Doctoral Thesis

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

Professional Quality of Life and Wellbeing with Mental Health Professionals

Doctorate in Clinical Psychology

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Statement of Word Count

Section	Main text	Appendices, including References, Figures and Tables	Total
Abstract	300	-	300
Literature Review	7,995	13,714	21,709
Empirical Paper	7,999	3,555	11,554
Critical Appraisal	3,999	1,436	5,435
Ethics	4,350	5,336	9,686
Total	24,643	24,041	48,684

Thesis Abstract

Professional quality of life (PQoL) examines the positive and negative emotions experienced in professionally helping roles, measured as compassion satisfaction (CS) and compassion fatigue (CF). Chapter One describes a systematic literature review examining factors associated with CS in mental health professionals (MHPs). Six databases were searched (AMED, Academic Search Ultimate, CINAHL, MEDLINE Complete, PsycArticles and PsycINFO) and 28 studies in 29 papers met inclusion criteria. CS was associated with: psychological characteristics, wellbeing, personal trauma, organizational commitment, workload, team-working, supervision, and social support. Services should target variables that can be limited (e.g. workload) or increased (e.g. supervision) to promote CS.

Chapter Two reports a research study investigating PQoL with Improving Access to Psychological Therapies (IAPT) practitioners. Participants (*N*=169) completed an online survey containing validated self-report measures of PQoL, general wellbeing, team psychological safety and quantitative workload. Participants reported average CS and average-high CF. In regression modelling, CF, wellbeing and psychological safety significantly accounted for 41% of the variance in CS. Higher wellbeing was significantly associated with higher CS. A second regression model demonstrated that CS, wellbeing, psychological safety and workload significantly accounted for 30% of the variance in CF. Higher perceived workload and lower wellbeing were significantly associated with higher CF. IAPT services are under constant pressure to meet national targets and growing access rates. Services should prioritise manageable workloads, a focus on wellbeing and psychologically safe environments to support practitioners PQoL.

Chapter three critically appraises the research processes, expanding on the limitations, implications and future research discussed in Chapters One and Two. Further, a post-hoc

mediation analysis of the empirical research data demonstrated that psychological safety indirectly effected CS through general wellbeing, which warrants further exploration. A more robust analysis of factors relating to PQoL, adopting longitudinal methodologies, is required to implement and evaluate strategies to enhance PQoL.

Declaration

This thesis reports research undertaken for the Doctorate in Clinical Psychology at Lancaster University between November 2019 and March 2022. The work presented here is the author's own, except where otherwise stated. The work has not been submitted for the award of a higher degree anywhere else.

Name: Rebecca Wright

Date: 25th March 2022

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Contents

Chapter One: Systematic Literature Review

Compassion Satisfaction in Mental Health Professionals: A Systematic Review

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Abstract: 271 words

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[1] See Appendix A for submission guidelines

Abstract

Background: Compassion satisfaction (CS) can serve as a protective factor against burnout. However, relatively little research has attended to predictors of CS. Most has focused instead on the negative consequences of caring, especially compassion fatigue (CF). Exploring prevalence, predictors, and strategies to reduce CF is important but learning more about the role of CS could reveal further opportunities for promoting professional wellbeing amongst mental health professionals (MHPs).

Aims: The current review aimed to systematically synthesise existing data on factors related to CS for MHPs.

Method: The protocol was registered on PROSPERO (CRD42021271422). Six databases were searched (AMED, Academic Search Ultimate, CINAHL, MEDLINE Complete, PsycArticles and PsycINFO) for relevant literature between 1st May and 30th November 2021. Studies were assessed using the Appraisal Tool for Cross-Sectional Studies (AXIS: Downes et al., 2016). Effect sizes were calculated and were subject to narrative synthesis to identify factors associated with CS.

Results: In total, 29 publications (*n* = 28 studies) were included, with a total of 6,939 participants. Appraisal revealed studies were of moderate-high quality. Several factors associated with increased CS were identified, including personal, organisational, and social variables.

Conclusions: Inconsistent findings regarding the influence of demographic variables on CS suggest their impact is negligible. Organisational factors of supervision, manageable workload, and colleague support are associated with improved CS for MHPs. A number of personal factors, such as improved wellbeing and use of self-care strategies are related to improved CS. Further research is required to reinforce conclusions regarding factors which

are associated with CS. Nevertheless, the findings form a base to deepen understanding of CS and consider developing and evaluating strategies to endorse CS.

Keywords: compassion satisfaction; mental health professionals

Introduction

Job satisfaction results from a range of psychological, organisational, and physiological factors that cause people to feel satisfied or dissatisfied with their work to varying degrees (Aziri, 2011). Existent theories and conceptualisations of job satisfaction broadly encompass evaluative judgments about the work, affective experiences within the working role and beliefs about the profession (Weiss, 2002). A wealth of research now exists in relation to factors that influence employees' emotional wellbeing and psychological health as predictors of organizational outcomes (Spector, 1997). This is particularly relevant to practitioners working in mental health services as the emotional availability of practitioners is related to therapeutic outcomes (Söderberg et al., 2013).

Although common facets of job satisfaction have been identified, including good communication, job conditions, reward, and supervision (Spector, 1997), different occupations attract specific individuals and occupations differ in their demands and opportunities. This suggests at least some of the factors that affect job satisfaction and employee wellbeing may be context specific. Within healthcare specifically there are inherent costs of caring (Figley, 1995; Newell et al., 2016; Rothschild & Rand, 2006), which can result in behavioural, cognitive, and emotional changes for practitioners (Bride et al., 2007). Mental health professionals (MHPs) in particular can experience changes in their wellbeing due to their exposure to the distress of others (Moore & Cooper, 1996).

Professional Quality of Life

Influenced by client interaction, professional quality of life (PQoL) refers to the negative and positive emotions an individual experiences in their professional role as a helper (Kim et al., 2015). PQoL is measured by assessing compassion satisfaction (CS) and compassion fatigue (CF), see Figure 1. CS is defined as the pleasure derived from helping or

caring for others, performing well at work, and feeling satisfied with colleagues and the societal value of one's work, which shapes the individuals' motivation to continue (Stamm, 2002). CF refers to the psychological stress associated with working with traumatized individuals (Cocker & Joss, 2016). CF comprises of negative feelings typically associated with burnout (BO) and secondary traumatic stress (STS). Although there is no valid and internationally agreed definition of BO (Kaschka et al., 2011), it is related to emotional exhaustion, depersonalisation and reduced ability and motivation. STS is described as the emotional and behavioural response to repeated exposure to the trauma of others (Figley, 1995). The Professional Quality of Life scale (ProQOL: Stamm, 2003, 2005, 2010) is the most widely used measure of the effects of professionally helping others (Stamm, 2010).

[FIGURE 1 ABOUT HERE]

In proposing the idea of CS, Stamm (2002) recognised a relationship between CF and CS, suggesting a balance between them with individuals experiencing CF but continuing to feel satisfied due to the belief the work they are doing is helping. Further, Tremblay & Messervey (2011) proposed CS offsets the negative aspects of work in helping professions by buffering the relationship between work overload and job strain. Consequently, one might expect to see a negative relationship between the two concepts, that is when one is higher, the other is lower. Indeed, significant negative correlations have been found between CS and BO and CS and STS (Babaei & Haratian, 2020; Burnett et al., 2019; Jarrad & Hammad, 2020). This may suggest factors predicting CF may also impact levels of CS. In addition, research has highlighted the fundamental consequences of reduced PQoL.

Consequences of Reduced Professional Quality of Life

Reduced PQoL can have physical, behavioural, and psychological consequences for individuals and services (Sinclair et al., 2017). For example, Dasan et al. (2015) found

emergency care staff with lower CS reported reducing their standards of care for patients and were more likely to be irritable with colleagues and patients alike. Additionally, public health nurses were more likely to quit their role or profession if they experienced high levels of CF and low levels of CS, which can result in high levels of staff turnover (Pérez-García et al., 2021), and absenteeism (Böckerman & Ilmakunnas, 2008; Campbell Jr. et al., 2001; Department of Health [DoH], 2009), leading to inconsistencies for service users.

