the coping strategies they use (Healy & McKay, 2000). Tyler & Cushway (1998) found that the inclusion of variables relating to work stressors into the hierarchical regression added major contributions to the variance in job satisfaction. As such, systemic interventions may also be needed to see the greatest impact for staff, such as increasing job control and improving the person-environment fit (Edwards et al., 1998; Yamaguchi et al., 2016). The intersect between individual coping and systemic interventions should also be a key consideration. It is possible that staff who frequently use physical and emotional avoidance strategies may struggle to engage in or benefit from systemic interventions. Further research is needed to consider these relationships.

Declarations

Conflict of Interest

There are no conflicts of interests to report that may impact on the interpretation of these results.

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Paper 2: Exploring the Emotional Experiences of Staff Working within Adult Mental Health Rehabilitation Services: A Grounded Theory Study

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This manuscript was prepared in accordance with author guidelines for the Psychiatric Rehabilitation Journal (Appendix F). The report is informed by the 2014 quality standards for reporting qualitative research (O'Brien et al., 2014). APA 7th edition reference style was used in line with The DClinPsy guidance. The DClinPsy word limited of 8,000 words for the main text and 250 words for the abstract was also used to ensure detailed information regarding the research process could be demonstrated. Tables and figures are imbedded within the text for the purposes of submission. These will be moved to the end of the document prior to submission for publication. Additional submission requirements that are beyond the scope of the DClinPsy submission will be added prior to submission to publication.

Abstract

Objective

Adult Inpatient Mental Health Rehabilitation Services (AIMHRS) provide intensive, holistic support for individuals experiencing severe and enduring mental health challenges that impact on their ability to carry out activities of daily living and live independently. Despite the high rates of stress and burnout reported across healthcare, there has been limited research considering the experiences of staff within AIMHRS. The current research aimed to understand staff's emotional experiences while working in AIMHRS and delineate processes that facilitate and challenge their wellbeing at work.

Methods

Nine members of staff working within AIMHRS engaged in semi-structured interviews regarding their emotional experiences at work. Constructivist Grounded Theory was used to analyse transcripts.

Results

Six primary categories emerged from the data: enabling relational safety, holding an explanatory framework, reinvigorating staff, systemic challenges, challenges to relational safety and connection and consequences of the 'perfect storm'. A primary challenge was elucidated: how can staff stay authentically and relationally connected in a system that poses inherent physical, emotional and systemic threats?

Conclusions and Implications for Practice

Creating psychologically and relationally safe environments where staff can bring all of themselves to work, drawing on their experiences and enabling them to connect on a human level, is important within this context. Space to reflect on the work supported staff to process challenges. Staff also needed to be held within a context of sufficient resource and with a clear model of care that was supported at all levels of the system. Recommendations for future research are discussed.

Key words

Mental health rehabilitation, staff, wellbeing, stress, qualitative

Introduction

Adult Inpatient Mental Health Rehabilitation Services (AIMHRS) were established to provide inpatient support local to the service users' existing social networks, reducing the need for out of area placements. The Royal College of Psychiatry (RCPsych) describe AIMHRS as a 'whole systems approach to recovery that maximises an individual's quality of life and social inclusion by encouraging [service users] skills, promoting independence and autonomy in order to give them hope for the future and lead[ing] to successful community living' (Killaspy et al., 2005, p. 163). AIMHRS are part of a wider rehabilitation pathway, spanning community-based support and inpatient services. They provide extended, flexible admissions for months or years, supported by a multidisciplinary team, in line with National Institute for Clinical Excellence guidance (NICE, 2020). AIMHRS hold a focus on collaborative working, moving away from crisis care and containment. Killaspy et al (2017) conducted research within National Health Service (NHS) AIMHRS across England and found several unique factors relating to AIMHRS care that were associated with successful service user discharge into the community. These included the promotion of social skills and increased activity levels, and the orientation of the ward towards recovery. However, as there was no control for this study, results should be interpreted with caution. Person-centred care is central and is enhanced through comprehensive, biopsychosocial assessments to inform professionals understanding of service users' needs (NICE, 2020). Without such support, service users may face extended and/or repeated acute hospital admissions and isolation from their support systems, both of which play a role in the maintenance and exacerbation of mental health challenges (Ismail, 2021; Leigh-Hunt et al., 2017).

A high proportion of individuals supported by AIMHRS meet the criteria for psychotic disorders and/or personality disorders (NICE, 2020; Ryan et al., 2016), with referrals frequently received from acute mental health wards and forensic mental health services (Killaspy et al., 2021). Support within AIMHRS should be considered for those experiencing complex, treatment resistant psychosis

necessitating recurrent or extended admissions to hospital and those experiencing psychosocial challenges resulting from their mental health condition (NICE, 2020). Approximately 10%-20% of those with a diagnosis of psychosis may receive AIMHRS support (Holloway, 2005; Morgan et al., 2014). Service users supported by AIMHRS have been found to experience a constellation of challenges. These include cognitive and social skills deficits (Thompson et al., 2003), reduced engagement in activities of daily living (Viertiö et al., 2012), increased negative symptoms (relating to low mood (Mäkinen et al., 2008)), difficulties with medication adherence or resistance (Higashi et al., 2013; Lieberman et al., 2005) and co-morbid mental health difficulties (Killaspy et al., 2008). These factors may impact on service users' ability to maintain stability with their mental health, as well as the necessary level of self-care and/or safety required to live independently.

Staff working in AIMHRS need to maintain flexibility in the face of service users fluctuating mental health needs, co-morbid physical health difficulties, and support the system around the individual (Killaspy et al., 2021). To do this, therapeutic optimism is key (Killaspy et al., 2021). The RCPsych have acknowledged the challenge for staff within AIMHRS in maintaining optimism, due to the context of extended admissions, complexity and risk (NICE, 2020).

Staff Wellbeing within Mental Health and AIMHRS Settings

Different terminology has been used within the literature to describe the negative impact personal and professional pressures have on staff. Stress has been described as the 'physiological or psychological response to internal or external stressors' (APA, n.d.). Stress is not considered inherently bad, as it is acknowledged that its presence can motivate people to achieve their goals. However, when stress is excessive in duration or intensity, this is described as chronic stress, which can have a negative impact on staff wellbeing. Further still, where an individual is under continued stress over a prolonged period, they may experience burnout. This is defined within the literature as

having three primary characteristics: emotional exhaustion (a lack of energy and fatigue), depersonalisation (detachment from the role, cynicism and withdrawal) and reduced personal accomplishment (poor professional self-efficacy and morale (Maslach & Jackson, 1981)). More recent research has also conceptualised burnout on a continuum from burnt out to engaged (Leiter & Maslach, 2016). Given the current climate of high demand for services and poor resourcing, staff stress and wellbeing are key challenges within NHS services. The 2021 NHS England staff survey found that 46.8% of respondents reported 'feeling unwell because of work-related stress' over the last 12 months (NHS, 2022, p.32). This was an increase of 8% since 2017. Similar rates (34%) have been found in Wales (NHS, 2018, p.7).

Poor staff wellbeing has been found to impact on the quality and efficacy of mental health services (Johnson et al., 2018). Ineffective teamwork (Garcia et al., 2019), reduced quality of care (Salyers et al., 2017), increased rates of absenteeism and staff turnover (Firth & Britton, 1989) are some of these potential risks. Poor staff wellbeing has also been linked to service users dissatisfaction (Garman et al., 2002; Killaspy et al., 2013). It is possible that this is due to the impact on the therapeutic relationship, and staff's reduced capacity for empathy under prolonged stress (Wilkinson et al., 2017). This is an important consideration within AIMHRS as there is evidence that relationships, including qualities such as compassion, connection and empathy, are integral to service users' recovery from severe mental illness (Jaiswal et al., 2020). Given the association between the therapeutic alliance and trust, mental health outcomes and treatment adherence, it is essential that the relationship is attended to (Priebe & McCabe, 2006; Thompson & McCabe, 2012).

Research into staff wellbeing within AIMHRS settings is limited. Across mental health settings, staff face particular stressors that place them at increased risk of distress and burnout (Johnson et al., 2018), including high caseloads, community factors (role ambiguity and lack of clinical supervision), emotional labour, exposure to violence, underfunding of services and exposure to suicide risk (Johnson et al., 2018; O'Connor et al., 2018).

Current research suggests that AIMHRS staff experienced the lowest rates of work demand when compared to other mental health settings (Johnson et al., 2012). However, staff within this setting experience different challenges, such as the increased duration of admission (NICE, 2020). Research using grounded theory asked staff about their experience of working within this setting and elucidated a number of key themes; 1) 'rehabilitation is different to treatment, 2) the service is 'a positive transitional space', 3) service users need to be ready to engage and 4) 'recovery is central to rehabilitation practice (Parker et al., 2017, p. 1). Queri (2016) undertook cross-sectional research, to consider the personal and organisational factors affecting staff stress withing a German AIMHRS. They found increased levels of chronic stress scores and high levels of 'gratification crisis' (i.e., insufficient reward for work performance) within this sample in comparison to the working population in Germany (Queri, 2016, p. 1). They also found that reduced occupational self-efficacy was higher than other health care professionals in Germany.

A 'Call to Action' (Rollins et al., 2021) emphasised the lack of research focused on the wellbeing of AIMHRS staff, particularly in the context of the COVID-19 pandemic. The authors described a 'dire need [for] effective interventions' to support workers in this context (Rollins et al., 2021, p. 201).

Given the prevalence of stress within wider mental health service, the known impact of stress on staff, service users and service provision, it is compassionate and prudent to consider how best to support healthcare staff. To do this effectively, an increased understanding of staff's emotional experiences within work is required. This knowledge may assist the development of bespoke interventions aimed at preventing and identifying difficulties and supporting staff at work.

Study Aims

This study aimed to enhance our understanding of staff's emotional experiences while working within AIMHRS. This research aimed to:

1. Gain insight into staff perceptions of the emotional impact of their work.
2. Understand the process of how staff experience and navigate challenges.
3. Delineate processes facilitating positive staff wellbeing.

Method

Ethical Review

This project was reviewed by the School of Psychology Research Ethics Committee (Appendix G) and the Research Integrity, Governance and Ethics Team (Appendix H) at Cardiff University. This was submitted to the Integrated Research Application System (IRAS) and received Health Research Authority (HRA) approval (Appendix I), as well as agreement from all participating Health Boards Research and Development departments (Appendix J).

Design

Grounded Theory (GT (Glaser et al., 1968)) provides a framework for consolidating participants views into an 'abstract theoretical understanding of the studied experience' (Charmaz, 2006, p. 4). Constructivist grounded theory (CGT; Charmaz, 2006) holds a subjectivist position, acknowledging the process through which the researcher co-constructs meaning with participants. To date, there has been no qualitative research considering the phenomenon of staff wellbeing within AIMHRS. Therefore, CGT was chosen over other qualitative methodologies as this enabled the analysis to be driven by the data, without holding a pre-existing theoretical framework. CGT allowed the researcher to construct a theory to explain the processes through which staff's wellbeing is bolstered or diminished. It was hoped that building an understanding of these processes will enable ward management to implement bespoke interventions (individual and/or systemic) to address key barriers and facilitators to wellbeing within this context. Interpretive phenomenological analysis

(IPA) was considered as an alternative methodology. IPA aims to explore the lived experience of a homogenous group of individuals, all of whom share the key demographic or experience under study. However, within the current sample, participants were heterogenous, spanning different wards, health boards and professions. A key aim of the project was also to understand processes that drive staff experiences of wellbeing in order to inform tailored intervention plans to support ward staff. As such, CGT was considered the best fit for this project.

In line with CGT, a semi-structured interview was developed collaboratively between researchers (Appendix K). The interview schedule was reviewed by a Service User and Carer (SUC) representative and field links from participating Health Boards. The interview provided open-ended questions to elicit responses from participants around their emotional experiences at work.

Inclusion/Exclusion Criteria

Table 1 details the inclusion and exclusion criteria for the study. The lead researcher ensured participants were eligible to participate both via email and at the beginning of each interview. Parameters of participants employment (such as duration, hours, and permanency of their employment) were included to ensure participants had a range of experiences within AIMHRS, and to confirm their responses related only to the ward from which they were sampled.

Inclusion Criteria	Exclusion Criteria
• Permanent members of staff who have been working in their role for a minimum of one year. • Those working a minimum of 30 hour per week in the setting in which they have been sampled. • Staff in which a minimum of half of their role consists of clinical contacts. • Staff with client facing roles across a range of specialties including nursing, health care support workers, psychiatry, psychology staff, occupational therapists etc.	• Students, locum or agency staff – as factors contributing to burnout in these staffing groups may differ to permanent staff. • Those who have been in their role less than one year prior to the interviews. • Staff with non-client facing roles. • Staff who exclusively work night shifts. • Those within a split post. • Those working less than 30 hours per week in the AIMHRS from which they have been sampled.

Table 1. A table summarising the inclusion and exclusion criteria for the study.

Participant Characteristics

Table 2 summarises the participant characteristics. Participants were recruited using volunteer sampling. The average duration of service was 7 years. There was a spread of contribution across the three participating Health Boards, with at least two members of staff participating from each Health Board. All participants have been allocated gender neutral pseudonyms to protect their identity. A breakdown of participants by ward or Health Board was redacted to ensure anonymity.

Participant Characteristics	
Gender	
Female	5
Male	4
Duration in current post	
0-2 years	3
3-5 years	2
6-10 years	1
11-20 years	3
Profession	
Therapies staff	3
Nursing staff	6
Age	
25-30	1
31-40	1
41-50	5
51-60	2

Table 2. Participant demographic information.

Recruitment and Data Collection

Four wards in south Wales, UK, participated. Field links disseminated information regarding the study to ward staff via email, word of mouth and a study poster (Appendix L). This included the lead author's contact details, through which participants made contact to express their interest in the study. The lead author liaised directly with participants and provided a copy of the study's participant information sheet (Appendix M). Participants completed a consent form (Appendix N) and were provided with opportunities to ask questions about the study. All these processes ensured

participants were able to provide informed consent. Participants completed a demographics questionnaire prior their interview (Appendix O) and a debriefing sheet on completion of the interview (Appendix P).

Interviews were completed between 19th January 2022 and 19th May 2022. A prize draw was offered in which participants were randomly selected to receive high street vouchers. These were disseminated on completion of all interviews.

Due to the impact of COVID-19, interviews were undertaken remotely. Interviews lasted between 54 and 83 minutes (average duration= 72 minutes). Interviews were recorded using an encrypted Dictaphone. Audio files were transcribed by a professional transcription service. All completed transcripts were redacted to remove personally identifiable information. Participant data was stored securely within Cardiff University servers. Identifiable information was stored separately from participant transcripts and demographic information.

Data Analysis

Data analysis and interpretation were completed in tandem with data collection, allowing constant comparison across the data, and enabled the development of higher order, focused codes (Glaser, Strauss & Strutzel, 1968).

Open coding was initially conducted where the researcher coded information line-by-line, staying close to the participants' own words (Appendix Q). This ensured that coding remained grounded in the data, building an understanding 'from the ground up' (Charmaz, 2006, p. 51) and minimising opportunities for bias in the interpretation. The second stage of analysis involved focused coding, in which key line-by-line codes were synthesised (Appendix Q).

Memos (Appendix R) were created concurrently with open and focused coding. Key ideas emerging from the data and ways in which data converged and diverged were reflected upon (Charmaz, 2006). Memos were used to raise focused codes to conceptual categories. These drew together theoretically significant categories that supported the development of an overarching theory. An interpretive theory approach was used which allowed for patterns and process between concepts to be illuminated (Charmaz, 2006). This process enabled the emergence of the theory (Figure 1). Diagrams depicting how the model evolved over time can be found in Appendix S.

Theoretical Sampling

As part of initial sampling, participants were sourced from across three health boards and to represent diversity in terms of years of experience within AIMHRS, ages and genders. Theoretical sampling describes the process of 'seeking out pertinent data to develop your emerging theory' (Charmaz, 2006, p. 96). Following the development of initial hypotheses and ideas, constant comparison of the data was used to notice gaps, outstanding questions and thinly described categories. This shaped the subsequent theoretical sampling, adapting interview questions to follow pertinent leads or gaps within the emerging data. This process continued throughout the subsequent data collection and analysis process. Examples of such exploration guided by theoretical sampling included systemic influences on staff experiences, experiences and impact of implicit and explicit feedback and staff's experience of managing risk and threat within their roles. This process enhanced the rigor of the study by ensuring key categories were robust, well supported and precise.