There are also implications for compassionate care. Compassionate care is vital for better patient safety and clinical outcomes (Zhang et al., 2018). However, there have been several accounts of organisational failures in compassionate care, despite the recognition that compassion should be a priority within healthcare guiding values and principles (American Medical Association [AMA], 2001; DoH, 2012a). In the UK, the Parliamentary and Health Service Ombudsman (2011) Report *Care and Compassion* identified ten patient stories in which staff failed to respond to the needs of elderly patients with care and compassion. Similarly, the Winterbourne View report (DoH. 2012b) identified major failures to meet the needs of people with learning disabilities and uncovered wider issues within the care system. Shortly after, the Francis (2013) report highlighted significant failings due to CF and high levels of demands on staff, resulting in high mortality rates and poor patient care. Elsewhere, Lown et al. (2011) reported survey results from a large sample of US patients and physicians, suggesting 47% of patients and 42% of physicians did not feel the health care system provided compassionate care. Compassionate care fails when staff feel fatigued, burnt out and experience STS (The Royal College of Psychiatrists, 2015). These examples suggest organisations, and individuals within them, can and do fail to respond with compassion due to high CF and low CS, highlighting the potential costs of reduced PQoL.

Strategies to Improve Professional Quality of Life

Increasing mindfulness can promote PQoL amongst MHPs by mitigating CF and improving CS. Christopher & Maris (2010) found mindfulness training enhanced the psychological and physical wellbeing of trainee counsellors and therapists which prevented CF. Other studies have reported similar benefits where mindfulness training has led to reduced CF (Best et al., 2020; Duarte & Pinto-Gouveia, 2016) and increased CS (Gregory, 2015). Alternative strategies may include education around CF and CS. Klein et al. (2018) reported increased CS and reduced BO after practitioners attended a resiliency programme focusing on education and awareness of CF and self-care practices (Klein et al., 2018). Similar results have been found elsewhere (Pehlivan & Güner, 2020).

Organisations have also introduced Schwartz Rounds to provide protected space for staff to share emotional and social experiences of care which have led to improved communication, higher levels of empathy, and enabled more compassionate care (Farr & Barker, 2017; Goodrich, 2012; Lown & Manning, 2010). It is worth noting, however, that participation in Schwartz Rounds is usually voluntary. Individuals who choose to attend are therefore likely to have more capacity and motivation to utilise this protected space and may already experience higher levels of CS. In addition, outcomes and perspectives were not obtained from non-attenders. It would be beneficial to examine patterns and relationships in those who do not attend to rule out any possibility of bias.

Leadership is crucial in facilitating compassionate care through rewarding practices, allocating resources, and shaping the structure and values of organizations (NHS England, 2014; Rafferty et al., 2015; West et al., 2013). Evidence suggests primary interventions, such as amending workload, are more cost and time effective than secondary interventions, for example influencing psychological mechanisms (Lamontagne et al., 2007; Montano et al., 2014), although both approaches have positive outcomes (Corbière et al., 2009).

While research suggests a number of positive strategies to improve PQoL, Stamm (2010) recognised a level of complexity in overall PQoL due to the number of variables involved. These variables include exposure to trauma at work, and occupational and personal characteristics (Stamm, 2010). Therefore, it is important to consider what factors specifically influence the constructs of CS and CF in different contexts. To do this, many authors have investigated the predictors of both constructs within varied populations, although much less attention has been paid to CS than to CF.

Factors Associated with Compassion Satisfaction

Demographic variables that have been associated with CS include age, marital status, gender, and work experience (Lee et al., 2021; Sacco et al., 2015; Wang et al., 2019). These are similar findings to that in CF literature in that female gender, younger age, less experience and being single were related to higher CF (Xie et al., 2021). However, there remain inconsistencies in findings regarding the nature of the relationship between demographic factors and PQoL (Turgoose & Maddox, 2017), indicating a degree of caution should be taken in drawing firm conclusions in relation to the impact of demographic variables on CS. Logically, those older in age are likely to have more work experience, which makes it difficult to establish whether age or experience, if either, may contribute to CS. Additionally, according to the World Health Organisation (WHO, 2006), women tend to dominate health service professions which may result in biased findings suggesting women are more or less likely to experience CS.

Personal factors that have been identified in relation to higher levels of CS include the use of self-care, (Butler et al., 2017), emotional intelligence (Bae et al., 2019), secure attachment, mindfulness (Buceta et al., 2019), empathy, reduced personal distress (Yi et al.,

2019), and aligning to one's values (Kulkarni et al., 2013). Meanwhile, personal history of trauma predicts lower CS (Kase et al., 2019).

Organisational factors that are related to higher levels of CS include autonomy (Gonzales-Mendez & Diaz, 2021), support from colleagues (Balinbin et al., 2020), positive work challenges, commitment to the organisation (Baugerud et al., 2018), and access to supervision (Senreich et al., 2020). Conversely, role ambiguity, conflict and overload (Barr, 2017), shift work (Burnett et al., 2018) and work setting, such as working in primary care (Ruiz-Fernández et al., 2020), are associated with reduced CS. Social support has also been found to be associated with CS (Barr, 2017; Varadarajan & Rani, 2021).

These findings are useful in suggesting potential factors related to CS. However they were obtained from a wide variety of physical health professions, utilising varied sample sizes and study methodologies. This makes it difficult to generalise findings and to assess whether specific factors are unique to specific job roles.

It is clear there are intersectional factors potentially related to the development of CS. However, much of this research focuses on physical healthcare populations. Two systematic reviews have been identified focusing on PQoL in MHPs. Both reviews focused on predictors of CF, with one also highlighting the relationship between CS and CF (Turgoose & Maddox, 2017) and the other briefly synthesising factors associated with CS (Singh et al., 2020). However, the narrow search strategy, by focusing predominantly on CF, did not allow for all research exploring factors associated with CS to be included.

Aim of the Current Review

Evidence suggests a relationship exists between CF and CS, and has identified several factors that may be related to CF, and therefore may relate to CS. Although MHPs are exposed to similar workplace stressors as other physical healthcare and non-healthcare

professionals, they also experience additional emotional strain in supporting individuals with mental health difficulties (Moore & Cooper, 1996). This emotional labour has been found to be positively correlated with stress amongst mental health nurses (Mann & Cowburn, 2005). Additionally, in a review of BO amongst MHPs, Morse et al. (2012) reported 21-67% of MHPs may experience high levels of BO. Further, psychiatrists (Fischer et al., 2007), qualified mental health nurses (Sahraian et al., 2008), and psychiatric occupational therapists (Gupta et al., 2012) are at greater risk of BO compared with other practitioners. The high risk of reduced PQoL for MHPs will undoubtedly affect work performance, job satisfaction and individuals' own physical and mental health.

No systematic review has been conducted explicitly focusing on CS amongst specific healthcare populations such as MHPs. Specific jobs will have unique risk factors affecting PQoL. Therefore, exploring the literature in specific populations would add vital information to determine which factors relate to CS, and consequently which strategies may enhance the positive aspects of caring. As such, this review aimed to systematically synthesise all existing data to consider the factors related to CS in MHPs. Advancing understanding of CS for MHPs could reveal important opportunities to promote professional wellbeing and lead to better working conditions for staff and outcomes for patients.

Methods

An initial scoping search was performed using PsycINFO and Google Scholar to determine the suitability of the systematic review topic and to identify existing published reviews in this field. In addition, the PROSPERO database was searched to identify whether any similar reviews had been registered. There were no existing or planned systematic literature reviews examining factors associated with CS in MHPs. The protocol was registered on PROSPERO (registration number: CRD42021271422) and the systematic

review was completed in line with guidelines and criteria published by the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA: Stewart et al., 2015).

Study Selection

For inclusion in this review, studies had to: (i) be written in English; (ii) be published in a peer-reviewed journal before 30th November 2021; (iii) be quantitative; (iv) measure CS and clearly state the measure utilized; (v) use samples consisting of at least 50% of participants identifying as a MHP, e.g., psychotherapist, therapist, counsellor, psychologist, psychiatrist, psychiatric nurse, or any professional role providing direct care to patients within a mental health team/unit; (vi) consist of analysis of the relationship(s) between CS and other variables.

Studies were excluded if any of the following criteria were met: (i) studies in which factors associated with CS was not the primary outcome; (ii) studies investigating intervention/strategies to improve CS; (iii) studies reporting prevalence of CS, without reporting relationships between other variables and CS; (iv) unclear study samples, or those consisting of participants with mixed (above 50% not MHPs) or unqualified professions e.g., psychiatric *and* medical health professionals, student therapists and lay trauma therapists; (v) unpublished articles, commentaries, theses, dissertations, conference papers or systematic reviews.

Search Strategy

Six databases (The Allied and Complementary Medicine Database [AMED], Academic Search Ultimate, Cumulative Index to Nursing and Allied Health [CINAHL], MEDLINE Complete, PsycArticles and PsycINFO) were independently searched for all relevant literature up until 30th November 2021. Highly sensitive search terms were developed in collaboration with a faculty librarian, using Boolean operators and subject

terms. Subsequently, search strategy tests were completed to ensure the search terms were appropriate. Table 1 shows the full search terms.

[TABLE 1 ABOUT HERE]

All papers generated in the search were exported into EndNote© reference management software version X9 and de-duplicated using the EndNote© de-duplication tool. Any missed duplicates were manually removed. The inclusion criteria were used to screen abstracts, titles, and keywords of remaining citations and those that were not relevant were excluded. Full texts were obtained for the remaining papers and were examined in line with the inclusion and exclusion criteria. Hand-searching of the remaining papers was conducted, and relevant citations were reviewed.

Data Extraction, Quality Appraisal and Data Synthesis

Details of all papers included in the review were exported into a purposefully designed form by one author. Extracted data included: The author(s); year of publication; location; study design; study aims; participant characteristics and demographics; factor(s) investigated; measure(s) used; main findings; and effect sizes.

The Appraisal of Cross-sectional Studies [AXIS] (Downes et al., 2016) tool was used for quality appraisal. The AXIS tool was chosen because it addresses both study quality and risk of bias and includes an extensive explanatory document to assist users. The tool consists of 20 items to assess design and reporting quality (see Appendix B). Areas covered by the checklist included study aims, methodology, results, discussion, funding and conflicts of interest, and ethical approval. Items were rated as “yes”, “no”, or “don’t know”. The tool does not explicitly define a numerical scale to score quality assessment, however studies were awarded a score of one for each item rated as “yes”, except for items 13 and 19 which were reverse scored due to the framing of the question. Thus, a maximum score of 20 could be

achieved, with higher scores indicating higher study quality and lower risk of bias. Papers were not excluded based on critical appraisal; however, the ratings were considered when drawing conclusions regarding included studies. Studies were assessed independently by one author. A colleague independently assessed quality of studies and risk of bias with a random sample of included studies (*n=5*) to improve consistency and reliability. One minor discrepancy was discussed in line with the explanatory document and consensus was achieved.

Effect sizes for the main study results were calculated for each of the included papers to examine the relevance of findings. Effect size measures were based on Cohen's (1988) rules of thumb. These were then subject to narrative synthesis to identify and group factors affecting CS for studies reporting medium to large effect sizes.

Results

A total of 8,098 records were identified from database searches. After screening of titles and abstracts, when checked against inclusion criteria, 28 papers fulfilled criteria. Citation searching identified a further 34 potentially relevant papers, for which full texts were retrieved. From this, one additional paper met the inclusion criteria. A total of 28 studies in 29 papers were suitable for inclusion in this review. There were several papers that appeared to meet the inclusion criteria but upon further examination were excluded. Predominantly, this was due to sample characteristics. For instance, several papers utilised samples made up of mixed professions across multiple specialities. Please refer to Figure 2 for full details of the selection process.

[FIGURE 2 ABOUT HERE]

Study Characteristics

The main characteristics of the 28 studies across 29 included papers are summarised in Table 2. Two papers used the same sample (Laverdière et al., 2019; Laverdière, Ogrodniczuk & Kealy, 2019), and as such they have been reported in the same row in Table 2 and will be collectively referred to as Laverdière et al. (2019) for brevity. A total of 6,939 participants across the 28 studies were included and reports were published between 2007 and 2021. All of the studies were cross-sectional.

Sample sizes varied from 36 (Bell et al., 2019) to 1,121 (Sprang et al., 2007), with an average of 248 participants. The average age of participants ranged from 29.68 years (Xie et al., 2020) to 53.67 years (Linley & Joseph, 2007). Six studies did not provide adequate information regarding the age of participants (Cetrano et al., 2017; Dehlin & Lundh., 2018; McKim & Smith-Adcock, 2013; Rossi et al., 2012; Sodeke-Gregson et al., 2013; Towey-Swift & Whittington, 2019). The proportion of female participants ranged from 41.7% (Bell et al., 2019) to 84.7% (Lakioti et al., 2020).

[TABLE 2 ABOUT HERE]

Measures of Professional Quality of Life

All studies included in this review used a version of the ProQOL scale (Stamm, 2003, 2005, 2010). The ProQOL 5 (Stamm, 2010) was used by 18. Version 4 (Stamm, 2005) was used by five (Başoğul et al., 2021; Mangoulia et al., 2015; McKim & Smith-Adcock, 2013; Ray et al., 2013; Sukut et al., 2021) and version 3 (Stamm, 2003) by the remaining five (Cetrano et al., 2017; Craig & Sprang, 2010; Killian, 2008; Lawson & Myers, 2010; Linley & Joseph, 2007; Rossi et al., 2012; Sprang et al., 2007). The main difference is within the scoring. Versions three and four are scored on a Likert scale ranging from 0-5, while version five is scored from 1-5.

Quality Appraisal

The results of the AXIS quality assessment tool (Downes et al., 2016) are displayed in Table 3. Out of a possible 20 points, quality assessment scores ranged from 11 (Sprang et al., 2007) to 17 (Başoğul et al., 2021), with a mean score of 14. All studies scored 0 on item-14 (information about non-responders described). This is often difficult to address in cross-sectional research as it can be hard to gain information about non-responders (Downes et al., 2016). There are no defined cut-offs for classifying the quality and risk of bias using the AXIS tool (Downes et al., 2016). However, the quality of studies could be considered moderate to high. The assessment revealed issues with one paper regarding the conclusions drawn by authors (Adeyemo Sunday et al., 2015). The results revealed no significant correlation between CS and distress ($r = -0.048, p > 0.05$). However, the authors concluded CS had a significant negative correlation with psychological distress. This discrepancy in the reporting of findings was interpreted with caution. Finally, four studies utilised measures that had not been validated previously (Bell et al., 2019; Dehlin & Lundh, 2018; Itzhaki et al., 2018; Killian, 2008).

[TABLE 3 ABOUT HERE]

Study Results

Factors have been synthesised into demographic, personal, occupational, and social factors to achieve a coherent narrative.

Demographic Factors

Fourteen papers reported significant relationships between demographic factors and CS, including age, experience, job role, type of organization, licensure, gender, marital status and having children. In most papers, these findings had small effect size suggesting results may not be clinically meaningful. With regards to age, Somoray et al. (2015) identified it had a significant positive correlation with CS scores, with medium effect, indicating older

subjects experienced higher levels of CS. Additionally, in regression analysis, age was found to significantly contribute to the variance in CS (Sodeke-Gregson et al., 2013; Somoray et al., 2015; Sprang et al., 2007; Xie et al; 2020). In these papers, the final model of regression had R^2 values that indicated medium to large effect sizes.

Craig and Sprang (2010) explored CS in a larger sample of trauma treatment therapists with findings suggesting years of experience became more powerfully associated with CS than age. This is perhaps indicative of a relationship between age and years of experience, i.e. one might assume older age would naturally correlate with increased number of years' experience. Elsewhere, it has been concluded experience was significantly independently related to CS, with medium and large effect sizes (Laverdière et al, 2019; McKim & Smith-Adcock, 2013). Conversely, though further significant relationships were found between experience and CS, the strength of these was weak (Dehlin & Lundh, 2018; McKim & Smith Adcock, 2013; Towey-Swift & Whittington, 2019).

Additional demographic factors have demonstrated moderate to strong correlations with CS, including type of organization (Lawson & Myers, 2010), education (Başoğul et al. 2021) and smoking status (Xie et al., 2020), however findings have not been replicated elsewhere.

Although, taken together, these findings demonstrate strong relationships between CS and some demographic factors, many authors considered these relationships and reported non-significant findings raising questions regarding their clinical significance.

Personal Factors

Psychological Characteristics.

Various psychological characteristics have been explored in relation to CS with meaningful findings. For example, Browning et al. (2019) explored the contributions of

certain traits to PQoL amongst counsellors. Findings indicated a significant association between CS and hope, with a large effect size.