Researcher Characteristics and Reflexivity

CGT posits that there is no truth, rather that processes are brought to light through an interactive process between participants and the researcher (Charmaz, 2006). As such, it is important to

acknowledge any influence the researchers' epistemological stance may have on the analysis (Willig, 2013). The lead author completed the following research as part fulfilment towards a doctorate in Clinical Psychology with the South Wales Clinical Psychology Programme, Cardiff University. They wrote from their stance as a 32-year-old, white-British, female. They hold no experience working within AIMHRS. They have experience working within adult community and acute inpatient mental health settings as an Assistant Psychologist. The researcher holds interests in attachment (Bowlby, 2008), children's mental health and staff wellbeing. They are currently working within an attachment service and forensic child and adolescent mental health service.

Quality assurance

To ensure the quality and credibility of the theory development, several safeguards were included:

- The interview schedule was reviewed by a SUC representative, field link and the research team.
- Transcripts were reviewed by members of the research team.
- A reflective journal (Appendix T for exerts) and memos were maintained throughout the data collection and analysis process.
- Initial reflections were shared with a member of the research team who currently works within inpatient mental health rehabilitation to check its face validity.

Quality of the research methodology was reviewed in line with Charmaz & Thornberg's (2021) checklist and guidance for ensuring quality in GT (Appendix U).

Results

Six primary categories were identified within the data: enabling relational safety, holding an explanatory framework, reinvigorating staff, systemic challenges, challenges to relational safety and connection and consequences of the perfect storm. Subcategories are identified throughout in italics. A narrative account of the primary categories will be provided, followed by a presentation of the model. Direct quotes will be used to ground the theory within the data. Redactions of identifiable information and clarification will be included within [brackets]. Omissions will be indicated with the use of ellipsis (…).

Enabling Relational Safety

Connecting on an authentic human level was raised by every participant and appeared to be a key factor in maintaining staff wellbeing, as this created relational safety for staff. There was an acknowledgement that all members of staff come into the role with their own *personal and professional experiences and values*, and that these shape the clinician that they are and want to be.

'The fact that I do have very strong values and things that I'm passionate about, that I think are important, but I suppose also experience, you know, the fact that I have worked in rehab for quite a long time' – Morgan

Staff described that these factors enabled them to connect with service users and staff, authentically. This appeared to be felt by service users and positively impacted on their relationship and connection.

'I think we've all got professional skills and academic abilities; but I think our basic human kindness is what helps people to heal' – Taylor

'If the patients are happy the staff are happy, and…if the staff are happy the patients are happy' - Cameron

All participants highlighted that authentic connection was equally as important within staff teams. Knowing each other's strengths and limitations and drawing on the resource of the collective, had the capacity to enhance emotional and physical safety for staff.

'My relationship with people, that's my certainty, it's the foundation' – Kennedy

'I think they feel very safe when I'm there, and I think they don't feel very safe when I'm not there… there's certain staff that when somebody is on shift and it goes pear-shaped, they go…thank God [they] were on shift' – Jordan

To work together safely as a team, staff needed to be in receipt of the type of care they provide to others. This required staff to be held within a relationally safe environment, with other staff and management who value their strengths, experiences, and provide permission to bring all of themselves to work.

'[Staff] need to feel valued, that what they are doing is valued and good and recognised, and it has an impact for people' – Kennedy

Having built these relationships, participants noted that when difficult situations arise, their colleagues and management were more attuned to their needs and able to use the relationships to provide informal support. This enabled difficulties to be addressed earlier and buffered against feelings of stress.

'The majority of stress is dealt with informally, just through communicating and supporting one another really' – Taylor

Holding an explanatory framework

Participants spoke about several models that were utilised on their wards, including medical models and person-centred models of care. Use of such frameworks may be shaped by the values and culture of the ward. The model impacts on staff wellbeing through several mechanisms.

Firstly, *enacting a clear and flexible model of care* that was bought into by all levels of the service helped provide consistent care, even during times of high stress and/or demand. This provided containment in which staff felt supported to stick to the ethos of the ward and hold personal and professional boundaries.

'[If] I feel really passionately about something and I've got the evidence to back it up…and [my colleagues are] really supportive of me, I'll go for it now. I'm far more confident' - Blake

Perceiving a goodness of fit between the service and the staff member also appeared important. Where staff held different values or models to those which are dominant on the ward, they could feel isolated and disempowered, impacting on how they feel about their role.

'Sometimes you are working with people who are very much for [a] very medical model of pathologizing way of approaching things…and that's when it can be really difficult and a bit soul destroying at times' – Morgan

Staff needed to be guided by a management team who understood and embodied the model. To do this, it was essential that management were adequately supported within this role.

'The environment definitely helps and having colleagues and management who also appreciate how important that is to you [needing to take breaks]. I don't get into any trouble for doing that, that I'm allowed to manage my own [time] just little and often' – Blake

Any model needed to be held flexibly. The relational nature of the ward means that one approach will not fit all, and that negotiation and curiosity were paramount. This allowed the system to accommodate the different needs, experiences, and values of all members of the system. The model also needed to hold support for staff at its heart.

'If you can help me through this short-term, you're probably going to have me long-term' – Blake

Even when clear models were in place, staff described variability in their application, and this could be influenced by resourcing challenges.

'Having enough time and space in the day to stop and talk, and for that to be okay, you know, is really important'- Morgan

A lack of consistency was described by five participants.

'I have seen [colleagues' values] get eroded because of pressures and…messages coming down [from above] from [people] who have got all the power…I don't think they realise how much sometimes their contradictory messages can impact people' - Morgan

Different models had different impacts on the power dynamic within the ward. Some models focused on sharing power and others implemented a more hierarchical power structure. The latter reduced the sense of agency for staff, leaving them feeling powerless.

'It often feels like I'm working with a very unhelpful patriarchal system, and just taking control away from people's lives really, which doesn't always sit very well with me' – Morgan

Reinvigorating the System

Participants described the importance of being in receipt of support through formal channels such as *clinical supervision or reflective practice*. This space allowed staff time to stop and reflect on their emotional experiences at work and develop a greater understanding of the service user's formulations. This appeared to buffer against some challenges.

'Being able to be open and honest in my supervision' – Morgan

'If I've had a difficult [situation] I can actually offload that a little bit, and just sort of process [it] so that I'm not carrying that with me into the next week' – Charlie

Every participant reported the value of *receiving feedback* from service users, families, colleagues, and the wider organisation, and this appeared to bolster their enthusiasm, even when things felt tough.

'It is a role that is very rewarding… there's a small word I think which does mean a lot, when a patient says thank you, that tells us we made a big difference - Frankie

Some members of staff benefitted from hearing explicit feedback.

'So, yeah, feedback from...[students] and from patient's families, we have letters and cards and... it's a good boost to the ego' – Blake

Some staff were nourished from subtle methods of feedback, such as noticing changes in coping or behaviour of service users over time. Other staff communicated an intrinsic reward and privilege from bearing witness to service users' progress. Participants acknowledged that the duration of admissions enabled them to see this change.

'[Seeing] massive improvements in their confidence and acceptance and an understanding of their symptoms and how they manage that going forward… I think it sort of renews that therapeutic optimism for [us] really' – Taylor

Witnessing this progress appeared to act as an antidote to the sometimes slow nature of change.

'It's very invigorating isn't it, because you can become a bit stale, a bit flat, feeling as if something isn't moving. And, when we have that positive feedback, it's really, it's re-invigorating. It's empowering. [Feeling you have] done a really good job and we've made a real difference' – Taylor

The context in which feedback was received felt important. One participant acknowledged that receiving constructive feedback can be difficult and as such, it is important that this is held within a relationally safe and connected context.

'I do find criticism painful sometimes...[however having the] opportunity to just reflect and to have feedback on whether I'm doing a good job or that, have I considered doing it another way, would be really helpful – Taylor

Staff also drew on their own resources, utilising *individual coping strategies* to manage the challenges of the ward.

'You know, practice what I preach a little, I do mindfulness as just part of who I am. So, I do these things that just encourage me to reflect, so me looking at myself and at my body' - Charlie

Of those who felt they managed well, six participants reflected that their ability to manage distress had been moulded over time through their personal and professional experiences.

'I can't say I've always done that. I think that is much more down to experience' – Taylor.

Systemic Challenges

Participants described how the wider NHS context and *lack of resources* could impact on their ability to carry out their work effectively. This affected patients' experiences on their wards and how staff felt about their roles.

'You've got the staffing issues and the lack of resources. We've got hardly any funding and we're just living off the goodwill of the staff. I bring so many of my own items from home to here for the patients to use' – Blake

Participants described having more time with service users as one of the factors that differentiate this setting from other mental health services and that this was an important factor in supporting rehabilitation.

'So, you take [service users] out for a walk and you just might see what makes them tick, whether that be martial arts, motorbikes, football, cricket, you know, whatever, whatever they seem to light up about, what they have got a passion about' – Jordan

However, participants described that these key functions could be eroded by the lack of resourcing, including reduced staffing and a pressure on beds.

'I know that there's a staffing crisis in most places, but I think with [this] clientele…it's a recipe for disaster…when you are on with three staff…you can't go on walks or go to visits in the community [with the service users], so they get frustrated, and I think that does build up then, the frustration in the [service users]…then that can be brought through then in, perhaps misbehaviour…it's not good for the patients, or for staff' - Frankie

Some participants expressed that this left them feeling pressured in their role, that they were working outside of their values, and that challenges were passed around the system.

'I suppose that pressure gets passed down the line. I've asked [a colleague] to do something, so they are passing something of theirs on to somebody else' – Taylor

It appeared important that ward models were fully supported by management and the wider organisation in order to maintain its therapeutic focus. However, participants also described times in which the model of care was inconsistent or contradictory because of service pressures. Six participants described occasions in which their service acted outside of their defined values, which made it difficult to buy into or sustain the model.

'All of those things that we are being told one minute are super important, the next minute we are being told, well never mind that, you have got to [admit] this person' – Morgan

Challenges to Relational Safety and Connection

Seven participants described being in constant proximity to service users and colleagues, meaning that opportunities to soothe themselves following difficult conversations was particularly important. However, staffing problems created barriers to this.

'I don't think that any of us...have regular time to, like, have some time out to have a drink, to have food, to go and have, literally just to sort of walk away from the patient area and have a little bit of time out' - Taylor

Some participants explained that *space for reflection and connection* could be cancelled at short notice or resourced so poorly that it communicated a lack of value from the system. This could leave tasks feeling like tick box exercises.

'Reflective practice, it's brilliant...then again, we haven't got the space, we end up doing it in [an inappropriate environment], you can't really have a conversation, group discussion there, it's like, there's lip service paid to those things' - Kennedy

If staff lacked opportunities for connection and to share the *emotional burden of the work*, this could impact upon their personal lives. Staff described giving up an expectation of support from the service and instead, five participants described seeking support from outside of the ward from family, friends, NHS staff support services and mental health services. This required staff to process work-related challenges outside of working hours and blurring work-home boundaries.

'I don't expect the support from work anymore, that's the difference. I know that it's not coming... and so I don't get frustrated that I'm not supported from work' – Kennedy

This placed the emphasis on individual and external ways of coping, such as using widely available mental health resources.

'I...think that you...give up [on trying to gain support from the system] and try and use wellbeing apps and carry on with...walking or carry on with the breathing exercises as best as you can' – Frankie

Two participants described feeling that they were not afforded the level of support and compassion that was offered to service users.

'The patient…that's why we are there for, I think sometimes support for staff, isn't evident. It's not as it should be' – Frankie

Although staff were able to manage challenges, as problems increased, this placed greater strain on the team and moved them away from their long-term goals.

Consequences of the Perfect Storm

When staff experienced resourcing challenges and an unclear service model, coupled with limited support to maintain wellbeing (e.g., lacking time, space, supervision and reflective practice), this could create a 'perfect storm' that impacted on wellbeing.

Staff described working with high levels of trauma, risk and service pressure, which could have an impact on their *experience of stress*. Participants described a range of emotional reactions to work and when the barriers to wellbeing outweighed the optimal factors, this led to consequences for staff.

'I am frustrated, stressed, tired, and often guilty that I'm not able to do as much as I'd like to do for the patients' - Taylor

These conditions seemed to result in staff *becoming disconnected* from their colleagues and management, especially when there were fewer opportunities to discharge stress within the system. Under these circumstances, participants described an absence of strong emotions and going through the motions. This showed up in their interactions with service users, colleagues and in the way they communicated about them.

'I've literally just switched off for months. I've just been like a robot...I've written reports and things on patients, they are very black and white and factual. Whereas, when I'm not feeling burnt-out, it's a lot more opinionated; I feel this, I feel that, I think they've done incredibly well. And they should be proud of themselves. It's a lot more personal' – Blake

Four participants described difficulties noticing this process at the time. One participant described it as 'silent'.

'I mean it's a quite silent process, because I don't think it's easy to notice actually, when that tipping point is' – Charlie

While some staff may not have recognised this process at the time, they were aware of *the physical impact* of stress at work, which in some circumstances, necessitated time off. This impacted upon the resources of staff to manage challenges as they arise and use their time outside of work to engage in activities that nourish them.

'And, always the knock-on effect, the home life. Everything, whether it's emotional, whether it's the fact that I can't sleep, whether it's [physical] symptoms...it impacts on my home life more than it impacts on work. It's like I hold it together for work' – Blake

'[I] actually don't feel that stressed, but it's leaking out, your body is giving you these signs and maybe psychologically it may be more emotional for example' – Charlie

Some participants described that other people may be best placed to notice signs of disconnection or distress. Having attuned and emotionally safe relationships with colleagues and/or management may help each other to notice these signs and consider support options sooner. However, where these relationships were not in place, staff needed time away from the ward to notice the impact of work on their physical and mental health. For those who had recovered from these difficult feelings, some described the learning they had gained, returning to work with a changed attitude, increased insight and maintaining personal boundaries to protect themselves.

'I think as well…checking in with, not just yourself, but with people around you…am I snappier lately, or have you noticed anything you know, am I just a bit more tired …there's a few colleagues that you are close to, and when you are sharing sort of experiences it can help you to realise that…I am feeling a bit tired or just a bit quieter…[its] a learning curve…[and when you have been through it] it's almost

as if you have to feel what it was like to remember that for the next time, and learn ways of actually bringing you back from that sort of tipping point' – Charlie

A primary challenge was identified within the data: how do staff stay authentically and relationally connected in a system that poses inherent physical, emotional and systemic threats?

Developing a Model for Wellbeing within AIMHRS

A model was developed to summarise the primary categories (Figure 1). A metaphor of a boat attempting to stay afloat and remain on course was used to capture the primary categories.

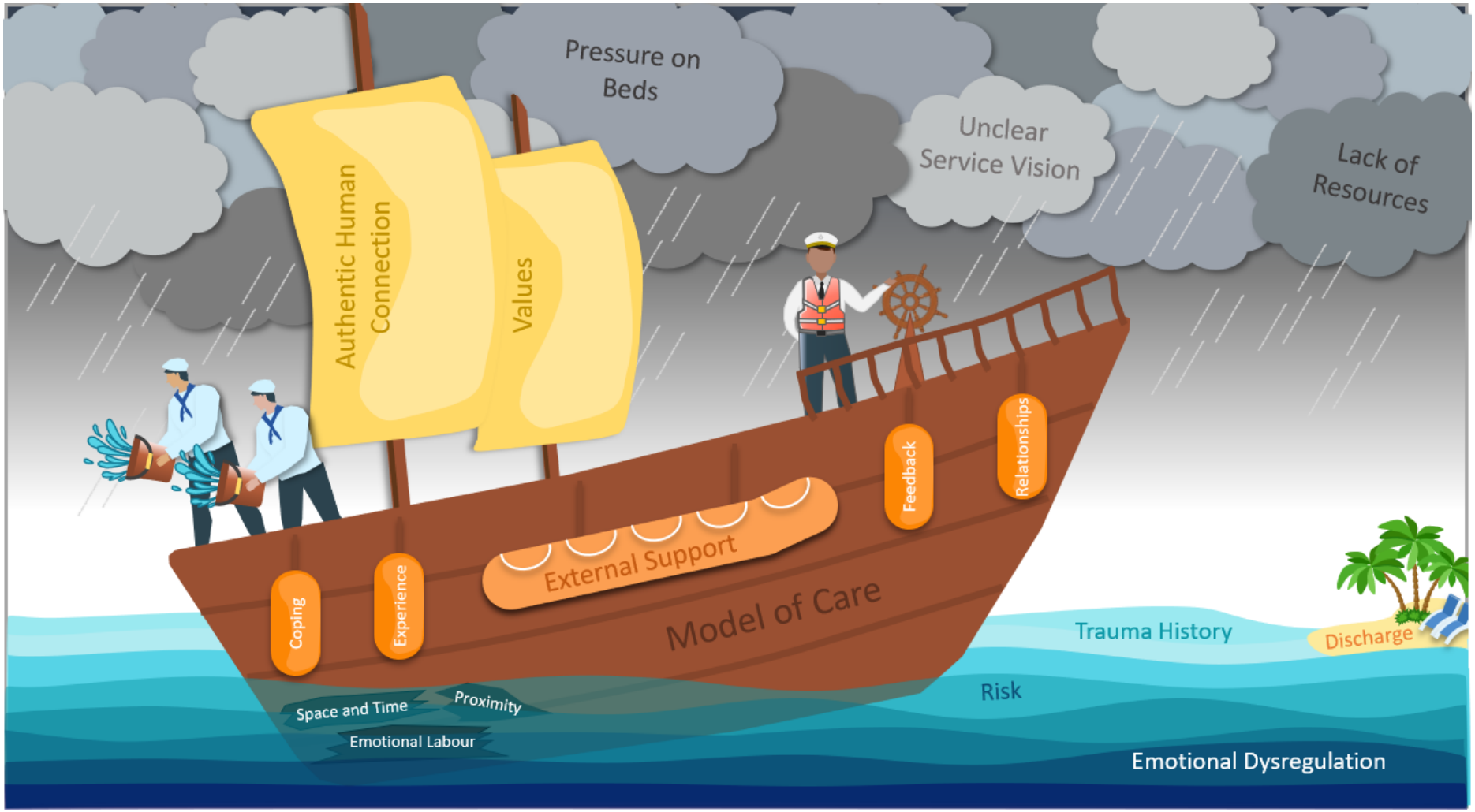

Figure 1. A model depicting the key categories that emerged from the data, and the processes through which staff negotiate the emotional impacted of their role.