With regards to empathy, in their two studies using the same sample of 240 psychotherapists, Laverdière et al. (2019) found empathy to be a positive and significant contributor to CS. In regression analysis, empathy uniquely contributed to their entire model, which had a large effect size, however correlation analysis suggested the relationship between empathy and CS was weak. Two authors have found no significant associations between CS and empathy in smaller samples of MHPs (Lakioti et al., 2020; Linley & Joseph, 2007).

Five studies explored personality factors in relation to CS. Examining several personality factors, Somoray et al. (2015) reported higher CS was moderately associated with lower neuroticism and higher extraversion and agreeableness. Of these personality traits, only conscientiousness was found to be significantly independently related to CS. Cynicism has been found to be strongly negatively associated with CS, accounting for a substantial proportion of variance with large effect size (Ray et al., 2013). This cross-sectional study of frontline MHPs also found a strong significant relationship between CS and personal efficacy. Lakioti et al (2020) found a similar relationship, with medium effect size. This study also found self-efficacy had a significant positive association with CS accounting for a unique contribution to the variance in CS. Resilience has also been found to have a moderate relationship with CS (La Mott & Martin, 2018; Sukut et al., 2021). In both studies, resilience was found to contribute to the variance in CS when all other variables were held constant.

Wellbeing.

Ten studies explored the relationship between wellbeing and CS. In a sample of psychiatric nurses (Mangoulia et al., 2015), those who described their mental and physical

health as excellent had significantly higher CS. A description of their mental health as not excellent was significantly related to lower CS. Similarly, Lakioti et al. (2020) explored five dimensions of well-being in relation to CS, reporting significant positive relationships between CS and all well-being dimensions (including positive emotion, engagement, meaning and accomplishment), with moderate to large effect sizes. In a larger sample of 506 professional counsellors, Lawson and Myers (2010) identified CS and total wellness were significantly and strongly positively correlated, suggesting as wellness increased, so did CS and vice versa. Furthermore, participants with higher wellness scores rated career sustaining behaviours significantly higher than those with low wellness scores. Career sustaining behaviours included behaviours that may be classed as self-care strategies, such as participating in personal therapy, spending time with friends and family, and engaging in physical activities. Several types of self-care (physical, psychological, emotional, spiritual and professional) were all found to have significant relationships of moderate strength with CS, accounting for a significant proportion of the variance in CS (La Mott & Martin, 2018). Similarly, though small in effect, Sodeke-Gregson et al. (2013) reported a positive correlation between time spent engaging in self-care and CS.

Conversely, reduced wellbeing has also been found to be related to CS, with all findings reporting medium to large effect sizes. Ray et al. (2013) reported a significant correlation between emotional exhaustion and CS, with higher levels of emotional exhaustion associated with lower levels of CS. In a similar vein, Rossi et al. (2012) found lower levels of CS amongst community mental health staff related to higher psychological distress. Further, distressed workers reported significantly lower CS than non-distressed ones. Similar findings were reported amongst psychotherapists (Laverdière et al., 2019). Litam et al. (2021) also concluded perceived stress was significantly associated with CS. Finally, Clark et al. (2021)

explored imposter phenomenon amongst MHPs, finding CS and imposter phenomenon shared 17% of their variance with one another.

Personal Trauma.

Seven studies considered whether professionals' experience of trauma, past or present, had a relationship with PQoL, with inconsistent findings. Interestingly, two studies reported significant positive correlations between post-traumatic stress disorder (PTSD) and CS (Litam et al., 2021; Tirgari et al., 2018), with large and moderate effect sizes respectively. Elsewhere, significant findings were reported in two studies, suggesting lower CS amongst those with a history of trauma, but with only small effect size (La Mott & Martin, 2018; Somoray et al., 2015). On the other hand, several authors have described a non-significant relationship between CS and trauma (Linley & Joseph, 2007; Martin-Cuellar et al., 2018; Rossi et al., 2012). These inconsistent findings suggest further exploration may be beneficial. Exploring factors which mediate the impact of trauma on CS, Martin-Cuellar et al. (2018) reported a moderately strong relationship between mindfulness and CS. Additionally, mindfulness was found to be independently associated with improved CS and reduce the impact of recent trauma.

Occupational Factors

Organizational Commitment.

Organisational commitment is a measure of workers' intention to continue in their organisation, rather than leave. Two studies examined relationships between organisational commitment and CS. In their study, Mangoulia et al. (2015) found participants reporting with low organisational commitment scored lower in CS than those who remained committed to their organisation, with moderate effect size. Additionally, it was reported those who desired a psychiatric nursing career for their children and would choose the same career again also

scored higher in CS with large effect sizes (Mangoulia et al., 2015). Similarly, Başoğul et al. (2021) found significant differences in CS scores between those considering changing units and those who were not, with those considering changing reporting lower CS scores. Multiple regression analyses indicated considering a change contributed to a proportion of the total variance in CS. In part, intention to leave may be influenced by work stress which has also been found to be associated with CS with a moderately strong relationship (Itzhaki et al., 2018).

Areas of Work Life.

The Areas of Work Life scale (AWS: Leiter & Maslach, 2011) measures the congruence between workers' expectations and the job across six dimensions of work life, these being control, values, workload, rewards, community, and fairness. Two studies reported a significant positive relationship between all areas of work life and CS with medium to large effect sizes (Ray et al., 2013; Towey-Swift & Whittington, 2019).

With regards to control, two researchers examined its relationship with CS, suggesting higher control and autonomy were associated with higher CS (Killian, 2008; McKim & Smith-Adcock, 2013). Başoğul et al. (2021) explored professional values in a sample of 120 mental health nurses, identifying a strong positive correlation between total professional values and CS. Examining these relationships further, caring, professionalism, activism and justice demonstrated relationships of moderate strength, while truth had a strong relationship and was found to be independently associated with CS in regression analysis.

Workload.

A variety of occupational activities were considered regarding their influence on CS in eight studies. Relationships of moderate strength have been found between CS and theoretical orientation (Laverdière et al., 2019) and superiority (Xie et al., 2020). Other

workload factors found to contribute significantly to the variance in CS across multiple studies with moderate to large effect size include: quality of meetings and the need to attend training (Cetrano et al., 2017); the use of evidence-based practice (Craig & Sprang, 2010); clinical contact (Killian, 2008); theoretical orientation and delivering individual work only (Laverdière et al, 2019); engaging in research and development activities (Sodeke-Gregson et al., 2013); job satisfaction (Xie et al., 2020); and the percentage of clients on caseload with PTSD (Sprang et al., 2007). Conversely, in other studies workload factors such as negative clientele (McKim & Smith Adcock, 2013), and working hours (Tirgari et al., 2018; Xie et al., 2020) were not significantly related to CS.

Team-Working.

Five studies considered various aspects of support from colleagues, suggesting perceived workplace belongingness (Somoray et al., 2015), good relationships with colleagues and working as a team (Mangoulia et al., 2015), and management support (Sodeke-Gregson et al., 2013) were associated with CS in MHPs with large effect sizes. Further, Bell et al. (2019) identified emotional support and encouragement from colleagues as significant factors, however effect sizes were not reported and their papers did not allow for these to be calculated.

Supervision.

Related to, but distinct from, support from colleagues, six authors examined whether supervision was associated with CS. Sodeke-Gregson et al. (2013) identified a positive relationship between perceived supervision support and CS although the number of hours of supervision was not significantly related. Access to supervision (Dehlin & Lundh, 2018) and regular supervision (Bell et al., 2019) have also been found to be related to levels of CS, with more access and more regular supervision associated with higher levels of CS. Meanwhile,

other authors found supervision was not significantly related to CS (Lakioti et al., 2020; Laverdière et al., 2019; Linley & Joseph, 2007).

Social Factors

Two studies examined the role of social support in CS, with findings suggesting those allocating time for social life (Başoğul et al., 2021) and those accessing social support (Killian, 2008) reported higher levels of CS. In both studies, social support accounted for a proportion of the variance of CS with the final models demonstrating large effect sizes.

Discussion

This review sought to synthesise findings from all relevant studies exploring factors associated with CS for MHPs. Systematic searching identified 28 studies within 29 papers for inclusion. CS was significantly associated with demographic, personal, organisational and social factors. Overall, this review found organisational factors to be the most widely researched factors associated with CS. Findings suggested improved levels of CS for MHPs were related to reduced and varied workload, positive team-working and dynamics, and regular supervision. Personal factors of higher wellbeing and growth associated with personal trauma were also positively related to CS. These findings indicate many of the factors associated with CF are also associated with CS. This has not previously been systematically explored.