The boat represents the model of care held by the ward. It is important that this is robust, fit for purpose and understood by all onboard. The captain represents the need for strong, flexible and compassionate leadership, who has a clear understanding of the direction of travel and can pull all the crew together to work towards a shared goal. It is important that the leadership embodies the values, model and ethos of the ward. The captain also needs to be provided with sufficient and consistent support from their managers (represented by wearing a life jacket) to carry out their crucial role. The sails represent the driving force for the ward. Authentic human connection and a strong sense of values appeared to be a key driver for wards that function well.

The buoys attached to the boat represent some of the key processes that help staff stay afloat, particularly during challenges. These include staff's coping strategies, as well as the personal and professional experiences they bring. Receiving feedback from all levels of the service, within the context of attuned and psychologically safe relationships throughout the ward were also important factors.

Where support cannot be gained from within the system and stressors exceed the resource, the dinghy represents external support that staff may need to access (e.g., NHS staff support services, self-help resources or time off).

The storm clouds represent the challenging systemic conditions under which staff are working (having an unclear service vision, pressure on beds and resourcing difficulties). This interacts with the water, creating larger waves. Under ideal conditions, the boat may be able to weather the storm until it passes, providing that it has sufficient resources to manage.

The water represents the service users (their histories, risk factors, interpersonal style and emotion regulation). The water is influenced by all other factors (storm and the boat) and it is the role of staff to navigate the changeable conditions of these waters in a flexible and person-centred way, whilst maintaining oversight of the destination.

The holes in the boat represent the challenges faced by ward staff that may weigh them down and move their attention away from their path (such as lack of time and space, difficulties in facilitating and prioritising supervision and reflective practice, constant proximity to patients and staff and emotional labour).

When the storms are relentless and the boat is taking on water, the crew may become threat-focused and turn to crisis management, making it difficult to maintain sight of the course they are travelling. Staff feel the effects of all the factors in the model, which could take a toll on the individual increasing physical symptoms and ultimately result in staff shutting off their emotions (weighing down the boat).

Discussion

The current research aimed to explore staff's emotional experiences while working within AIMHRS, the processes that influence these experiences and how staff negotiate challenges. Six core categories emerged from that data: enabling relational safety, holding an explanatory framework, reinvigorating staff, systemic challenges, challenges to relational safety and connection and consequences of the perfect storm.

Enabling relational safety

The need for connection and relational safety was consistently described by participants. Where the context allowed staff to bring all of themselves to work and facilitated connection, participants described building strong, safe therapeutic and collegial relationships that buffered the impact of ward challenges.

The therapeutic alliance is consistently cited as important to within mental health support services (Baier et al., 2020; Shattock et al., 2018) owing to the relational nature of interventions. Qualitative research exploring service users' experience of inpatient psychiatric services found that the therapeutic relationship, including safety, trust and communication, played a key role in creating a context for recovery (Gilburt et al., 2008). Therapeutic relationships have been found to influence service user outcomes such as symptom reduction (Bourke et al., 2021). The current research suggests that psychological and relational safety must be present through all layers of the system (e.g. individual, team and organisation), to support staff. This is evidenced in the NICE Mental wellbeing at work guidance (2022), highlighting the importance of creating a context of psychological safety and compassion for staff at work.

Holding an Explanatory Framework and Values

The current research identified that receiving contradictory messages from management could lead to increased stress for staff and disillusionment with the model of care. When the model of care was clear and consistently enacted by the system, this offered a sense of psychological containment and predictability. The challenges in maintaining consistency with a model have been highlighted in the literature. Without ongoing support and supervision, the benefits of person-centred approaches to care and recovery training were not sustained (Killaspy et al., 2017).

The fit between staff and the organisation or model was also highlighted in the current findings. Risman et al (2016) reported that a higher person-organisation fit (in which staff and employers' values were congruent) was associated with higher rates of job satisfaction and perceived quality of care. As such, wards may benefit from collaboratively (across management, staff and service users) defining their values and including values-based questions into recruitment processes.

Consistent with existing literature, staff described person-centred models of care particularly nourishing within their roles. Rathert & May (2007) found that staff who felt their place of work was person-centred, reported greater job satisfaction and in turn, improved service user safety (Rathert & May, 2007). Within AIMHRS, models of care need to consider these factors and may benefit from considering existing models such as Safe Wards (Mullen et al., 2022) and trauma-informed organisations (Traumatic Stress Wales, 2022), which have been found to be beneficial in creating safety, reducing physical containment and building strong relationships (Finch et al., 2022; Muskett, 2014)

Supporting Staff within Mental Healthcare settings

Participants described that they were not always afforded the same support and care as services users. Participants described developing their coping skills over time in the context of increased experience, to manage the emotional strain of the work. However, Rollins et al (2021) highlight the danger of increasing staff's coping skills, without focusing on the systemic challenges within AIMHRS. In the context of the current research and model, this is akin to adding more buoys to the boat without attending to the holes. Research has found that the use of adaptive coping strategies enhances staff compassion satisfaction (Dearth, 2015) but does not attenuate experiences of burnout (Dearth, 2015; English, 2021; Fukui et al., 2021). However, using maladaptive coping strategies has been found to impact negatively on staff's professional quality of life (PQOL), including prediction of burnout, secondary traumatic stress, compassion fatigue and compassion satisfaction (Dearth, 2015; English, 2021; Zeidner et al., 2013). This suggests that enhancing staff's PQOL and protecting against the negative emotional impact at work may require more than increasing staff's adaptive coping resources. However, research into the field coping and resilience and mental health staff's reports of PQOL is limited, and further research is needed to understand how these findings apply within a AIMHRS context.

Psychological flexibility (PF) is an alternative skill that staff may draw upon to manage challenges. PF describes an individual's ability to 'respond to situations in ways that facilitate[s] valued goal pursuit' (Doorley et al., 2020). Research has found positive associations between increased PF and staff wellbeing, and negative associations between poor PF and distress and burnout (Puolakanaho et al., 2018; Young et al., 2021). A randomised control trial evaluated an eight-week Acceptance and Commitment Therapy intervention for staff from a range of professional backgrounds. This intervention reduced experiences of ill health relating to burnout and psychological symptoms, and improved wellbeing. Changes in these key variables were mediated through the mechanism of increased PF (Puolakanaho et al., 2020). Although this study did not specifically consider staff within AIMHRS, interventions aimed at supporting staff to increase their PF may be fruitful in improving wellbeing and reducing burnout.

Research suggests it is important to also attend to systemic support structures to best support staff (NICE, 2022). Staff described the benefits of receiving clinical supervision and reflective practice. Clinical supervision holds three key functions: restorative, normative and formative support (Proctor, 1987). A systematic review of the literature found that clinical supervision is associated with staff retention and fewer experiences of burnout (Martin et al., 2021). However, the quality of this supervision is also important. Where staff described the supervision they received as inadequate, the impact of this was neutral or could lead to burnout and stress (Martin et al., 2021).

Service Pressures and Resourcing

Participants described a context of limited resources, primarily in terms of staffing. Resourcing created difficulties for staff in carrying out their roles in the way they would like to and to reliably act in line with their service models of care. Research has described the importance of having the right resources to be able to provide person-centred care. Where this is not the case, quality of care can

be compromised (Fukui et al., 2021). Research has consistently demonstrated resource challenges throughout healthcare services, highlighting recruitment, retention and absenteeism as key barriers to the provision of high-quality care (The Kinds Fund, 2022). The King's Fund report (2022) described the importance of addressing staff pay and offering appealing employment packages (e.g. providing supportive and compassionate leadership, opportunities for flexible working). These initiatives may support the retention of existing, experienced members of staff, as well as attracting new staff.

Emotional Burden of the Work and its Consequences

Experiences of stress and pressure impacted on their ability to carry out their roles and affected wellbeing. More broadly, evidence suggests that mental health staff experienced reduced wellbeing when compared to their physical heath counterparts (Johnson et al., 2018). As experiences of stress continued, participants described shutting down, experiencing a lack of strong emotions and noticing an increase in physical symptoms. These descriptions fit with the concept of burnout (Maslach & Jackson, 1981) and is consistent with existing research reporting prevalence rates of burnout between 21-67% within mental health staff (Morse et al., 2012; O'Connor et al., 2018).

The job demands resources model (JD-R) posits that work hindrances or an imbalance produced by high job demands and limited job resources can serve as fundamental drivers of burnout (Demerouti et al., 2001; Xanthopoulou et al., 2007). Research by Scanlan & Sill (2019) found that job demands were positively associated with exhaustion and turnover intention for mental health staff. Job resources, including receiving feedback, rewards and recognition and supervisory support were negatively associated with experiences of exhaustion and turnover intention, and were positively associated with job satisfaction. These findings fit with the current research, in which participants reported feedback is a key motivator. Services may benefit from embedding opportunities for feedback and reflection on successes into regular ward processes. The current research also

provides insights into the context that is needed for feedback to be useful i.e., within psychologically and relationally safe relationships.

Strengths of the Current Research

Despite extensive research considering staff experiences across mental health services, there is a significant gap in the literature exploring staff's emotional experiences within AIMHRS. The current paper provides the first qualitative research elucidating a model to understand these experiences.

Achieving a greater understanding of the processes underlying both positive and negative emotional experiences at work will support the development of tailored staff support interventions that address the unique challenges faced by staff within this setting. This research highlights the importance of enabling relational safety within the system, as well as addressing key systemic and resourcing challenges that create barriers for staff in providing the person-centred care. Future research may benefit from further exploration of staff's emotional experiences using validated psychometric measures. This will provide a baseline for which interventions aimed to improve staff experiences and wellbeing within the settings can be compared.

Participants were recruited from wards across three Health Boards and four wards in south Wales. Participation was also gained from a range of professionals, representing a range of ages, gender and experience working within this setting. This enhances the generalisability of the findings.

Limitations of the Current Research

Volunteer sampling was employed which posed challenges to understanding the demographic and experiences of those who did not opt in to participate. It is possible that those who chose to engage, held an interest in staff wellbeing, research or felt disenfranchised by the service. Alternatively, staff

who experienced the greatest negative emotional impact of the work may have been absent, reducing opportunities for participation. Those who did not participate may hold different views and may have offered valuable insights into the range of experiences within this setting. Recruitment was a key challenge within this research. The impact of COVID-19 and the additional pressure faced by staff may have created barriers to participation. Time constraints associated with completion of the doctorate process was also a key barrier. To attenuate the impact of these limitations, theoretical sampling was employed to capture a breath and subtlety of staff experiences. Research supervision was used to determine when sufficient data had been collected to provide meaningful analysis. In doing this, quality guidelines created by Charmaz & Thornberg (2021) were consulted to enhance the rigor of the research. Within the literature, there is no definitive guidance regarding the optimum number of participants required for grounded theory research to be considered valid or to reach 'saturation' of the data. The term 'saturation' has also been challenged due to the difficulty in quantifying this process (Nelson, 2017; Vasileiou et al., 2018). Instead, there has been a move towards achieving theoretical sufficiency. This describes the process of obtaining an adequate level of data and understanding, to allow researchers to sufficiently theorise about the phenomenon under review (Nelson, 2017) . Despite challenges with recruitment, it was agreed that an appropriate range of experiences were gathered, with key categories emerging across interviews. Categories were complex, interconnected (as evidenced in Appendix S) and the nuance of these were delineated through constant comparison across the data. Findings resonated with broader literature within staff wellbeing and offered valuable insights regarding the processes driving staff wellbeing with AIMHRS. These qualities fit within the conceptual depth criteria created by Nelson (2017) to support decision making regarding theoretical sufficiency.

All participants were sampled from AIMHRS in Wales. As healthcare is devolved within Wales, this may limit the generalisability of the results to other healthcare contexts across the UK and beyond. The impact of the Covid-19 pandemic did not feature within staff's narratives, however it is important to acknowledge that research began nine months after the onset of the pandemic. It is

possible that increased physical and psychological stressors related to the pandemic may have influenced responses. Future research may benefit from replicating these findings at another time point to assess whether similar themes emerge.

Implications for Clinical Practice

The current research culminated in the development of a model that depicts the emotional experiences of staff within AIMHRS. This may be used to consider areas for support at staff, management and commissioning levels.

The current research suggests that services may benefit from achieving clarity regarding the model of care. The model should fit with the ethos and functions of the ward, staff values, and be extended to staff. Based on the findings of Killaspy et al (2017) services may benefit from ongoing support to sustain the benefits of any intervention, such as ongoing reflective space and support for ward management.

Teams would also benefit from time and space to reflect on the challenges and strengths of their work. Group reflective practice interventions offer opportunities to normalise challenges and connect as a team. Schwartz rounds (Cullen, 2016) are a group forum for reflective practice widely used across healthcare settings. Staff report benefits from Schwartz Rounds including validation, space to share their emotional experiences at work and to receive support from their colleagues (Allen et al., 2020).

Hunt et al (2021) identified practices that may be useful in supporting the development of psychological safety within services (Figure 2). These include enabling opportunities to increase open communication within systems (e.g. through committees and dialogue meetings), as well as enhancing opportunities for facilitating connections through spaces such as Schwartz rounds. To

embed and maintain these changes within systems, psychologically safe practices should be linked to service policies such as codes of conduct (Hunt et al., 2021).

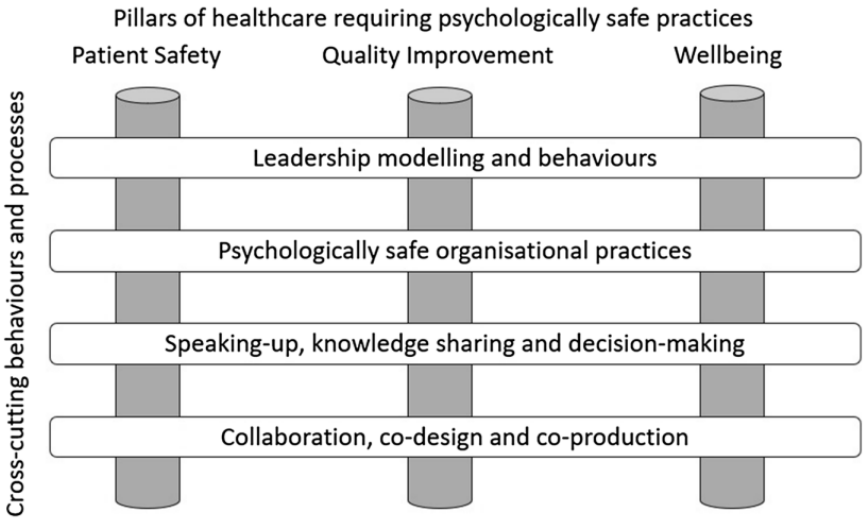

Figure 2. A diagram representing the key pillars required to develop and sustain psychologically safe work environments (Hunt et al., 2021) .

However, developing psychological safety can be a challenge due to the systemic nature of the interventions and the difficulties adequately measuring the concept in order to assess change over time (Hunt et al., 2021).

Conclusion

The current research aimed to gain insight into staff perceptions of the emotional impact of working within AIMHRS. A theory detailing processes underpinning their wellbeing at work was created. Future research would benefit from considering the scale of these difficulties using quantitative methodologies and piloting interventions tailored to meet the specific demands of this cohort, ultimately improving staff wellbeing and service user care.

Declarations

Conflicts of Interest

There are no conflicts of interests to report that may impact on the interpretation of these results.

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Appendices

Appendix A – Author Guidelines for the International Journal of Psychiatry in Clinical Practice

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Queries

Should you have any queries, please visit our Author Services website or contact us here.

Updated 24th November 2021

Appendix B – Table of Abbreviations

Table of Abbreviations	
APA	American Psychological Association
AQ	Adversity Quotient (Stoltz, 1997
ARP	Adversity Response Profile (Stoltz, 1997)
AXIS	The Appraisal tool for Cross-Sectional Studies (Downes et al., 2016)
ASSIA	Applied Social Sciences Index and Abstracts
C	Coping
CD-RISC	Connor Davidson Resilience Scale
CF	Compassion Fatigue
CISS-SSC	Coping inventory for stressful situations situation specific coping (Endler & Parker, 1994)
CORE	Control, Ownership, Reach and Endurance – subscales on the Adversity Response Profile (ARP, Stoltz, 1997)
CS	Compassion Satisfaction
FOC	Frequency Of Contact
IBSS	International Bibliography of the Social Sciences
JDI	The Job Descriptive Index (Balzer, et al, 1997)
JIG	Job In General scale (Balzer, et al, 1997)
JS	Job Satisfaction
MH	Mental Health
MMSS	The McCloskey and Mueller Satisfaction Scale (Mueller & McCloskey 1990)
MSQ	Minnesota Satisfaction Questionnaire (Weiss, Dawis, England, & Lofquist, 1967)
NHS	National Health Service
NR	Not Reported
NS	Non-Significant
PQOL	Professional Quality Of Life
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
ProQOL	Professional Quality of Life measure (Stamm, 2010)
PROSPERO	The international database of prospectively registered systematic reviews in health and social care
PTSD	Post-Traumatic Stress Disorder
R	Resilience
RS-14	The Resiliency Scale 14 (Wagnild & Young, 2011)
SD	Standard Deviation
STS	Secondary Traumatic Stress
UK	United Kingdom

Appendix C – Table of Effect Sizes

A table summarizing the effect sizes using conversions from Ferguson (2009) to ensure consistency across data sets.

Effect Size Conversions			
	Small	Medium	Large
Cohen's r (1988)	.1 to .3	.3 to .5	.5 to 1.0
B Taken from Ferguson (2009)	.2	.5	.8

Effect Size				
	Resilience and Job Satisfaction	**Resilience and Professional Quality of Life**	**Coping and Job Satisfaction**	**Coping and Professional Quality of Life**
Dearth, 2016				**Adaptive coping & burnout** = NS **Maladaptive coping & burnout** = β=.579 Moderate effect size **Adaptive coping & secondary traumatic stress** = NS **Maladaptive coping & secondary trauma stress** = β=.630 Moderate effect size **Adaptive coping & compassion satisfaction** = β=.209 Small effect size **Maladaptive coping & compassion satisfaction** = β= -.443 Small effect size
English, 2021				**Self-blame & burnout** = β = .212 Small effect size
Little, 2016		**Resilience & burnout** = adjusted β= .522 Moderate effect size **Resilience & secondary traumatic stress =** NS		

		Resilience & compassion satisfaction= adjusted β= .495 Small effect size		
Matos et al, 2010	**Resilience & job satisfaction** = r=0.33 Medium effect size			
Oberland, 1990			**Coping & job satisfaction=** r=.19 Small effect size	
Sukut et al, 2021		**Resilience & burnout**- r=-0.247 Small effect size **Resilience & compassion fatigue** = NS **Resilience & compassion satisfaction =** r=0.424 Medium effect size, β = 0.391 Small effect size		
Thomas-Sharksnas, 2003	**Resilience & job satisfaction** = NS **Adversity response profile & job in general**= NS **Control & job in general** = NS **Ownership & job in general =** NS **Reach & job in general** = NS **Endurance & job in general =** NS **Adversity response profile & job in general** = NS			

Tyler and Cushway (1998)			**Coping & job satisfaction**= NS	
Zeidner et al, 2013				**Problem focused coping & all ProQOL subscales**= NS **Emotion focused coping & burnout**= r=48 medium effect size **Emotion focused coping & secondary traumatic stress** = r=.39 medium effect size **Emotion focused coping & compassion fatigue**= r=.49 medium effect size **Avoidant coping & burnout**= r=26 small effect size **Avoidant coping & secondary traumatic stress**= r=.23 small effect size **Avoidant coping & compassion fatigue** = r=.30 medium effect size
Zheng et al, 2017	**Job satisfaction & Resilience** = β=0.109 Negligible			

Results below the threshold for a small effect size have been described as 'negligible' within this review. NS= Non-Significant. ProQOL= Professional Quality of Life measure (Stamm, 2010).

Appendix D - A table summarising all measures used within the included papers.

Coping	
Coping Items Scale (Latack, 1986)	The Coping Items Scale is a 25 item, self-report measure. Participants are asked to indicate the frequency with which they use each coping strategy. Responses are provided on a five-point scale. The measure includes active and passive coping strategies. Strategies include self-esteem building strategies, avoidant strategies, cognitively reconstructing problematic situations and discussing problems.
Brief COPE Inventory (Carver, 1997)	The Brief COPE is a self-report measure consisting of 28 questions. It is based on the original COPE scale which consisted of 60-items (Carver et al., 1989). The measure aims to capture effective and ineffective coping strategies used by individuals to cope with stressful life events. The measure includes 14 subscales, and each response is provided on a 4-point Likert scale (1= I haven't been doing this at all – 4= I've been doing this a lot). It measures: • Adaptive coping (problem-focused); active coping, acceptance, planning, religion, use of emotional support, use of instrumental support, positive reframing and humour. • Maladaptive coping (emotion-focused); denial, behavioural disengagement, substance use, self-distraction, venting and self-blame. This measure was validated by Carver (1997) within a community sample. Results suggested adequacy of the factor structure. However, further research has found difficulties with the humour and religion subscales with a physical health population (Eisenberg et al., 2012) and self-distraction and humour subscale within a nursing sample (Abdul Rahman et al., 2021).
Coping inventory for stressful situations situation specific coping (CISS-SSC, Endler & Parker, 1994).	The Coping Inventory for Stressful Situations – Situation Specific Coping (CISS-SSC) is a self-report measure consisting of 21-items that measures three domains of coping: • task focused (adaptive) • emotion focused coping • avoidance Participants are asked to indicate how often they use each coping strategy in response to stressful situations, with responses provided on a 5-point Likert scale (1= not at all to 5=very much). This scale provides a total score for each domain. Data is treated as continuous rather than categorical and as such, there are no cut off scores.
Health and Daily Living Form - The Coping Items Scale - Adapted (Moos & Billings, 1982)	The Health and Daily Living Schedule captures sociodemographic information, health related social functioning, coping responses and social resources, and life stressors and strains. The coping subscale explores coping and social resources that support individuals to prevent and adapt in light of stressful circumstances.

	Within the coping responses subscale, participants are asked to identify a recent stressful event and then review 32 coping strategies, indicating to what extent they employ these on a scale of 4-point scale (0= no - .3= yes, fairly often). Index score can range from 0-33. This measure was evaluated using within a sample of community-based adults. The following mean scores were reported: • active cognitive – mean = =17.50, SD =5.55, max score 33, • active behavioural – mean = 19.49, SD=7.09, max score 39 • avoidant coping – mean = 3.55, SD=3.29, max score 24
Job Satisfaction	
The Minnesota Satisfaction Questionnaire (Weiss, Dawis, England, & Lofquist, 1967).	The Minnesota Satisfaction Questionnaire was created to measure workers satisfaction with their job, including both intrinsic and extrinsic factors (such as job stability, advancement opportunities, degree of responsibility, and salary). The measure includes 21 items, with items scores on a five-point scale (not satisfied to extremely satisfied). A review of job satisfaction measures found that the MSQ demonstrated good internal consistency but did not satisfy other quality standards within the review (Van Saane et al., 2003). However, there has since been a revision of the MSQ (the MSQ- revised), which attempts to address some of these challenges, which included producing responses that are more equally spread around the 'satisfied' category.
The Job Descriptive Index (JDI; Balzer, et al, 1997) including the Job in General Scale	The JDI provides an 18-item measure of employees self-reported satisfaction with their role. Participants are presented with different aspects of their job and are asked to indicate their level of satisfaction with each one. These factors include: pay, co-workers, promotion, the work itself and supervision. Responses are provided on a three-point scale: yea, no, or not sure. The Job In General scale sits within the JDI and provides a measure of global job satisfaction. In a systematic review of job satisfaction measures, the JIG provided adequate internal consistency, as well as convergent and discriminant validity (Van Saane et al., 2003).
The McCloskey and Mueller Satisfaction Scale (Mueller & McCloskey 1990)	The McCloskey and Mueller Satisfaction Scale is used to measure nurses' self-reported job satisfaction. The scale consists of 31-items and eight domains: satisfaction with extrinsic rewards, scheduling, family/work balance, co-workers, interaction, professional opportunities, praise/recognition, and control/responsibility. Responses are provided on a 5-point Likert (5=very satisfied, 3=neither satisfied nor dissatisfied, 1=very dissatisfied). All responses are summed to create a total score with a possible score range of 31-155. This measure does not provide cut off scores.

	In a systematic review of job satisfaction measures looking at twenty-nine measures, the MMSS was found to be one of seven measures that meet the quality criteria of the review, considering reliability and construct validity (Van Saane et al., 2003).
The Index of Work Satisfaction (IWS) Part B, (Stamps, 1997)	The Index of Work Satisfaction (IWS) Part B is a self-report measure of job satisfaction used within nursing staff. This measure includes the following domains: task requirement, professional status, pay, organizational policies, autonomy and interaction. The measure consists of 44 items, which are scored on a 7-point Likert scale (1=agree to 7= disagree). Possible scores range from 44 to 308. Higher scores indicate higher job satisfaction. Limited information has been found regarding the validity of the IWS.
Job satisfaction measure unclear – Bespoke (Tyler & Cushway, 1998)	Method of job satisfaction assessment not specified.
Resilience	
Resilience Scale - 14 (RS-14, Wagnild & Young, 2011)	The 14 Item Resilience Scale provides and assessments of an individual's overall resilience. Participants are asked to read a set of statements and choose the response that best describes their experience, using a 7-point Likert scale (1= strongly disagree to 7= strongly agree). Total scores range from 14 to 98. Higher scores equate to a greater sense of resilience. *Total score interpretation:* Very low (14-56) Low (57-64) 'On the low end' (56-73) Moderate (74-81) Moderately high (82-90) High (91-98) The RS-14 has been found to have appropriate psychometric properties across a sample of non-clinical (undergraduate students) and clinical samples (those seeking mental health support following a traumatic incident; Aiena et al., 2015).
The Resilience Scale (Wagnild and Young, 1993)	The Resilience Scale is a 25-item self-report measure that assesses an individual's sense of resilience. Responses are provided on a 7-point Likert scale (strongly disagree to strongly agree). Total scores range from 25 to 175. The measure incorporates five-subscale: perseverance, self-reliance, purposeful life, equanimity, and existential aloneness. *Total score interpretation:*

	25-100= very low 101-115= low 116-130= moderately low 131-145= moderately high 145-160= high 161-175= very high Research reports this measure as being both valid and reliable (Ahern et al., 2006; Windle et al., 2011).
Connor Davidson Resilience Scale (Connor & Davidson, 2003)	The Connor Davidson Resilience Scale (CD-RISC) is a 25-item self-report questionnaire that considers an individual's resilience to respond to life stressors. Participants respond on a 5-point Likert (0=not true at all, 4=true nearly all of the time). Total scores range from 0 to 100. Higher scores indicate a greater sense of resilience. A review of psychometrics assessing resilience found the CD-RISC to be one of the best measures in terms of quality and validity (Windle et al., 2011)
Adversity Response Profile (ARP, Stoltz, 1997)	The Adversity Response Profile is a self-report questionnaire assessing an individual's style of responding in the face of stressors. The ARP is a measure of resilience, describing the extent to which an individual is able to prevail over adversity. The measure has been widely used within business settings. The ARP provides the participant with 14 scenarios and the participant responds using a 5-point Likert scale (1=complete control to 5=no control). Only 10 items are scores. Questions correspond to four domains: • Control – whether an individual perceives that they have control over the challenges they face. Greater scores indicate a greater sense of control. Sc*ore interpretation:* 10-32= low, 33-40= moderate, 41-50= high • Ownership – Assess the extent to which and individual can learn from challenges and take responsibility for their actions. Sc*ore interpretation:* 10-36= low, 37-42= moderate, 43-50= high. • Reach – the extent to which individuals perceive challenges as extending into all aspects of their lives, contributing to feelings of overwhelm, or as see's events as isolated. Sc*ore interpretation:* 10-31= low, 32-41= moderate, 42-50= high. • Endurance – considers the perceived impact and temporal nature of stressors, i.e., whether an individual perceives a stressor as having long lasting impacts on their life or seeing stressors as isolated. Sc*ore interpretation:* 10-28= low, 29-36= moderate, 37-50= high. A total adversity quotient score is produced from the four domains. Sc*ore interpretation:* 40-117= low, 118- 134= moderately low, 135-160= moderate, 161-177= moderately high, 178-200= high. Matore et al (2020) evidence good psychometric properties of this measures.

Professional Quality of Life	
Professional Quality of Life	Stamm (2010, pg. 8) defines PQOL as 'the quality one feels in relation to their work as a helper'. The ProQOL is one of the most commonly used measure of PQOL. Iterations of the ProQOL encompasses four key variables, including: • Compassion satisfaction (CS): Experiencing pleasure from doing your job well. • Burnout: Feeling hopeless and futile in your efforts to create change and carry out your job effectively. • Compassion fatigue (CF): CF describes the exhaustion and negative impact on mood associated with feelings of burnout. • Secondary Traumatic Stress (STS): STS considers the impact of exposure to traumatic and stressful events through the course of your work. Participants provide responses on 5-point scale (1=never to 5= very often). Each subscale is scored separately. Despite the widespread use of this measure within the literature, critical enquiries into the ProQOL's psychometric properties have raised concerns regarding the validity of this measure within samples of nurses and child protection workers (Geoffrion et al., 2019; Hagan, 2019; Hemsworth et al., 2018). In particular, the burnout and secondary traumatic stress subscales have demonstrated limited construct validity. Research has recommended that the scale be revised to address these challenges and as such, the validity of this measure and results within this review should interpreted with caution.

Appendix E - Quality assessment summary table.

Final AXIS Quality Assessment Summary																				
	Intro	**Method**										**Results**					**Discussion**		**Other**		**Total**
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	
Dearth (2016)	✔	✔	✗	✔	✔	✗	✗	✔	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	DK	✔	14
English (2021)	✔	✔	✗	✔	✔	✗	✗	✔	✔	✔	✔	✔	✔	✗	✗	✔	✔	✔	DK	✔	13
Little (2016)	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	DK	✗	15
Matos et al (2010)	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	✗	✗	✔	✔	✔	✔	DK	✔	15
Oberlander (1990)	✔	✔	✗	✔	✔	✗	✔	✔	✔	✔	✔	✔	✗	✗	✗	✗	✔	✔	DK	✔	8
Sukut et al (2021)	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	✗	✗	✗	✔	✔	✔	✗	✔	17
Thomas – Sharksnas (2003)	✔	✔	✔	✔	✔	✔	✗	✔	✔	✔	✔	✔	✗	✗	✔	✔	✔	✔	DK	DK	16
Tyler & Cushway (1998)	✔	✔	✗	✔	✔	✗	✗	✗	✗	✔	✗	✔	✔	✗	✔	✔	✔	✗	DK	DK	9
Zeidner et al (2013)	✔	✔	✗	✔	✔	✗	✗	✔	✔	✔	✔	✔	DK	✗	✔	✗	✔	✔	DK	✔	13
Zheng et al (2013)	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	✔	✔	✗	✗	✗	✔	✔	✔	DK	✔	16

Notes:

Q1 = Were the aims/objectives of the study clear?; Q2 = Was the study design appropriate for the stated aims?; Q3 = Was the sample size justified?; Q4 = Was the target/reference population clearly defined?; Q5 = Was the sample frame taken from an appropriate population base so that is closely represented the target/reference population under investigation?; Q6 = Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?; Q7 = Were measures undertaken to address and categorise non-responders?; Q8 = Were the risk factors and outcome variables measured appropriate to the aims of the study?; Q9 = Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously? Q10 = Is it clear what was used to determined statistical significance and/or precision estimates?; Q11 = Were the methods (including statistical methods) sufficiently described to enable them to be repeated?; Q12= Were the basic data adequately described?; Q13= Does the response rate raise concerns about non-response bias (Reverse Scored); Q14 = If appropriate, was information about non-responders described?; Q15= Were the results internally consistent?; Q16 = Were the results presented for all the analyses described in the methods?; Q17= Were the authors' discussions and conclusions justified by the results?; Q18= Were the limitations of the study discussed?; Q19 = Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results (Reverse Scored)?; Q20 = Was ethical approval or consent of participants attained?