Overall, the quality of the included studies was considered moderate to high (average 14/20). However, the quality appraisal indicated there were potential issues with all studies failing to describe non-responders, which is a common issue within cross-sectional research. Further, one study (Adeyemo Sunday et al., 2015) reported statistical results inconsistent with the written narrative, and the use of non-validated measures of associated variables in four

studies (Bell et al., 2019; Dehlin & Lundh, 2018; Itzhaki et al., 2018; Killian, 2008) may have impacted findings.

Relationships Between Professional Quality of Life Variables

As in physical healthcare populations (Babaei & Haratian, 2020; Burnett et al., 2019; Jarrad & Hammad, 2020), this review found a relationship between CS and CF. In those studies that explored this relationship, the majority reported negative associations between CS and CF and/or BO with effect sizes of moderate and large strength. Although this does not imply causality, it suggests that if CS can be increased it might minimise the prevalence and effects of CF. Conversely, if CF is reduced it might maximise CS. For STS, the relationships with CS were weak (Başoğul et al., 2021; Clark et al., 2021; Dehlin & Lundh, 2018). This echoes previous findings (Stamm, 2010) suggesting strategies that target CS and BO may complement each other but are less likely to impact STS (Singh et al., 2020). Given the paucity of research exploring CS and the relationship between CS and CF in MHPs, these finding suggests it may be possible to draw at least tentative comparisons and conclusions from the results of studies of CF and CS in the wider healthcare community.

Factors Associated with Compassion Satisfaction

It has frequently been hypothesised demographic characteristics may impact on levels of CS, however there are several inconsistencies. The CF literature indicated gender may impact PQoL, however this has not been supported in relation to CS. Although two studies indicated female gender related to higher reported CS, effect sizes were small and many more studies reported non-significant findings. This may be reflective of population characteristics, since women often make up a large proportion of staff teams in physical and mental healthcare (WHO, 2006). Indeed, in the studies included in this review, all but two (Bell et al., 2019; Itzhaki et al., 2018) utilised samples in which females made up more than 60% of

the sample. Age and experience also showed inconsistent findings, with six studies indicating these variables were associated with CS, but many more reporting weak or non-significant results. Taken together, although demographic variables may account for a small variance in CS, in some populations, demographics may not be a key area on which to focus.

In terms of personal factors, this review highlighted psychological characteristics, well-being, and personal trauma are significantly associated with CS. This parallels findings in CF literature that trauma history, mindfulness and empathy are associated with CF (Turgoose & Maddox, 2017). Six studies in this review reported a relationship between CS and personal trauma, although only two demonstrated moderate effect sizes (Litam et al., 2021; Tirgari et al., 2018). This perhaps reflects differences in study design, as both studies reporting larger effect sizes utilised the same measure of PTSD (PTSD checklist; Weathers et al., 2013), while the remaining studies all utilised different measures to examine trauma history. Importantly, both studies identified a significant positive correlation between trauma and CS. This is inconsistent with findings within CF literature which suggest personal trauma history relates to higher levels of CF (Turgoose & Maddox, 2017). This may be reflective of the personal growth practitioners experience with a personal history of trauma (Linley & Joseph, 2007) or reflect the study participants who had relatively high rates of CS and low rates of CF. Bell et al. (2019) identified exposure to traumatic events was associated with reduced CS, however their report did not allow for effect sizes to be calculated and the sample size was small.

This may also indicate other variables can protect against the potential impact of personal trauma on CS. These could be worth exploring in more depth. For example, mindfulness has been found to moderate the relationship between recent trauma and CS amongst MHPs (Martin-Cuellar et al., 2018). Interestingly, few studies have considered the relationship between CS and mindfulness, although strategies to reduce CF, which may

improve CS, included mindfulness practice (Best et al., 2020; Duarte & Pinto-Gouveia, 2016; Gregory, 2015). Mindfulness has also been found to be associated with enhanced CS in healthcare professionals (Buceta et al., 2019) and reduced CF amongst MHPs (Turgoose & Maddox, 2017). Therefore, implementing strategies incorporating mindfulness techniques may support MHPs whose personal histories may decrease their capacity for CS.

Several psychological characteristics were identified in relation to CS within this review. Though hope, conscientiousness, cynicism and self-efficacy were determined to be independently associated with CS, samples sizes were small and few studies have explored these concepts. Therefore, it would be prudent to replicate these findings elsewhere to determine their influence. Resilience was identified to be associated with CS in two studies, which fits with strategies aimed at improving CS and reducing CF (Klein et al., 2018; Pehlivan & Güner, 2020). Empathy has been implicated as related to CF (Stamm, 2002) amongst social workers (Yi et al., 2019) and MHPs (Turgoose & Maddox, 2017). It is therefore surprising only one study found a clinically meaningful relationship for this concept in relation to CS (Laverdière et al., 2019). It may be that empathy is more directly associated with CF than CS. However, it would be beneficial for further research to investigate relationships between CS and other psychological characteristics to clarify their nature, including empathy and mindfulness.

Ten studies reported statistically meaningful results pertaining to a link between improved wellbeing and improved CS. Though this highlights the importance of protecting staff wellbeing, it is less clear what gives rise to improved wellbeing. Three studies suggested self-care had a positive relationship with wellbeing, however it is likely that wellbeing is also impacted by factors associated with CS such as social support and occupational stressors.

Social support was related to CS, with two studies suggesting those who make time for and engage in social support reported higher levels of CS (Başoğul et al., 2021; Killian, 2008;). This corroborates findings in physical healthcare literature (Barr, 2017; Varadarajan & Rani, 2021). It is useful to be aware of personal and social factors associated with CS to protect against reduced CS, which may lead to increased CF and the negative consequences of caring. However, occupational health research suggests resources are better focused on primary interventions, such as adequate staffing and reduced workload (Lamontagne et al., 2007; Montano et al., 2014), which would target organisational factors associated with CS.

Several occupational factors have been implicated in increasing CF in MHPs, including workload, co-worker support and supervision (Singh et al., 2020; Turgoose & Maddox, 2017). These factors have also been identified as relating to CS in physical healthcare literature. Similar findings were noted in this review, with workload factors demonstrating significant associations with CS in 11 studies. In two studies, this was in relation to the congruence between workers' expectations and several aspects of their job. This highlights the importance of transparency when hiring staff and throughout their employment. Other studies explored caseload factors and work activities, underlining the importance of staff having manageable and varied workloads of mixed presenting problems and duties, as well as feeling equipped to do their jobs.

Finally, this review demonstrated a relationship between team working, co-worker support and supervision, which echoes findings in other populations. Four studies suggested support from colleagues related to higher CS in MHPs and three reported positive relationships between supervision and CS. These have also been found to be protective factors for reducing CF (Singh et al., 2020) and strategies which promote peer support have demonstrated positive outcomes (Farr & Barker, 2017; Goodrich, 2012; Lown & Manning, 2010). Conversely, some authors concluded supervision was not significantly related to CS. It

could be worth exploring this in more depth to determine which aspects of supervision enhance CS, for example type of supervision (group, management, or clinical) or quantity of supervision which will enable services to specifically target supervisory support.

Within this review, several types of MHP were represented, including community mental health staff, counsellors, trauma therapists and unspecified psychotherapists. While this has been useful to provide an overview of factors associated with CS, it is also important to home in on specific factors within particular mental health contexts. Although several organisational factors were highlighted, these may differ between settings.

Strengths and Limitations

The main strength of this systematic review is that it was first to synthesise data on factors associated with CS within mental healthcare. It was also inclusive of a wide range of variables potentially relevant to CS. This unique approach has added important information regarding the relationship between concepts of PQoL and factors specifically related to the CS of practitioners working in mental health. The search strategy was thorough, with only one additional paper identified through reference list searching. In this way, this review has enabled the presentation of a more in-depth understanding of PQoL in MHPs, and has created a platform for further exploration of unique factors associated with PQoL in more specific mental health contexts.

In relation to transparent limitations, systematic searches were undertaken by one author. This may impact on the rigor of the selection process and replicability of the review. However, the search process was informed by an academic librarian and the PRISMA guidelines (Stewart et al., 2015), which should mediate this limitation. All studies were cross-sectional. This precludes conclusions being drawn about causality. Relatively small sample sizes limit the generalisability of findings. There were also several inconsistencies in the

literature and several themes were explored in only a small number of papers. Nonetheless, it is hoped the findings are sufficiently robust to inform future research into PQoL both within and outside the field of mental healthcare.