NR = Not reported.

Appendix F – Submission Guidelines for the Psychiatric Rehabilitation Journal

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.

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To submit to the editorial office of Sandra G. Resnick, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.

SUBMIT MANUSCRIPT

Articles and brief reports published in the journal should include implications for practice and/or policy to promote the translation of research findings into useful applications for the field.

Psychiatric Rehabilitation Journal gives priority to submissions that are clearly applicable to the development, administration, and delivery of psychiatric rehabilitation services and those that inform the development of person-centered systems that support and broaden psychiatric rehabilitation approaches.

Data-driven articles that report results of rigorous research such as randomized controlled trials are especially welcome.

We will also consider:

- quasi-experimental studies such as pre-post evaluations of services if they are adequately powered, with preference to those with comparison groups;
- relevant measurement development or testing research;
- high-quality qualitative studies that follow established procedures for qualitative research including well-justified sample sizes and clearly documented analytic strategies; and
- impactful comprehensive literature reviews, policy studies, and conceptual papers which significantly advance the theory or practice of psychiatric rehabilitation through literature synthesis.

Upon receipt, manuscripts will be reviewed for originality, timeliness, importance to the field, and alignment with the mission of the journal.

Manuscripts that do not significantly contribute to the literature in psychiatric rehabilitation may be returned without review.

Data-driven manuscripts are evaluated by the *Psychiatric Rehabilitation Journal* editorial team according to the following criteria:

- material is original and timely
- writing is clear, concise
- appropriate study methods are used
- data are valid

- conclusions are reasonable and supported by study results
- findings are relevant and make a contribution to the field of psychiatric rehabilitation

Conceptual manuscripts are evaluated according to the following criteria:

- material is original and timely
- claims made by authors are clear and understandable
- claims have a clearly articulated theoretical basis and are adequately substantiated (e.g., through facts and statistics, prior literature, etc.)
- claims are relevant and make a contribution to the field of psychiatric rehabilitation
- the manuscript significantly advances the theory or practice of psychiatric rehabilitation through literature synthesis

From these criteria, the editors select papers for peer review. Papers of insufficient priority or quality are promptly rejected.

Masked review

This journal has a policy of masked review for all submissions.

A title page should include all authors' names and institutional affiliations as well as contact information for the corresponding author, including mailing address, email, and telephone.

The manuscript should include a blinded title page, omitting author information, but maintaining the title of the manuscript and an abbreviated title to serve as the running head on each page of the manuscript.

Authors must make every effort to see that the manuscript itself contains no clues to the authors' identities. This includes removing the names of academic or other institutions from human subjects assurance statements, and references to authors' prior publications that include citations revealing their identities.

Manuscripts are sent for peer review to at least two independent reviewers.

A separate statistical review is obtained when a reviewer or the editors request it. Authors are informed about the review decision after the review process is completed.

Manuscripts that are not rejected after the first round of peer review usually require revision and re-review by one or more of the original reviewers.

Revised manuscripts must conform to the general requirements listed below, including specified word counts, and word counts must be adhered to in revised submissions.

Psychiatric Rehabilitation Journal is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

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The APA *Publication Manual* (7th ed.) stipulates that “authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study.” In the spirit of transparency and openness, *Psychiatric Rehabilitation Journal* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.

Corresponding authors will be asked to identify the contributions of all authors at initial submission according to this taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an Author Contributions Statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.

CRediT includes 14 contributor roles, as described below:

- **Conceptualization:** Ideas; formulation or evolution of overarching research goals and aims.
- **Data curation:** Management activities to annotate (produce metadata), scrub data, and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later reuse.
- **Formal analysis:** Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.
- **Funding acquisition:** Acquisition of the financial support for the project leading to this publication.
- **Investigation:** Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.
- **Methodology:** Development or design of methodology; creation of models.
- **Project administration:** Management and coordination responsibility for the research activity planning and execution.
- **Resources:** Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.
- **Software:** Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
- **Supervision:** Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
- **Validation:** Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
- **Visualization:** Preparation, creation, and/or presentation of the published work, specifically visualization/data presentation.
- **Writing—original draft:** Preparation, creation, and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
- **Writing—review and editing:** Preparation, creation, and/or presentation of the published work by those from the original research group, specifically critical review, commentary, or revision—including pre- or post-publication stages.

Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author. More information about CRediT and definitions of contributor roles can be found on the CRediT website.

Manuscript preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Abstract and keywords

All research manuscripts should include a structured abstract containing a maximum of 250 words.

Abstracts that are incomplete or do not conform to the following structure will be returned to the authors for revision.

- **Objective:** the primary purpose of the article should be clearly stated.
- **Methods:** this section must state the sample size and nature of subjects, data sources, study design, how dependent variables were measured and the specific analytic techniques (statistical tests, qualitative analysis strategy) that were used.
- **Results:** primary findings should be stated clearly and concisely, describing statistical results as appropriate.
- **Conclusions and Implications for Practice:** implications of the findings for the field of psychiatric rehabilitation, mental health, or recovery should be clearly stated and future directions may be described.

All conceptual manuscripts should include a structured abstract with the following required sections:

- **Objective:** the primary purpose of the article should be clearly stated.
- **Method:** this section should describe the methodology used and type of analysis conducted. Here, authors should note the theoretical basis as well as sources of data used to support their claims.
- **Findings:** primary findings should be stated clearly and concisely.
- **Conclusions and Implications for Practice:** implications of the findings for the field of psychiatric rehabilitation, mental health, or recovery should be clearly stated and future directions may be described.

Abstracts for brief reports should not exceed 150 words.

Please supply up to five keywords or brief phrases after the abstract.

Impact and implications statement

Psychiatric Rehabilitation Journal publishes impact and implications statements (also referred to as public significance statements) in addition to regular abstracts. This feature allows authors to support *Psychiatric Rehabilitation Journal's* efforts to increase dissemination and usage of research findings by larger and more diverse audiences.

At the start of each paper, the authors should provide one to three sentences, approximately 30 to 70 words long, with the header "Impact and Implications," that answer the following questions: What did the study find? Why are these findings important to the audience you are trying to reach (e.g., practitioners, policy makers, news media, or other parties)? The impact statement is intended to summarize the significance of the study's findings for a general audience. Please do not use list formatting (e.g., bullet points); the impact statement should use full sentences.

Please refer to Guidance for Translational Abstracts and Public Significance Statements to help you write your statement.

Your Impact and Implications Statement should be placed below the abstract in the manuscript file you upload during the submission process.
Authors of accepted manuscripts will be encouraged to promote their published research on social media, such as Twitter and Facebook, using this impact and implications statement.

Manuscript contents

Manuscripts must follow the guidelines outlined in the *Publication Manual of the American Psychological Association* (7th edition) and APA's Journal Manuscript Preparation Guidelines.
The method section of each paper reporting quantitative or qualitative data must include the specific years when the data were collected in order to provide context for the findings. These methods sections should also contain a detailed description of the study participants. Please include the following variables:

- age
- sex
- gender identity
- racial and ethnic identity
- sexual orientation

Other important demographic variables should be included as relevant to the work provided. Although not required, *Psychiatric Rehabilitation Journal* encourages reporting of socio-economic status (SES) or other variables related to income (including entitlements) and financial status (e.g., percentage of participants living in poverty).
The method section also must include a statement describing how informed consent was obtained from the participants (or their guardians) if appropriate, and indicate that the study was conducted in compliance with an appropriate Internal Review Board.
Authors must review and follow principles of bias-free language in APA Journals. Language should reflect the fundamental values of the psychiatric rehabilitation field, including respecting the worth and dignity of all persons and groups, honoring and advocating for individual rights and interests, and opposing discrimination in services and in society.

Manuscript length

Manuscript Length Articles should not exceed 5,000 words; Brief Reports should not exceed 1,500 words, and Letters to the Editor should not exceed 300 words. Word counts are exclusive of tables, figures, and references. All revisions must adhere to these word limits.
Authors must include the word count (exclusive of tables, figures, and references) on the title page of their manuscripts.

Formatting

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 APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

References

List references in alphabetical order. 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

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- an additional $600 for the second figure
- an additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

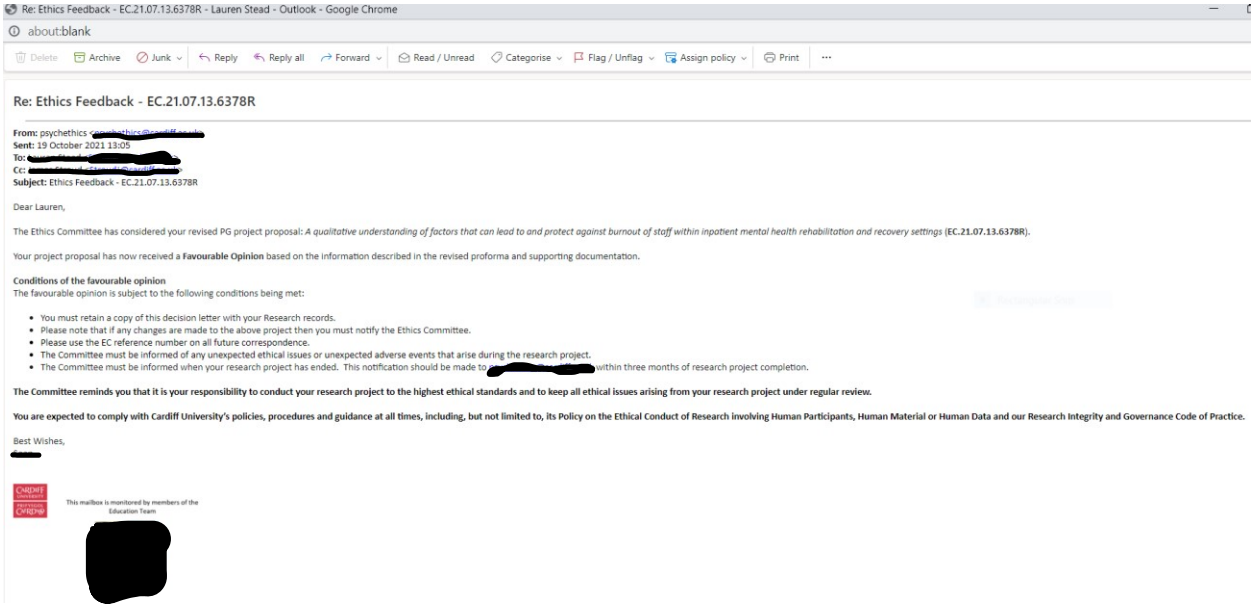
- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix G – School of Psychology Research Ethics Committee



Re: Ethics Feedback - EC.21.07.13.6378R - Lauren Stead - Outlook - Google Chrome

about:blank

Delete | Archive | Junk | Reply | Reply all | Forward | Read / Unread | Categorise | Flag / Unflag | Assign policy | Print | ...

Re: Ethics Feedback - EC.21.07.13.6378R

From: psychethics [redacted]
Sent: 19 October 2021 13:05
To: [redacted]
Cc: [redacted]
Subject: Ethics Feedback - EC.21.07.13.6378R

Dear Lauren,

The Ethics Committee has considered your revised PG project proposal: *A qualitative understanding of factors that can lead to and protect against burnout of staff within inpatient mental health rehabilitation and recovery settings* (**EC.21.07.13.6378R**).

Your project proposal has now received a **Favourable Opinion** based on the information described in the revised proforma and supporting documentation.

Conditions of the favourable opinion
The favourable opinion is subject to the following conditions being met:

- You must retain a copy of this decision letter with your Research records.
- Please note that if any changes are made to the above project then you must notify the Ethics Committee.
- Please use the EC reference number on all future correspondence.
- The Committee must be informed of any unexpected ethical issues or unexpected adverse events that arise during the research project.
- The Committee must be informed when your research project has ended. This notification should be made to [redacted] within three months of research project completion.

The Committee reminds you that it is your responsibility to conduct your research project to the highest ethical standards and to keep all ethical issues arising from your research project under regular review.

You are expected to comply with Cardiff University's policies, procedures and guidance at all times, including, but not limited to, its Policy on the Ethical Conduct of Research involving Human Participants, Human Material or Human Data and our Research Integrity and Governance Code of Practice.

Best Wishes,
[redacted]

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD

This mailbox is monitored by members of the Education Team

[redacted]

Appendix H – Research Integrity, Governance and Ethics team (RESGOV) ethical approval

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Research and Innovation Services
Gwasanaethau Ymchwil ac Arloesi

Cardiff University
McKenzie House, 7th Floor
30-36 Newport Road
Cardiff CF24 0DE
Wales UK

Tel +44(0)29 2087 5834
Fax +44(0)29 2087 4189

Prifysgol Caerdydd
Tŷ McKenzie, 7fed Llawr
30-36 Heol Casnewydd
Caerdydd CF24 0DE
Cymru, Y Deyrnas Unedig

Ffôn +44(0)29 2087 5834
Ffacs +44(0)29 2087 4189

17th August 2021

Dr [redacted]
School of Psychology
Cardiff University
11th Floor Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Dr [redacted]

Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services

I understand that you are acting as Chief Investigator for the above project.

I confirm that Cardiff University agrees in principle to act as Sponsor for the above project, as required by the UK Policy Framework for Health and Social Care Research.

Scientific Review
I can also confirm that Scientific Review has been obtained from: the Clinical Psychology Doctoral Programme research project proposal review service.

Insurance
The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals
On completion of your IRAS form (required for HCRW permission), you will be required to obtain signature from the Research Governance team for the 'Declaration by the Sponsor Representative'. Please note that you are also required to provide the Organisation Information Document and Schedule of Events to the Research Governance team for review prior to submission to HCRW.

Please then submit the project to the following bodies for approval:

- A Cardiff University School Research Ethics Committee (SREC)
- Health & Care Research Wales (HCRW)- to arrange HCRW Approval for Welsh NHS sites.

The University is considered to have accepted Sponsorship when Research and Innovation Services has received evidence of the above approvals. **Responsibility for providing the Local Information Pack to NHS organisations is delegated from the Sponsor to the Chief Investigator (or their appropriate delegate). Once an NHS organisation has confirmed capacity and capability, responsibility lies with the Chief Investigator (or their appropriate delegate) to follow an appropriate 'green light' procedure to open the study at that Site.**

Roles and Responsibilities

As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the UK Policy Framework for Health and Social Care Research. In accordance with the University's Research Integrity & Governance Code of Practice, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfil their delegated roles including ensuring adequate supervision, support and training.

If your study is adopted onto Health & Care Research Wales Clinical Research Portfolio you are required to upload recruitment data onto the portfolio database.

Contracts

- The following contracts will be in place prior to research commencing:
  - Model Non-Commercial Participant Identification Centre Agreements (mNC-PICA) with Cwm Taf Health Board, Hywel Dda Health Board and Swansea Bay Health Board.

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

- register clinical trials in a publicly accessible database before recruitment of the first participant and ensure that the information is kept up to date
- ensure you are familiar with your responsibilities under the UK Policy Framework for Health and Social Care Research;
- undertake the study in accordance with Cardiff University's Research Integrity & Governance Code of Practice (available on the Cardiff University Staff and Student Intranet) and the principles of Good Clinical Practice;
- ensure the research complies with the General Data Protection Regulation 2016/679;
- where the study involves human tissue, ensure the research complies with the Human Tissue Act and the Cardiff University Code of Practice for Research involving Human Tissue (available on the Cardiff University Staff and Student Intranet);
- inform Research and Innovation Services of any amendments to the protocol or study design, (including changes to start /end dates) and submit amendments to the relevant approval bodies;
- respond to correspondence from the REC, HRA/HCRW and NHS organisation R&D offices within the required timeframes;
- co-operate with any audit, monitoring visit or inspection of the project files or any requests from Research and Innovation Services for further information.

You should quote the following unique reference number in any correspondence relating to Sponsorship for the above project:

SPON1856-21

This reference number should be quoted on all documentation associated with this project.

Yours sincerely

[redacted]

Mr [redacted]
Acting Head of Research Integrity, Governance and Ethics
Direct line: [redacted]
Email: [redacted]

TO WHOM IT MAY CONCERN

1st August 2021

Dear Sir/Madam

CARDIFF UNIVERSITY AND ALL ITS SUBSIDIARY COMPANIES

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:

EMPLOYERS' LIABILITY

Certificate No.	Y016458QBE0121A/165
Period of Indemnity	1st August 2021 to 31st July 2022
Limit of Indemnity	£50,000,000 any one event unlimited in the aggregate
Includes	Indemnity to Principals
Cover provided by	QBE UK Limited and Excess Insurers

PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM165/13
Period of Indemnity	1st August 2021 to 31st July 2022
Includes	Indemnity to Principals
Limit of Indemnity	£50,000,000 any one event and in the aggregate in respect of Products Liability and unlimited in the aggregate in respect of Public Liability
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE UK Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

[redacted]

For U.M. Association Limited

[redacted]

Appendix I - Integrated Research Application System (IRAS) and Health Research Authority ethical approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr [redacted]
Senior Clinical Tutor
Cardiff Unviersity
South Wales Doctoral Programme in Clinical Psychology , Cardiff University
Tower Building, 70 Park Place, Cardiff
CF10 3ATN/A

Email: [redacted]

23 November 2021

Dear Dr [redacted]

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services.**
IRAS project ID:	**295960**
Protocol number:	**Spon No: SPON1856-21**
REC reference:	**21/HCRW/0043**
Sponsor	**Cardiff University - Research Integrity, Governance and Ethics Team Research and Innovation Servic**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **295960**. Please quote this on all correspondence.

Yours sincerely,

[redacted]

Approvals Specialist

Email: [redacted]

Copy to: *Ms* [redacted]

Appendix J – Ethical Approval from all Health Boards and Research and Development Departments

GIG CYMRU NHS WALES [redacted]

[redacted]

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg. We welcome correspondence in Welsh or English.

Research and Development Department
[redacted]

Date: 4th April 2022

[redacted]
Trainee Clinical Psychologist
School of Psychology
Doctoral Programme in Clinical Psychology
Cardiff University
11th Floor Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Ms [redacted]

Letter of access for research – NHS to [redacted]

STUDY: **Burnout within Mental Health Inpatient Rehabilition Setttings**
REF: **295960**

This letter should be presented to each participating organisation before you commence your research at that site.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below.

This right of access commences on **4th April 2022** and ends on **30th September 2022** unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with [redacted] are satisfied that the research activities that you will undertake are commensurate with the activities you undertake for your employer.

Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to [redacted] that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in [redacted] Evidence of checks should be available on request.

[redacted]

You have a right of access to conduct such research activities as outlined in the study procotol for research from this organisation. Please note that you cannot start the research until the Principal Investigator/Sponsor for the research project has received a letter from [redacted] confirming the capacity and capability to conduct the project.

You are considered to be a legal visitor to [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by [redacted] or this organisation to employees and this letter does not give rise to any other relationship between you and [redacted] or this organisation, in particular that of an employee.

While undertaking research through [redacted] you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions of your nominated manager [redacted] in the organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [Insert organisation] or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating [Insert organisation] prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[redacted] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that [redacted] accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend [redacted] terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of [redacted] or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation.

Yours sincerely

[redacted]

[redacted]
Research Facilitator
[redacted]

cc:
[redacted]
Senior Programme Administration Manager
Cardiff University
[redacted]

[redacted]

Your Ref/ eich cyf [redacted]
Our ref/ ein cyf: [redacted]
Date/ dyddiad: 01/12/2021
Tel/ ffôn: [redacted]
Fax/ ffacs: [redacted]
Email/ ebost: [redacted]
Dept/ adran: Research & Development Dept

Ms [redacted]
Trainee Clinical Psychologist
School of Psychology,
Doctoral Programme in Clinical Psychology,
Cardiff University,
11th Floor Tower Building,
70 Park Place,
Cardiff,
CF10 3AT

Dear Ms [redacted]

Re: LETTER OF ACCESS FOR RESEARCH

[redacted]	**Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services.**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through [redacted] for the purpose and on the terms and conditions set out below. This right of access commences on **01/12/2021** and ends on **30/09/2022** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to [redacted] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions within this NHS organisation or those given on his/ her behalf in relation to the terms of this right of access.

Cyfeiriad Dychweld/Return Address:
[redacted]

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [redacted] policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[redacted] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority (ISA) registration in-line with the phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA-registered, your employer will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

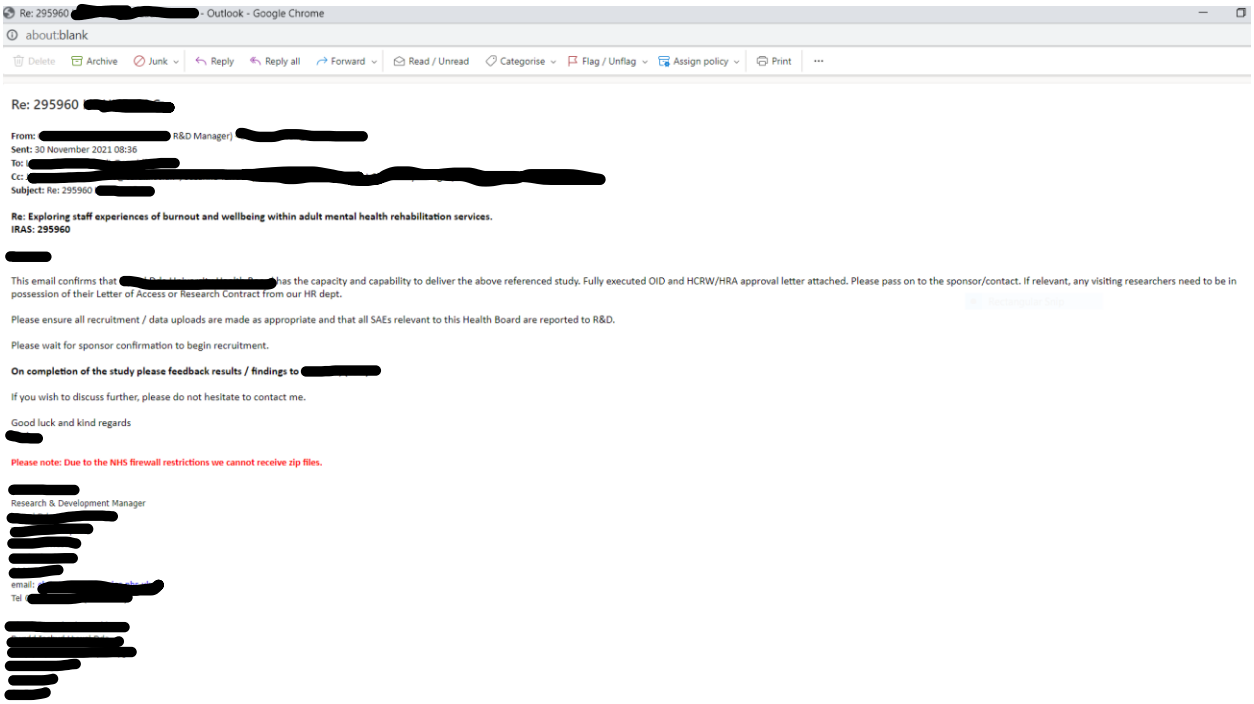
Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours Sincerely

[redacted]

R&D Officer



Re: 295960 [redacted] - Outlook - Google Chrome

about:blank

Delete | Archive | Junk | Reply | Reply all | Forward | Read / Unread | Categorise | Flag / Unflag | Assign policy | Print | ...

Re: 295960 [redacted]

From: [redacted] R&D Manager) [redacted]
Sent: 30 November 2021 08:36
To: [redacted]
Cc: [redacted]
Subject: Re: 295960 [redacted]

Re: Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services.
IRAS: 295960

[redacted]

This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. Fully executed OID and HCRW/HRA approval letter attached. Please pass on to the sponsor/contact. If relevant, any visiting researchers need to be in possession of their Letter of Access or Research Contract from our HR dept.

Please ensure all recruitment / data uploads are made as appropriate and that all SAEs relevant to this Health Board are reported to R&D.

Please wait for sponsor confirmation to begin recruitment.

On completion of the study please feedback results / findings to [redacted]

If you wish to discuss further, please do not hesitate to contact me.

Good luck and kind regards

[redacted]

Please note: Due to the NHS firewall restrictions we cannot receive zip files.

[redacted]
Research & Development Manager
[redacted]
email: [redacted]
Tel [redacted]
[redacted]

GIG CYMRU NHS WALES

[redacted]

Ein cyf/Our ref: [redacted]
Gofynnwch am/Please ask for: [redacted]
Rhif Ffôn /Telephone: [redacted]
E-bost/E-mail: [redacted]
Dyddiad/Date: 24th September 2021

PRIVATE AND CONFIDENTIAL

[redacted]
Trainee Clinical Psychologist
School of Psychology
Doctoral Programe in Clinical Psychology
Cardiff University
11th Floor Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Ms [redacted]

Letter of access for research
295960

This letter should be presented to each participating organisation before you commence your research at that site.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 24th September 2021 and ends on 30th September 2022 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating organisation. The organisation is satisfied that the research activities that you will undertake in the organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation. Evidence of checks should be available on request.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from

[redacted]

us giving the organisation permission to conduct the project.

You are considered to be a legal visitor to the organisation's premises. You are not entitled to any form of payment or access to other benefits provided by the organisation to employees and this letter does not give rise to any other relationship between you and the organisation, in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your employer [redacted] but you are required to follow the reasonable instructions of your nominated manager [redacted], in the organisation or those given on his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [Insert organisation] or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisation's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the organisation in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisation's premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 2018. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 2018. Any breach of the Data Protection Act 2018 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation accepts no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of

any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation.

Yours sincerely

[redacted]

Senior Workforce Manager

Copied to: [redacted] **R&D Manager,** [redacted] **Senior Programme Administration Manager, Cardiff University**

Appendix K – Interview schedule

Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services

Study Objectives:

This study aims to gain insight into the experiences of burnout and wellbeing for staff working within adult inpatient rehabilitation and recovery services, through qualitative exploration.

To add to the research base considering the contributing and protective factors for burnout for rehabilitation staff.

Thanks for taking the time to meet with me today.

I wanted to ask you some questions about your experiences of burnout and wellbeing at work. I will ask you about different aspects of your role and please share as much as you feel comfortable to discuss. It is important that you know that what you share will remain confidential. I will have access to the personally identifiable information you provide. Dr James Stroud and Dr Victoria Samuel from Cardiff University will also have access to audio recordings and transcripts of recordings to support with the analysis of the data and for supervision purposes. If you would prefer that either of these clinicians do not hear your audio recording for any reason, please let me know and I will ensure this remains confidential.

Data will be gained from participants across three mental health rehabilitation settings in South Wales. Information will be pooled, anonymised and analysed so that we can better understand the factors that influence burnout and wellbeing in staff working within inpatient mental health rehabilitation settings. Quotes from all the information gained will be used to illustrate the themes we have found but anything identifiable will be removed. It is hoped that these findings will be published and contribute to the research base in this field. Finalised data will also be shared with ward managers to help contribute to their understanding of burnout in this area and how best they can support their staff.

Throughout the course of the interview, should I have concerns about the safety of yourself or others, I may need to share information with appropriate services or people. Where possible, I will raise any concerns with you so that we can discuss who may be best placed to provide support. This will be shared with the people or service that would be best placed to support you.

The interview will take up to an hour and a half, but you are welcome to take a break or stop at any time. I'll be recording the session, so I have an accurate account of what you have said. The recording will be deleted when this has been transcribed.

When answering the following questions, please consider how they apply to your current role within mental health inpatient rehabilitation services.

The title of the study is around staff experiences of burnout and wellbeing. However, I am interested in the whole range of emotional experiences you may have at work and what things impact upon this, rather than diagnostic labels.

1. **To start, can you tell me a little bit about your job role, please?**
How long have you been working in this role? Your contact with service users/the support you provide? How have you found working in this role? Has it been as you expected? What is your experience of working in other healthcare settings? How does this role differ?

2. **Are there aspects of the job that you find particularly rewarding?** How do you know if you have done a good job? Are there things that you notice about the job that nourish you and allow you to keep going? When you think about these things, do you notice any commonalities?

3. **Can you tell me a bit about aspects of your job that you, or others, find most challenging or that can be stressful?** When you think about these things, do you notice any commonalities?

4. **When these challenges arise, does this impact on you/others? If so, what do you notice?** Physically, psychologically, practically.

5. **What keeps you going when things feel tough?** You may wish to think about all aspects of the role, such as client work, teams, systems etc.

6. **What things do you notice yourself doing, psychologically or actively, to manage these challenges?** How does this impact your ability to cope with these challenges?

7. **Burnout can be described as physical and mental exhaustion resulting from excessive or prolonged stress. It is widely considered that there are three primary factors that may suggest that someone is experiencing burnout. These are emotional exhaustion, depersonalisation and a reduced sense of accomplishment (Maslach, 2001 and Maslach & Jackson, 1981). Is staff 'burnout' something that's ever talked about on your ward or something that you notice in yourself or your colleagues? What does this experience mean to you?** How would you describe this experience (prompt for thoughts, feelings and behaviours)?

8. **Do you feel there is a difference between stress and burnout? If so, how do you differentiate between these two experiences?** Would/do you respond to these experiences differently and if so, in what way?

9. **What do you feel this range of experiences have taught you?**
Prompt - personally, professionally, work with clients/teams. Are there any ways in which your approach to managing your wellbeing has changed throughout your time on working on the ward?

10. **Having reflected on these different experiences, what are the most helpful things that you feel could be done, practically or psychologically, that may help you/other to cope with the challenges of the role?**
Prompt – Personal factors, systemic factors. Would do you feel could be done to support staff in this setting? Are there things that are already in place that you have found helpful?

11. **When thinking about the things we have discussed, is there something else you would like to add?**

12. **Do you have any questions you would like to ask me?**

Appendix L– Study Poster

Health Board logo

Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

What is the study about?	Who would we like to speak with?
Burnout is the feeling of physical and mental exhaustion and is prevalent across staff working within mental health services. However, the experience of staff within inpatient mental health rehabilitation services is currently under researched. Building our understanding of these experiences will support the development of tailored support packages to improve wellbeing at work.	• Permanent members of staff, working within an inpatient adult mental health rehabilitation ward and who have been working in their role for a minimum of 1 year. • Those working a minimum of 30 hour per week. • Staff in which a minimum of half of their role consists of clinical contacts. • Staff with client facing roles across all professions.
What will participating look like?	**How to participate…**
You will be asked to provide some demographic information and complete an interview (up to 1 ½ hours) about your experiences of burnout and wellbeing at work. All those who participate in the interviews will be entered into a prize draw to win high street vouchers (1st prize=£50, 2nd=£30 and 3rd=£20).	• Please direct any informal queried to any of the contacts listed below. • To receive a copy of the participant information sheet (which includes more detailed information regarding the study) and to register your interest in participating, please contact Lauren Stead using the email address below.

Lauren Stead
Trainee Clinical Psychologist at Cardiff University
[redacted]

Dr James Stroud
Clinical Psychologist at Cardiff University
[redacted]

Dr [redacted]
Clinical Psychologist
[redacted]

Appendix M – Participant Information Sheet

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Participant Information Leaflet

Thank you for your interest in this research project. Please find below, some information about what your participation will involve and how to proceed should you wish to participate.

This project will be submitted as part of a professional qualification in Clinical Psychology, with the South Wales Clinical Psychology Doctoral Programme.

Study

Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services.

Information about the study

Burnout is described as feeling both physically and mentally exhausted as a result of experiencing long periods of stress. Burnout has been found to be a common experience within mental health settings, with between 21-67% of staff reporting signs of burnout (Morse et al, 2012). However, little is known about how this is experienced by those within inpatient adult mental health rehabilitation settings.