It would be prudent for further research to overcome these limitations by adopting longitudinal or qualitative designs to explore the wide variety of potential factors associated with CS and to complement the existing literature. Additionally, there are several populations within the field of mental health: it would be helpful to implement further research in well-defined populations to further explore important variables. Once factors associated with CS have been explored, it would be beneficial to identify and implement strategies to improve CS and to evaluate outcomes to determine their effectiveness and the impact they have on both CS and CF. This may add to the empirical evidence base regarding the nature of the relationship between CF and CS and whether the focus should remain on the negative aspects of caring, or whether a focus on CS is equally or more helpful.

Implications

Although further evidence is needed before firm conclusions can be drawn, provisional recommendations are presented to enhance CS in MHPs at both individual and organisational levels.

At the individual level, this review highlighted the relationship between CS and wellbeing and self-care. Individuals should attempt to take reasonable steps to maintain their wellbeing and engage in self-care activities that are meaningful for themselves, including making time to socialise outside of work. While demographic and personal factors may account for some variance in CS, these may be more difficult to target. It is recommended that organisations familiarise themselves with these risk factors (for example, personal

trauma, age and experience) and continually monitor employees, providing extra support should these variables impact on staff.

At the organisational level, this review highlighted several other areas in which organisations can develop clear frameworks for enabling staff to deliver care with compassion and avoiding the negative physical, behavioural, and psychological consequences of reduced CS. Understanding their employees and implementing strategies to improve organisational commitment may improve job satisfaction. It seems important that staff have reasonable and manageable workloads, with variability of duties and clientele to avoid a reduction in CS. Similarly, there should be opportunities for training and development, which may bridge the gap between expectations and realities of the role, and to work autonomously which may give rise to more satisfied staff. Peer support has been highlighted as an important factor contributing to differences in CS, therefore it would be paramount to focus on supervision arrangements and opportunities for co-worker support. Based on the findings of this review, peer-support to nurture CS could be operationalised for MHPs through protected opportunities for socialising and reflecting on the emotional aspects of caring for others.

Conclusion

The present review is the first to systematically collate the variables associated with CS in MHPs. To deliver good outcomes for clients, MHPs need to have high PQoL, which comes from high levels of CS and low levels of CF. The results of this review suggest a fairly close, but not exact, negative correlation between CS and CF. Consequently, it cannot be assumed that improving CF will result in higher levels of CS, so it is also important to consider determinants of CS. Several variables may be associated with CS, including personal, social, and organisational factors. Although inconsistencies arose within all categories, the review has enabled the identification of a number of practical implications.

Several of the variables that likely contribute to differences in CS are organisational. This suggests the primary focus of any improvement strategy should be on targeting those variables that can be limited (e.g., workload) or increased (e.g., access to supervision and peer support), rather than putting the onus on staff members to participate in additional practices or interventions on top of their usual workload which might exacerbate issues arising from lack of time and resource. Additionally, it could be wise to implement robust workplace support, particularly for staff with demographic and personal factors which may make them more vulnerable to lower CS and higher CF.

Although tentative implications are discussed, a more robust analysis is needed of factors relating to CS pertinent to supporting individuals' PQoL. Further research with larger, clearly defined samples, adopting alternative methodology is required to explore factors associated with CS among MHPs. This would create space for strategies to be piloted and evaluated to improve CS, which in turn may reduce CF, and allow for delivery of effective and compassionate care.

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Tables and Figures

Table 1: Systematic search terms

String	Search Terms
String 1	TI “compassion satisfaction” OR AB "compassion satisfaction”
String 2	DE “Occupational Stress” OR DE “compassion fatigue” OR DE "Resilience (Psychological)" OR DE "psychological endurance" OR DE "resilience" OR TI burnout OR burn-out OR burnout OR compassion fatigue OR resilience OR endurance OR AB burnout OR burn-out OR burnout OR compassion fatigue OR resilience OR endurance
String 3	DE “sympathy” OR DE “self-compassion” OR TI compassion OR empathy OR kindness OR OR AB compassion OR empathy OR kindness
String 4	S2 AND S3
String 5	S1 or S4

Table 2: Study characteristics

Study / Location	Study Design / Aims	Participant Characteristics & Sample Demographics	Factor(s) investigated / Measures Used	Main Findings / Comments	Effect Size
Adeyemo Sunday et al. (2015) / Nigeria	Cross-sectional / Examined factors influencing professional quality of life	Professionals in a Nigerian mental health facility *N = 234* 67.9% female 76.9% married *M* age = *39.23* (±7.79) years	**Psychological Distress** / GHQ-12 (Goldberg & Williams, 1988) **Professional Quality of Life** / ProQOL 5 (Stamm, 2010)	Participants who were married reported significantly better ProQOL (t (218) = -2.220, $p < 0.05$).	Cohen's d = .392
Başoğul et al. (2021) / Turkey	Cross-sectional / Investigated the relationship between professional values and professional quality of life	Nurses working in three mental health units *N = 194* *M* Age = *39.88* ± 5.69 years 75.8% female 82.5% married 47.6% undergraduate degree	**Nurse Professional Values** / Turkish validated version of NPVS-R (Weis & Schank, 2017; Geçkil et al., 2012) **Professional Quality of Life** / Turkish validated version of ProQOL-4 (Stamm, 2005**;** Yeşil et al., 2010)	There were significant correlations between CS and: NPVS mean scores ($p < .05$) BO ($p < .05$) CF ($p < .05$) Caring ($p < .05$) Professionalism ($p < .05$) Activism ($p < .05$) Justice ($p < .05$) Truth ($p < .05$) Nurses with low CS considered changing units (F (2,117) = 4.402, $p < .05$) CS scores were higher in those allocating time for social life (F (2,117) = 6.670, $p < .01$) CS was significantly predicted by education level, considering changing units, allocating time for social life and truth, accounting for 44% of the total variance in CS (R = .664, R^2 = 0.441, $p < 0.001$).	 r = .526 r = .271 r = -.234 r = .488 r = .444 r = .413 r = .484 r = .538 η_p^2 = .067 η_p^2 = .102 R^2 = .441

Bell et al. (2019) / UK	Cross-sectional / Assessed levels of burnout, compassion fatigue and compassion satisfaction, and to explore whether risk and protective factors found in other settings are associated with the above in prison setting	Mental health nurses and correctional officers working within a large male remand prison *N = 36* *M* age = *40.31* (±1.57) years 58.3% nurses 41.7% correctional officers 41.7% female 55% White/Caucasian 72.2% married	**Exposure to traumatic events and support** / questionnaire collecting data on whether staff had witnessed or experience traumatic events, how many times they had been exposed to these events, organisational and peer support, and whether they felt they had the skills needed for their role **Professional quality of life** / ProQOL 5 (Stamm, 2010)	Higher CS was found to be significantly associated with: Black ethnicity (B = 8.87, p = 0.003) Higher self-reported levels of emotional support from colleagues (B = 5.33, p = 0.005) Regular supervision (B = 3.51, p = 0.005) Encouragement (B = 3.76, p = 0.023) Consultation from management (B = 6.26, p < 0.001) Feeling equipped with appropriate skills for the role (B = 5.27, p = 0.012) Lower CS was significantly associated with: Living alone (B = –7.08, p = 0.032) Being employed as a correctional officer rather than a mental health nurse (B = –9.45, p = 0.001) Working in prisons for over 10 years (B = –11.55, p = 0.042) Higher levels of exposure to traumatic events (B = –14.31, p = 0.005)	Effect sizes not reported and unable to calculate
Browning et al. (2019) / USA	Cross-sectional / Examined the contributions of demographic variables, hope, gratitude, and daily spiritual experiences as predictors of professional quality of life	Counsellors attending a stated counselling association conference *N = 98* 82.7% female Aged 24-77, *M = 44.55* years 65.3% married 53.1% White/Caucasian	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Gratitude** / GQ-6 (McCullough et al., 2002) **Trait Hope** / Trait Hope Scale (Snyder et al., 1991) **Daily Spiritual Experiences** / DSES (Underwood, 2011)	There was a significant relationship between CS and: Hope (p < .01) BO (p < .01) CS was predicted by higher trait hope. (β = .41, p < .001). The final model accounted for 22% of the variation in counsellors' CS.	 r = .420 r = -.480 R^2 = .223
Cetrano et al. (2017) / Italy	Cross-sectional / Investigated if and how quality	Mental health staff working in three Italian	**Quality of Working Life** / Quality of Working Life	CS was significantly associated with: Ergonomic problems (p = .012) Trust (p < .001)	 r_s = -.120 r_s = .200