To understand this further, we aim to interview staff from adult mental health rehabilitation and recovery inpatient settings across South Wales, to share their experiences. We hope that this will add to the current research base, increase understanding of staff experiences within these settings and lead to tailored interventions to support staff.

What will taking part involve?

As part of the research, you will be asked to complete a demographic questionnaire and consent form. Demographic information will help ensure that we speak to members of staff with a range of experiences. You will be invited to attend an interview about your experiences of burnout and wellbeing at work. This will take up to an hour and a half to complete. Interviews will take place remotely using video conferencing or telephone. This will mitigate the risk of infection in light of COVID-19. We encourage you to find somewhere comfortable, quiet and confidential to complete the interview. The possibility for face-to-face interviews can be discussed and will only take place if agreeable by you, the research team and in line with both national and health board policy. A time (and if appropriate, location) that is mutually convenient for you and the researcher will be negotiated to complete the interview.

The interview will be recorded using a secure dictaphone or ipad and will be accessed by the academic researchers (a student and tutors from Cardiff University who do not work within any of the participating wards) and confidential transcribing service. Only audio, rather than video will be recorded. When transcribed, your responses will be anonymised and care will be taken to ensure that no personally identifiable information will be included in the study findings and that quotes cannot be linked back to any participant. Your recording and transcript will be allocated a code number and will be stored separately from your identifiable information, such as that included within your consent form.

Data gathered from all participants will be collated and themes developed to inform our research questions. Anonymised, verbatim quotes from a range of participant responses will be used to illustrate key themes within the data. These will be included as part of research feedback to participants and ward staff, as well as academic publications and Cardiff University thesis submission

To check the validity of our identified themes, we would like to invite you to provide your feedback via a focus group or individual feedback. You will be contacted by the research team following data analysis. During the interview, you will be asked if you wish to receive a copy of the finalised results and if so, these will be sent via the contact information you provide. A summary of the results will also be disseminated to participating ward managers.

How will your data be stored and confidentiality ensured?

All data you provide will be held securely, in accordance with General Data Protection Regulation (GDPR), and in line with Cardiff University records retention policy, for 15 years. After this time, your raw data will be destroyed. All data will be stored on Cardiff University secure servers. Paper documents will be scanned for storing and the original, destroyed.

We will need to use information about you for the purposes of this research. This will include sensitive information such as your name, age, gender, information about your job (place of work, contracted hours, permanent/temporary status of employment, profession and banding, duration working in current service, weekly hours of client facing contact) and contact information (email address and contact number). This information will be used to ensure you fit the criteria for the project and to make contact with you. The lead researcher will process your information and allocate a code number to your interview recording and transcript to ensure confidentiality. Documents containing identifiable information (such as your consent form) will be stored on secure servers and separately from your interview data. Your raw data will be accessible to lead researchers who do not work on the participating wards. People who do not need to know who you are will not be able to see your identifiable information.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason. We will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
- If you agree to take part in this study, you will have the option to be contacted to feedback about the conclusions of the research. You can consent or decline to engage with this follow up without giving a reason and can change your mind at any time. We will keep the information that we already hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- by asking one of the research team (please see section labelled 'study team details')
- by viewing the Cardiff University Data Protection Policy and Privacy Notices: [redacted]
- by contacting the Cardiff University Data Protection Officer by email: [redacted] or in writing to: Assurance Services, Cardiff University, Friary House, Greyfriars Road, Cardiff CF10 3AE
- Cardiff University School of Psychology Research Ethics Committee: [redacted] – Psychology Research Ethics Committee, School of Psychology, Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT - [redacted]

What to consider before deciding whether to participate or not?

Some participants may benefit from the opportunity to talk through their experiences at work and the opportunity to contribute to the evidence base within the area of staff burnout / wellbeing.

All participants will be entered into a draw to win vouchers from a discrete list of high street stores; 1st place - £50 voucher, 2nd place - £30 voucher, 3rd place - £20. We will require your email address so that we can make contact with you should you win.

Some people may find talking about challenges experienced at work, difficult. Support will be provided by the interviewer and participants will be signposted to support services where appropriate. Information regarding sources of support can also be found at the bottom of this information sheet.

Risks associated with COVID-19 will be managed through the use of remote communication where possible. Should face-to-face be deemed appropriate by all parties, care will be taken to adhere to infection control procedures.

Your participation in this research is entirely voluntary. You can decline to participate, without giving a reason. If you decide to withdraw after having taken part in the research, data you have already provided may continue to be used.

Study Team Details

If you have any questions about the research, you can contact the lead researchers at Cardiff University or any of the ward contacts highlighted below, before proceeding with your interview.

Lauren Stead - Trainee Clinical Psychologist at Cardiff University
[redacted]

Dr James Stroud – Clinical Psychologist at Cardiff University [redacted]
Dr [redacted] – Clinical Psychologist [redacted]

If you wish to complain or have grounds for concerns about any aspect of the manner in which you have been approached or treated during the course of this research, please contact Dr James Stroud (Clinical Psychologist). If your complaint is not managed to your satisfaction, please contact Dr Andrew Thompson (Programme Director – South Wales Clinical Psychology Doctoral Programme).

What happens next:

1. **If you would like more information before deciding whether or not to take part in the interview, you can speak with a member of the Study Team (please see details above).**
2. **If you would not like to take part in the interview then there is nothing else you need to do. Thank you for taking the time to read this.**
3. **If you would like to take part in the interview, please make contact with a member of the study team to arrange a convenient time to meet to discuss this further. Please review the consent form for the interview. Please discuss any questions regarding this with the study team. You will go through the consent form with the interviewer prior to completing the interview.**

Thank you for your time.

Lauren Stead

Trainee Clinical Psychologist

Cardiff University Clinical Psychology Doctoral Programme

Under the supervision of:

Dr James Stroud

Clinical Psychologist

Cardiff University Clinical Psychology Doctoral Programme

Health board Support Information

In the first instance, we recommend speaking with your ward or service manager regarding any difficulties you may be experiencing. They will be best placed to provide support and if appropriate, signpost to any other services that may be useful.

[redacted] Health Board offer an Employee Assistance Programme, providing 24/7 support. This is accessed by calling [redacted] or visiting [redacted] for a list of services offered.

To access other support services offered by the Employee Wellbeing Support Service, email: [redacted]

Universal Support

For further support with your mental health, your GP will be able to provide signposting and appropriate support.

There are also a number of charitable agencies that can provide confidential listening services and signposting:

C.A.L.L. Helpline – Mental health helpline for Wales

Offering emotional support and information, 24/7.

https://www.callhelpline.org.uk/ 0800 132 737 Or text 81066

The Samaritans

Offering a safe place to talk, 24/7.

https://www.samaritans.org/?nation=wales or call: 116 123 for free

Appendix N – Consent Form

Health Board logo

CONSENT FORM

Title of Project: Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services

Name:

Date:

Contact email address:

Please initial box

1. I confirm that I have read the information sheet dated [23.01.22] 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 or decline to participate at any time without giving any reason. ☐
3. I understand that I can decline to answer any questions within the interview without explanation. ☐
4. I understand that if any risks to myself, others or patient care are identified through the course of the study, information may need to be shared with your line manager and other agencies. ☐
5. I understand that themes and verbatim quotes (anonymised) from the data will form part of a doctoral research project within Cardiff University and may also be shared with participating services and or research papers. ☐
6. I understand that interviews will be audio recorded and this will, along with all other data, be retained as a research record in line with Cardiff University Records Retention Policy for 15 years. Data will be stored on secure Cardiff University servers and be destroyed following the retention period. ☐
7. Your data will remain confidential and only people who need to see your data for research or governance purposes will have access to your personal information. ☐
8. I agree that I can be contacted using the email address provided above, should the researcher ☐

need to contact me regarding the study or results of the prize draw.

9. I agree to take part in the study. ☐

Participant:	**Consent taken by:**
Name	Name
Date	Date
Signature	Signature

Appendix O – Demographics Questionnaire

Health Board logo to be added

Demographic Sheet

Age	
Gender	
Place of work	
Hours worked per week (on average)	
Permanent or temporary member of staff	
Profession and banding	
Duration working in current service	
Does your current role involve direct client contacts? If so, please estimate hour many hours this accounts for within your working week.	
Preferred contact details (e.g. email address, mobile phone number)	

The sensitive information you provide will be stored securely and will be stored separately from your other responses such as questionnaires, which will be allocated a number code. The contact details you provide will be used to contact you should you be selected for interview and to contact you should you win one of three prizes.

Thank you for your time completing this form.

Appendix P – Debriefing Sheet

Health Board logo

Debriefing Form

Title of Project: Exploring staff experiences of burnout and wellbeing within adult mental health rehabilitation services.

Thank you for your participation in this research study exploring your experiences of burnout and wellbeing while working within an inpatient mental health rehabilitation service. You completed an interview about your experiences which will be invaluable in helping to understand the contexts in which feelings of wellbeing are depleted or nourished.

Your identifiable, sensitive information will be stored separately from your qualitative responses, which will be allocated a number code. People who do not need to know who you are will not be able to see your name or contact details. The data you have provided will be stored on secure Cardiff University servers for 15 years, in link with the university data retention policy (this includes raw audio recordings, transcribed data, consent form and demographics sheet). The anonymised data you have provided, including verbatim quotes, will form part of a thesis project with Cardiff University, may form part of published academic research and will be shared with ward managers.

Should you feel that you require additional support regarding your wellbeing and mental health, we encourage you to speak to your ward manager who will be best placed to offer support and signposting. Further information around sources of support are provided at the bottom of this form.

When all data has been analysed, you will be contacted to invite you to provide feedback on the research themes that have been developed. At this point you are able to consent or decline to participate in this process, without having to provide a reason.

The results of the prize draw will be shared in due course and you will be contacted via email if you have been randomly selected to receive one of three prizes.

If you have any further questions, please do not hesitate to speak to a member of the researchers, ward links or the Cardiff University Psychology Ethics department.

Cardiff University School of Psychology Research Ethics Committee
[redacted]

Psychology Research Ethics Committee, School of Psychology, Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT [redacted]
Lauren Stead - Trainee Clinical Psychologist, Cardiff University [redacted]
Dr James Stroud – Clinical Psychologist, Cardiff University [redacted]
Name and contact details of the field link for the health board

Thank you for your time.

Lauren Stead

Trainee Clinical Psychologist

Cardiff University Clinical Psychology Doctoral Programme

Under the supervision of:

Dr James Stroud

Clinical Psychologist

Cardiff University Clinical Psychology Doctoral Programme

Health board Support Information

In the first instance, we recommend speaking with your ward or service manager regarding any difficulties you may be experiencing. They will be best placed to provide support and if appropriate, signpost to any other services that may be useful.

[redacted]

[redacted] offer an [redacted] Programme, providing 24/7 support. This is accessed by calling [redacted] or visiting [redacted] for a list of services offered.

To access other support services offered by the Employee Wellbeing Support Service, email: [redacted]

Universal Support

For further support with your mental health, your GP will be able to provide signposting and appropriate support.

There are also a number of charitable agencies that can provide confidential listening services and signposting:

C.A.L.L. Helpline – Mental health helpline for Wales

Offering emotional support and information, 24/7.

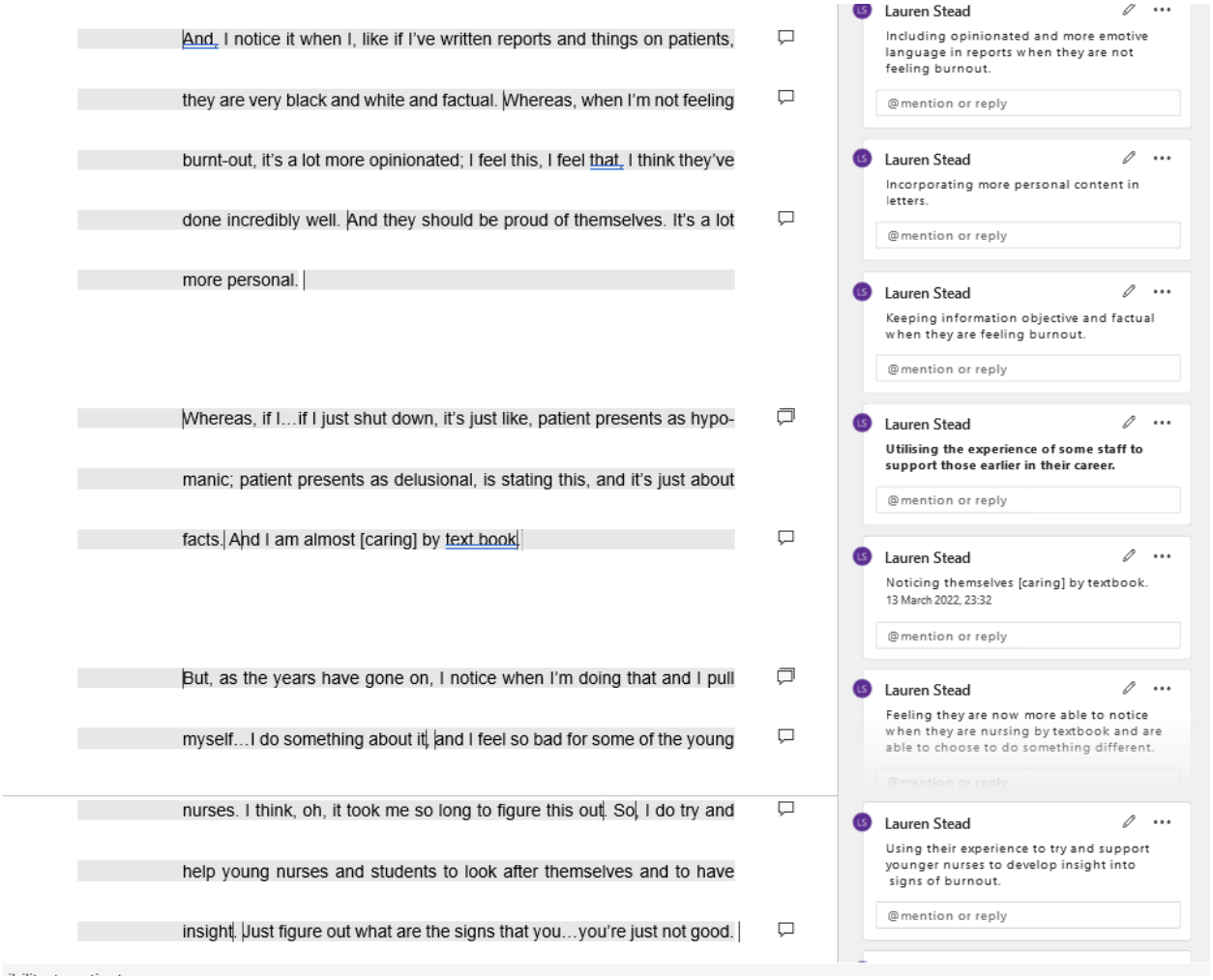
https://www.callhelpline.org.uk/ 0800 132 737 Or text 81066

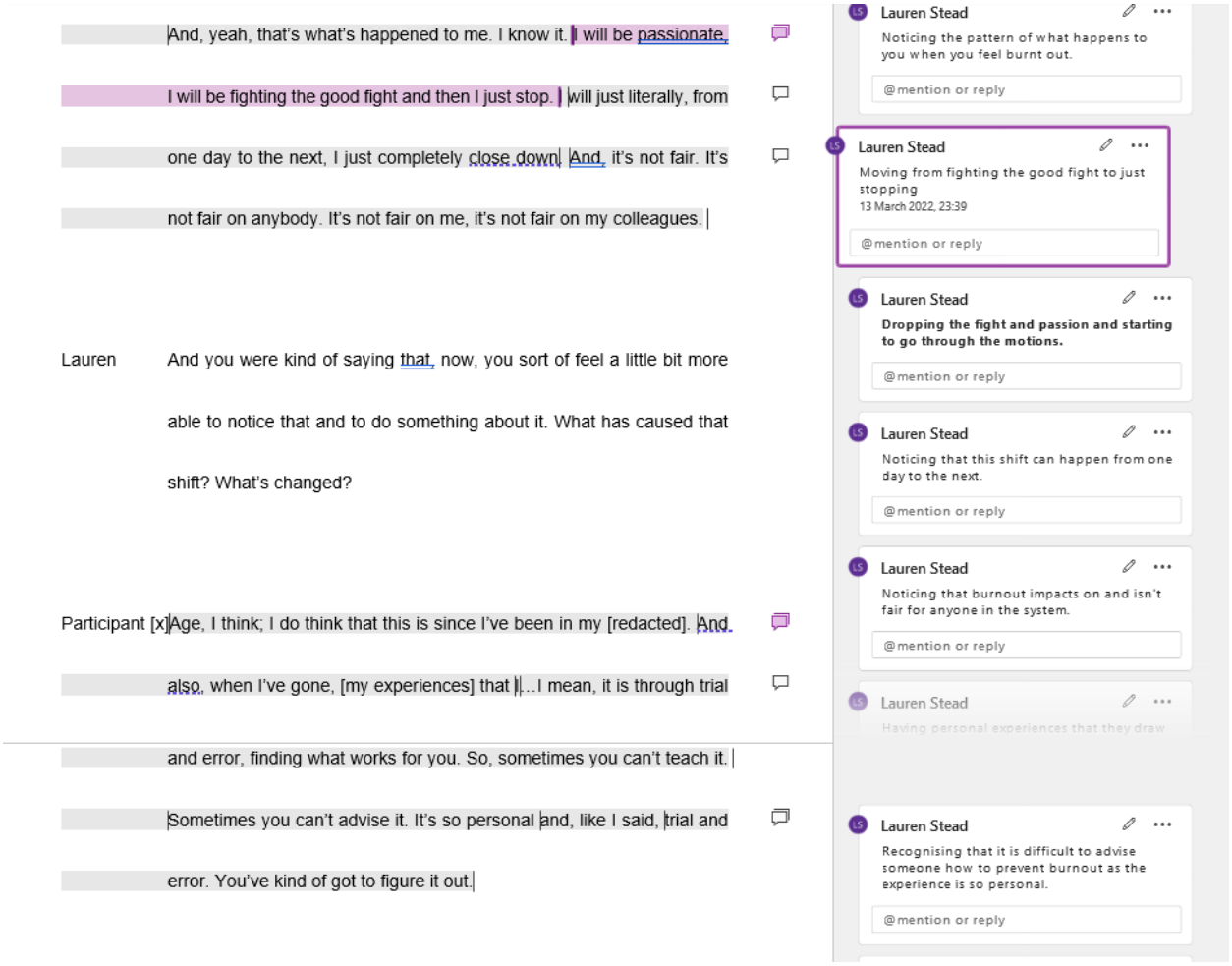
The Samaritans

Offering a safe place to talk, 24/7.

https://www.samaritans.org/?nation=wales or call: 116 123 for free

Appendix Q – An example of the open and focused coding process. Focused codes are differentiated with bold text.




And, yeah, that's what's happened to me. I know it. I will be passionate, I will be fighting the good fight and then I just stop. I will just literally, from one day to the next, I just completely close down. And, it's not fair. It's not fair on anybody. It's not fair on me, it's not fair on my colleagues.
Lauren
And you were kind of saying that, now, you sort of feel a little bit more able to notice that and to do something about it. What has caused that shift? What's changed?
Participant [x]
Age, I think; I do think that this is since I've been in my [redacted]. And, also, when I've gone, [my experiences] that I...I mean, it is through trial and error, finding what works for you. So, sometimes you can't teach it. Sometimes you can't advise it. It's so personal and, like I said, trial and error. You've kind of got to figure it out.
Lauren Stead
Noticing the pattern of what happens to you when you feel burnt out.
@mention or reply
Lauren Stead
Moving from fighting the good fight to just stopping
13 March 2022, 23:39
@mention or reply
Lauren Stead
Dropping the fight and passion and starting to go through the motions.
@mention or reply
Lauren Stead
Noticing that this shift can happen from one day to the next.
@mention or reply
Lauren Stead
Noticing that burnout impacts on and isn't fair for anyone in the system.
@mention or reply
Lauren Stead
Having personal experiences that they draw
Lauren Stead
Recognising that it is difficult to advise someone how to prevent burnout as the experience is so personal.
@mention or reply

Appendix R- Examples of memo's created during the coding process.

Memos
The impact of work on physical health Staff described how the work impacted them physically. This has shown up in two ways. Firstly, staff have described how shift patterns and the physical demands of the role can impact on their sleep and overall physical health. Secondly, during times of high stress, staff noted how this often showed up as tiredness and fatigue and other physical health symptoms and that these were sometimes more prominent than their emotional responses.
Physical and emotional proximity to patients Participants have spoken to the fact that you are around patients all the time. Your contact isn't boundaried to a 'session'. There is no punctuation between different parts of your role, different hats you may wear with different patients. How do you do what you need to do in a context where you don't have opportunities to stop, reflect and calm down. How do you continue to provide person centred care when you are rapidly moving between different patients with different presentations and needs? Staff as an emotional sponge for all of the patients. Where does this get discharged? If you don't have anywhere to do this, how does it come out?
Burnout as a silent process

It seems to be a real dilemma that the very nature of burnout means it is silent. How do you then recognise this happening? Staff are relying on physical experiences and feedback from those around them in order notice this experience. Staff are describing the necessity of stepping back from the ward (leave, sickness etc) in order to notice the impact and recover.

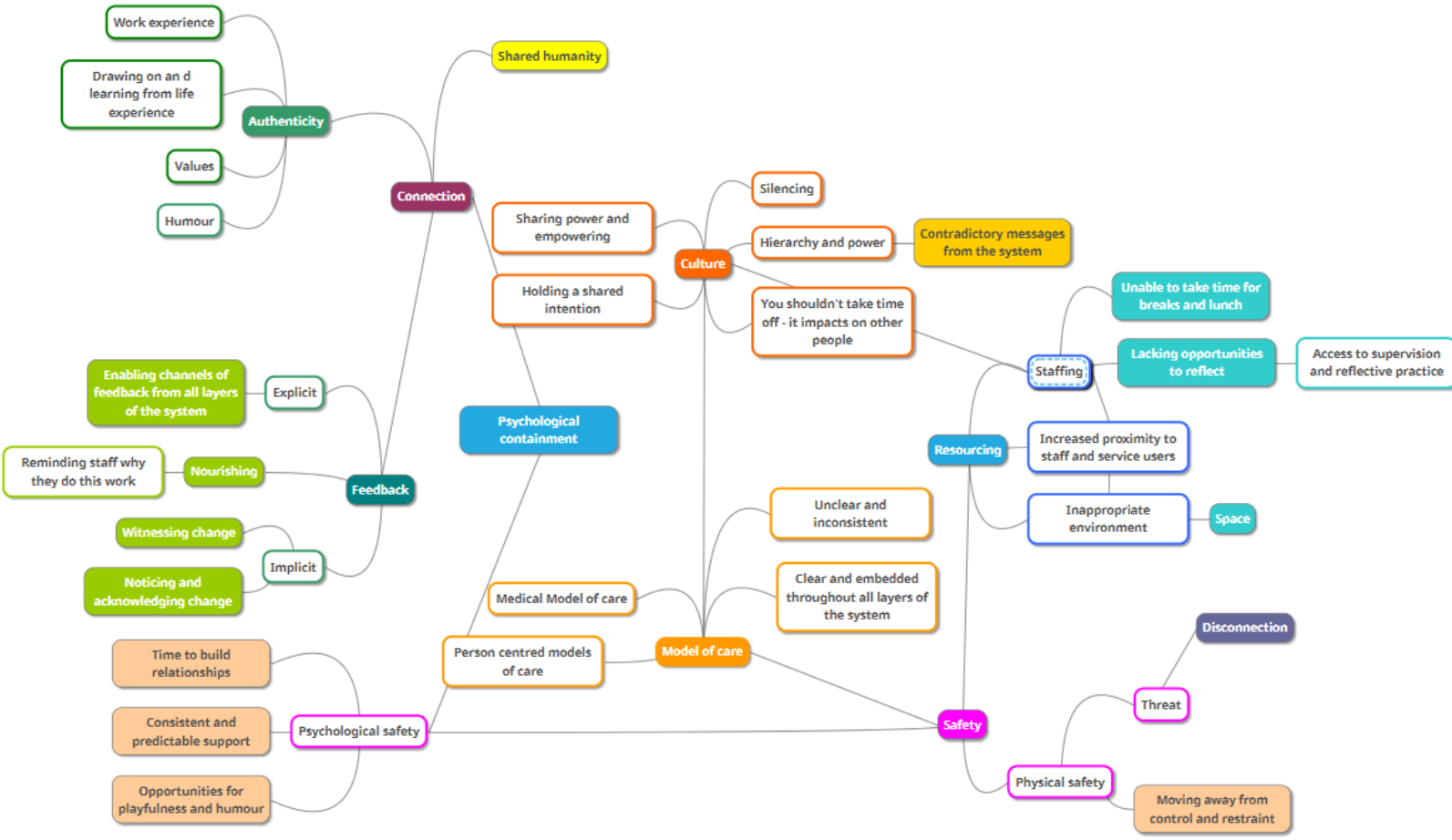
Experiencing of this process means that staff are more switched onto this process should the signs show up again. They have felt it so they can identify it.

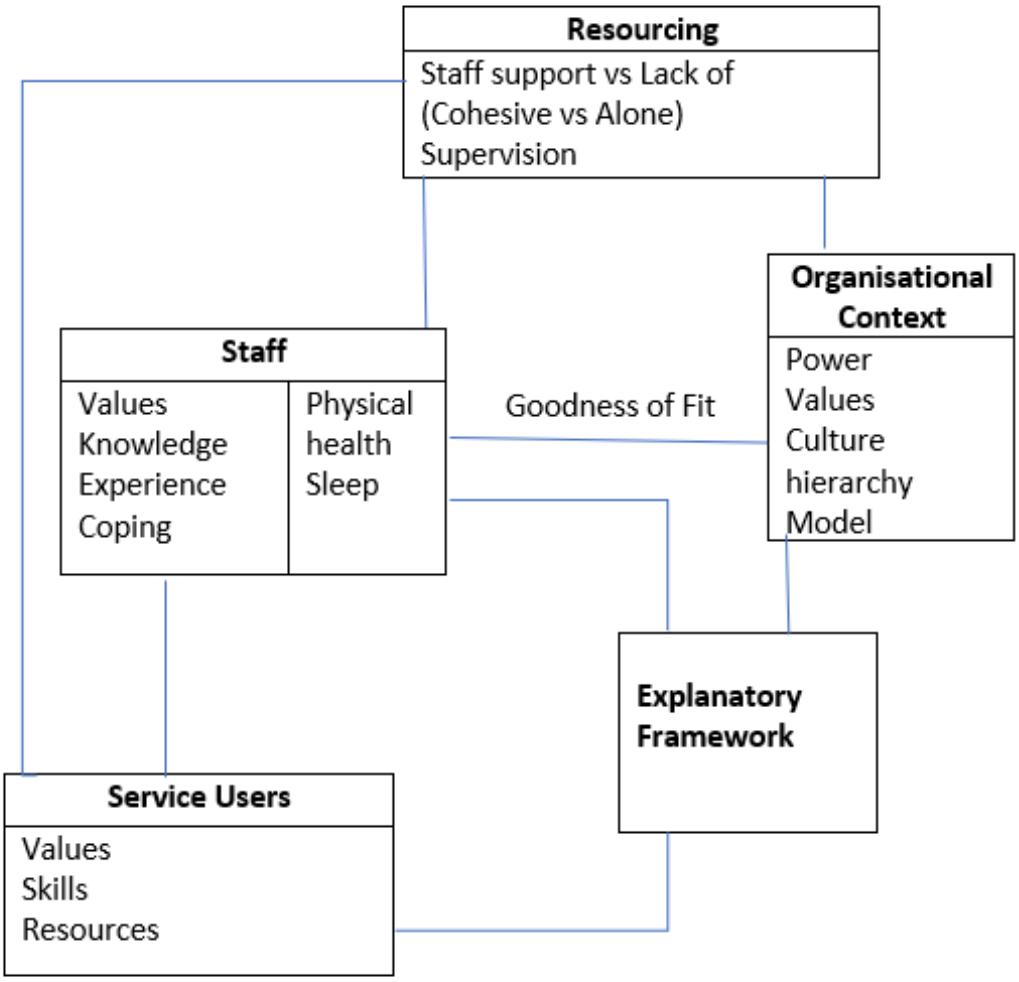
Authentic connection

There seems to be something important about the authenticity staff are bringing to their role. This may be drawing on life experiences, personal/family values, hobbies etc. Participants have shared that they feel patients really pick up on this and it can have a big impact on their ability to form authentic relationships with staff. This feels important as it seems like it is the relationship that is the key intervention when patients are feeling dysregulated and can be the difference between the ward feeling settled or feeling chaotic/risky.

Staff seem to draw on what they have. For some, that is experience around risk, for some it is family values, for some it is strong interests. Having a range of staff with a range of strengths, builds a strong and flexible team.

Appendix S – Development of the model. The first diagram depicts the process by which focused codes were brought together and the second diagram is included to demonstrate the stepped progress towards the final model.




Resourcing
Staff support vs Lack of
(Cohesive vs Alone)
Supervision
Organisational Context
Power
Values
Culture
hierarchy
Model
Staff
Values
Knowledge
Experience
Coping
Physical health
Sleep
Goodness of Fit
Explanatory Framework
Service Users
Values
Skills
Resources

Appendix T – Extracts from the authors reflective Journal

January 2022 The passion and enthusiasm for their role was striking. Despite having been in their role for some time, it appeared that this passion has not diminished. Before beginning interviews, I assumed that much time would be spent thinking about the challenges faced by staff and so the passion this person showed was surprising and refreshing. Within their current role, it appeared that management allowed a high degree of autonomy, trust and enabled them to pursue the things they felt most passionate about. This led me to think about the level of autonomy we are often afforded within psychology and whether this supports our clinical practice and wellbeing.
May 2022 During this interview, the participant spoke about challenges in working with some colleagues on the ward. When describing them, they closely resembled [redacted]. I noticed the reaction this provoked in me and was mindful of how this could influence the interview. This may have led me to being more reserved or cautious with my questions and may have meant that some hunches were not followed up as thoroughly as within some other interviews, e.g. the impact of [demographics] on the dynamics on the ward. On reflection, I wonder if some of the comments made by the participant reflected some of the attitudes I have encountered within [redacted].

Appendix U - Charmaz & Thornberg's (2021) Checklist and Guidance for Ensuring Quality in Grounded Theory

Checklist and Guidance for Ensuring Quality in Grounded Theory Charmaz & Thornberg's (2021)	
1	Strive to achieve methodological self-consciousness (Charmaz 2017). Why have you chosen the specific topic, methodology and methods, and how do these fit with who you are and your research objectives and questions? What version of grounded theory have you adopted and why? What are the ontological and epistemological assumptions, and what do these mean for the research process, researcher position, findings, and quality issues, including transferability?
2	Learn everything you can about the type of qualitative inquiry you adopt, whether it's narrative inquiry, discourse analysis, or a version of grounded theory. If possible, work with a mentor who is knowledgeable about your approach.
3	Take an open, non-committal, critical, analytic view of the existing literature in the field. In contrast to Glaserian grounded theory but in line with Straussian and constructivist grounded theory, we recommend that you review the literature to establish a defensible rationale for the study, to avoid re-inventing the wheel, and to increase theoretical sensitivity. Treat the literature as provisional and fallible, not as the Truth (for further reading, see Thornberg 2012; Thornberg and Dunne 2019).
4	Gather rich data. For psychologists, rich data usually means learning and collecting the stories of people who have had or are having a specific experience. Rich data means an openness to the empirical world and a willingness to try to understand the experiences of people who may be far different from you
5	Be transparent. Describe how you conducted your study, obtained your sample and state how and why you have included the participants, and how you have used grounded theory and data collection methods. Include justifications of your choices
6	Go back and forth between data and your developing analysis to focus your subsequent data collection and to fill out your emerging analytic categories.
7	Tolerate ambiguity while you struggle to gain intimate familiarity with the empirical world and to create an analytic handle to understand it.
8	As you proceed, ask progressively focused questions about the data that help you develop your emerging analysis.
9	Play with your data and your ideas about it. Look for all possible theoretical explanations of the data and check them
10	Collect sufficient data to: (a) make useful comparisons, (b) create robust analytic categories, and (c) Convince readers of the significance of your categories.
11	Ask questions about your categories: (a) What are their properties? (b) In which ways do they subsume minor categories? (c) How are your main categories connected? (d) How do they make a theoretical statement? (e) What is the significance of this statement?
12	Always treat your codes, categories and theoretical outlines as provisional and open for revision and even rejection in the light of new data and further analysis.

13	After you have completed your analysis, compare it with relevant material from the literature, which may well include case studies and perspectives that you did not address during your earlier review. At this time, your review will be focused on the ideas that you have developed. This review gives you the opportunity to show how your analysis fits, extends, or challenges leading ideas in your field.