	of working life affects compassion fatigue, burnout and compassion satisfaction	Mental Health Departments *N = 400* 75.9% female Aged 18-60+ years 61.3% married	Questionnaire (Gosetti, 2014) **Professional Quality of Life** / Italian validated version of ProQOL 3 (Stamm, 2003; Palestini et al., 2009)	Autonomy ($p < .001$) Participation ($p = .003$) Perceived quality of meetings ($p < .001$) Organizational commitment ($p < .001$) Perceived need of training ($p = .024$) Perceived risks for the future ($p = .007$) Higher CS was significantly predicted by perceived quality of meetings ($B = 1.873$, $p = 0.0007$), perceived need to attend training ($B = 3.138$, $p = 0.035$) and perceiving no risks for the future ($B = -3.170$, $p = 0.012$).	$r_s = .200$ $r_s = .150$ $r_s = .290$ $r_s = .280$ Effect sizes not reported, unable to calculate Adjusted $R^2 = .180$
Clark et al. (2021) / USA	Cross-sectional / Examined imposter phenomenon on professional quality of life	Mental health professionals *N = 158* Aged 22-77 *M = 41.24* (±13.74) years 83.5% female 85% Caucasian 66.5% married	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Imposter Phenomenon** / Imposterism Scale (Leary et al., 2000)	CS had significant relationships with: Imposter phenomenon ($p < .01$) CF ($p < .01$) BO ($p < .01$) STS ($p < .01$) When controlling for age and years of work in mental health, these relationships decreased slightly Imposter phenomenon ($p < .01$) CF ($p < .01$) BO ($p < .01$) STS ($p < .01$) When controlling for age and years of work, imposter phenomenon and CS shared 17% of their variance with one another	 $r = -.433$ $r = -.506$ $r = -.650$ $r = -.258$ $r_{partial} = -.417$ $r_{partial} = -.493$ $r_{partial} = -.641$ $r_{partial} = -.247$ $R^2 = .173$
Craig & Sprang (2010) / USA	Cross-sectional / Investigated the impact of evidence-based practices on	Trauma treatment therapists *N = 532*	**Professional Quality of Life** / ProQOL 3 (Stamm, 2003) **Evidence-Based Practices** / Trauma Practices	Those reporting special training in trauma treatment reported significantly higher CS than those without specialist training ($t(499) = -4.42$, $p<.001$)	Cohen's $d = .400$

	compassion fatigue, burnout, and compassion satisfaction	Aged 27-83 *M = 53.2* years 65% female	Questionnaire (Craig & Sprang, 2009; Sprang & Craig, 2007)	There were significant differences in CS and type of organization (F (5,500) = 4.38, p < .001*)* with those working in community health centres reported significantly higher CS than those working in private, non-profit agencies. Years of clinical experience (β = .260, p < .001) and use of evidence-based practice (β = .170, p < .001) were significantly associated with CS, explaining 14% of the variance in CS.	η_p^2 = .042 R^2 = .140
Dehlin & Lundh (2018) / Sweden	Cross-sectional / Investigated how the availability of supervision and the importance of reflection about relational processes are associated with compassion fatigue and compassion satisfaction	Psychologists *N = 384* Aged 20-54 years 83.3% female	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Supervision and Reflective Stance** / 3 items constructed specifically for the study, rated on a 5-point Likert scale from 1 (never) to 5 (very often)	CS was significantly associated with: Age (p < .05) Years of clinical experience (p < .01) Availability of supervision/collegial support (p < .01) Reflection (p < .01) Relevance of reflection (p < .01) BO (p < .001) STS (p < .05) The low supervision/low reflection cluster scored lower than all the other clusters for CS. In addition, the high supervision/low reflection cluster scored significantly lower than the high supervision/high reflection cluster and the high supervision/average reflection clusters (F (4,374) = 17.42, p < .001)	 r_s = .110 r_s = .160 r = .320 r = .230 r = .320 r = -.650 r = -.130 η_p^2 = .157
Itzhaki et al. (2018) / Israel	Cross-sectional / Investigated the effect of job stress, and exposure to	Mental health nurses from various departments *N = 114*	**Violence Exposure** / Four questions using Likert scale from 1 (not at all) to 5 (very often)	CS was associated with: Work stress (p < .01) BO (p < .01)	 r = .390 r = -.470 R^2 = .210

	violence or nurses ProQOL	Aged 26-64 years *M = 47.3* (±9.02) 56.3% female 77.2% married	**Professional Quality of Life** / Translated version of ProQOL 5 (Stamm, 2010) **Job Stress** / rating of job stress from 1(not at all) to 5 (very often) (Shen et al., 2005)	The multiple regression model explained 21% of the variance in CS, only work stress significantly predicted CS ($\beta = -0.47$, $p < 0.01$).	
Killian (2008) / USA	Cross-sectional / Determined the individual and contextual factors that predict compassion satisfaction, compassion fatigue and burnout	Systemically oriented therapists working with trauma survivors *N = 104* Aged 25-64 *M = 38.65* (±11.17) years 79.8% female 47% White	**Social Support** / Social Support Index (McCubbin, et al., 1982) **Personal Trauma History** / checklist of traumatic events asking whether the event had happened, how many times, and how stressful it had been at the time of its occurrence **Affective Coping** / Brief COPE (Carver, 1997) **Self-Care** / Questions designed by author **Compassion Satisfaction and Fatigue** / Compassion fatigue and satisfaction subscales (ProQOL R-3; Stamm, 2003) **Burnout** / Emotional exhaustion subscale of MBI (Masclach & Jackson, 1981) **Emotional Self-Awareness** / Emotional Self-Awareness Questionnaire (Killian, 2007) **Perceptions of Work Environment** / Questions designed by the author focusing on resources,	Social support ($\beta = .360$, $p < .001$), weekly hours of clinical contact ($\beta = -.370$, $p = .007$) and therapist's locus of control at work ($\beta = .220$, $p = .047$) accounted for 41% of the variance in CS ($F = 14.32$, $p < .001$).	Adjusted $R^2 = .410$

			sources of stress and work morale **Autonomy** / (Trudeau et al., 2001)		
Lakioti et al. (2020) / Greece	Cross-sectional / Investigated the factors that help therapists maintain their resilience to work stressors	Mental health practitioners *N = 163* Aged 26-63 *M = 40.62* (±9.75) years 84.7% female 51.5% married	**Professional Quality of Life** / Greek version of ProQOL 5 (Stamm, 2010) **Counselor Activity Self-Efficacy** / Greek validated version of CASES (Lent et al., 2003; Lakioti & Karamouzi, 2017) **Empathy** / Greek adapted form of B-IRI (Ingoglia et al., 2016; Tsitsas & Malikiosi-Loizos, as cited in Tsitsas, 2009) **Well-being** / Greek adaptation of PERMA Profiler (Butler & Kern, 2016; Pezirkianidis et al., 2019)	CS was associated with: BO ($p < .001$) STS ($p < .01$) Counselling self-efficacy ($p < .001$) Positive emotion ($p < .001$) Engagement ($p < .001$) Relationships ($p < .01$) Meaning ($p < .001$) Accomplishment ($p < .001$) Counselling self-efficacy (F (1,154) = 5.06, p = .026) and meaning (F (1,155) = 60.33, p = .000) had a significant positive influence on CS, explaining 30.3% of the variance.	 r = -.570 r = -.230 r = .350 r = .400 r = .350 r = .270 r = .530 r = .360 Adjusted R^2 = .294
La Mott & Martin (2018) / USA	Cross-sectional / Examined the moderating effects of self-care on compassion outcomes	Licensed mental health professionals *N = 371* *M* age = 41.12 (±12.52) years 94.1% female 70.1% married	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Resilience** / BRS (Smith et al., 2008) **Self-Care** / SCAW (Saakvitne & Pearlman, 1996) **Adverse Childhood Experiences** / ACE questionnaire (Felitti et al., 1998)	CS was significantly higher in mental health providers with no history of ACEs compared to those with a history of ACEs (t (369) = 1.98, p = 0.048). CS was significantly associated with: Resilience ($p < .001$) BO ($p < .001$) STS ($p < .001$) Physical self-care ($p < .001$) Psychological self-care ($p < .001$) Emotional self-care ($p < .001$) Spiritual self-care ($p < .001$)	Cohen's d = .289 r = .400 r = -.660 r = -.340 r = .320 r = .300 r = .420 r = .420

				Professional self-care ($p < .001$) Balance ($p < .001$) Total self-care ($p < .001$) Resiliency ($B = 1.680$, $p < .001$) and self-care ($B = 4.96$, $p < .001$) accounted for a significant portion of the variance in CS, with the final model accounting for 26% of variance (F (6,364) = 22.52, $p < 0.001$).	$r = .430$ $r = .360$ $r = -.560$ $R^2 = .260$
Laverdière et al. (2019) / Canada	Cross-sectional / Explored work conditions, self-care behaviours, and dispositional empathy as possible correlates of professional quality of life	Psychotherapists *N = 240* *M* age = *42* (± 11.66) years 78% female Psychotherapists	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Empathy** / TEQ (Spreng et al., 2009)	CS was significantly associated with: Years of experience ($p < .001$) Empathy ($p < .001$) CS was higher in those working in independent practice compared to institutional settings (t(187) = 2.41, $p = .017$) Those doing only individual therapy with adults had less CS than those doing other modes of therapy (t(236) = -3.44, $p < .001$) Theoretical orientation was related to CS (F(3, 231) = 7.00, $p < .001$), with psychodynamic psychotherapists experiencing less CS compared to others. Those working with clients with a personality disorder reported lower CS than those not working with them (t(236) = -2.65, $p = .235$). Psychodynamic orientation ($\beta = -.200$, $p < .05$), individual work only ($\beta = -.190$, $p < .05$), years of experience ($\beta = .210$, $p < .05$) and empathy ($\beta = .27$, $p < .05$) significantly predicted CS, explaining 18% of the variance in CS. Empathy had a significant and unique contribution, explaining an additional 7% of the variance	 $r = .280$ $r = .270$ Cohen's $d = .352$ Cohen's $d = .448$ $\eta_p^2 = .083$ Cohen's $d = .345$ $R^2 = .250$

/	/		/	/	/
Laverdière, Ogrodniczuk & Kealy (2019) / Canada	Cross-sectional / Explored the relationship of empathy to compassion satisfaction, burnout, and secondary traumatic stress, while also considering the influence of important work conditions		**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Empathy** / IRI (Davis, 1983)	CS was associated with: Cognitive empathy ($p < .01$) Empathic concern ($p < .01$) Personal distress ($p < .01$)	 $r = .260$ $r = .170$ $r = -.370$
Lawson & Myers (2010) / USA	Cross-sectional / Addressed gaps concerning counsellor wellness in relation to professional quality of life and career sustaining behaviours	Professional counsellors *N = 506* *M* age = *49.9* (±11.1) years 78.8% female 89.1% Caucasian	**Professional Quality of Life** / ProQOL 3 (Stamm, 2003) **Wellness** / 5F-Wel (Myers & Sweeney, 2004, 2005) **Career Sustaining Behaviours** / CSBQ (Stevanovic & Rupert, 2004)	Counsellors who worked in private practice scored higher on the CS subscale than counsellors working in other settings (F (4, 481) = 7.82, $p < 0.001$). CS was significantly associated with: Percentage of high-risk clients ($p < 0.001$) Total wellness ($p < 0.01$)	$\eta^2_p = .061$ $r = -.180$ $r = .570$
Linley & Joseph (2007) / UK	Cross-sectional / Investigated salient factors that may be associated with positive and negative aspects of well-being	Therapists *N = 156* Aged 27-85 years *M = 53.67* (±10.9) 78.2% female 97% White 64% married	**Social Support** / Crisis Support Scale (Joseph et al., 1992) **Empathy** / JSPE (Hojat et al., 2002) **Personal Attachment between Client and Therapist** / WAI-Bond (Horvath & Greenberg, 1989)	CS was significantly associated with: Transpersonal training ($p < .01$) Eclectic training ($p < .05$) Transpersonal practice ($p < .05$) Eclectic practice ($p < .05$) CS was significantly predicted by sense of coherence ($\beta = -.440$, $p < .001$) and working alliance/therapeutic bond ($\beta = -.450$, $p < .001$)	 $r = .190$ $r = .180$ $r = .180$ $r = .140$ Effect size not reported, unable to calculate

			Professional Quality of Life / ProQOL 3, Stamm, 2002) **Coherence** / SOC-13 (Antonovsky, 1993) **Personal Growth** / PTGI (Tedeschi & Calhoun, 1996) **Psychological Changes** / CiOQ (Joseph et al., 1993)		
Litam et al. (2021) / USA	Cross-sectional / Examined the experiences of counsellors during the pandemic	Professional counsellors providing services during the COVID-19 pandemic *N = 161* Aged 21-66 years, *M = 39* (±11) 83.9% female 67.1% White	**Perceived Stress** / PSS (Cohen et al., 1983) **Professional quality of life** / ProQOL 5 (Stamm, 2010) **Coping Strategies** / CSI-SF (Addison et al., 2007) **Resilience** / RS (Wagnild & Young, 1993) **PTSD** / PCL-5 (Weathers et al., 2013)	ProQOL was significantly associated with: Perceived stress ($p < .001$) Resilience ($p < .001$) PTSD ($p < .001$) Posttraumatic stress ($\beta = .070$, p = NS), coping responses ($\beta = .080$, p = NS), resilience ($\beta = .060$, $p < .001$), and perceived stress ($\beta = -.170$, p = NS) significantly predicted CS ($F(4, 154) = 35.56$, $p < .001$).	 $r = .450$ $r = -.210$ $r = .480$ Effect size not reported, unable to calculate
Mangoulia et al. (2015) / Greece	Cross-sectional / Investigated the prevalence of compassion fatigue, compassion satisfaction, burnout and compassion satisfaction, and their risk factors	Psychiatric nurses *N = 174* *M* age = *36.87* (±7.37) years 70.1% female 54% married	**Professional quality of life** / ProQOL 4 (Stamm, 2005) **Personal and work related characteristics** / questionnaire items designed specifically for study	Choice to work in a psychiatric unit ($B = 6.393$, $p < .001$), opinion that the staff only worked sometimes as a team ($B = -5.838$, $p < .001$) and description of their mental health as not excellent were significant predictors of CS. Those who desired nursing career for their children experienced higher CS than those who did not ($t(173) = -4.57$, $p < .001$) Those who would choose nursing again for their selves experienced higher CS than those who would not ($t(173) = -5.55$, $p < .001$) CS was higher in those who: Described having very good relationships with colleagues ($F(4,169) = 9.64$, $p < .001$)	$R^2 = .374$ Cohen's $d = .831$ Cohen's $d = .845$ $\eta^2_p = .186$

				Felt staff work always as a team (F (4,169) = 7.40, p < .001) Described their physical health as excellent (F (4,169) = 5.91, p < .001) Described their mental health as excellent (F (4,169) = 10.78, p < .001) CS was lower in those who: Desired to leave the hospital soon (F (4,169) = 4.63, p = .001) CS was significantly associated with: BO (p < .001) CF (p < .001)	η^2_p = *.149* η^2_p = *.123* η^2_p = *.203* η^2_p = *.099* r = -.600 r = -.250
Martin-Cuellar et al. (2018) / USA	Cross-sectional Addressed models of mindfulness as a protective factor for the associations between a clinician's history of trauma and their experience with CS	Mental health professionals *N = 113* 77% female Aged 24-26 years, *M* = 44.06 (±13.83) 69% non-Hispanic white	**Childhood Trauma** / Childhood Trauma Questionnaire (Pennebaker & Susman, 2013) **Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Mindfulness Attention and Awareness** / MAAS (Brown & Ryan, 2003)	CS was significantly associated with mindfulness (p < .01) Past trauma had no effect on CS (β = .-.03, p = .71), but mindfulness positively predicted CS (β = .30, p = .001). Recent trauma had no effect on CS (β = .14, p = .12), while mindfulness had a significant effect (β = .34, p < .001), Mindfulness was found to moderate and reduce the effect of recent trauma on CS (β = −.22, p = .02).	r = .380 R^2 = 0.100 R^2 = 0.150
McKim & Smith-Adcock (2013) / International	Cross-sectional / examined individual and workplace characteristics to determine their relative influence on compassion satisfaction and	Mental health professionals *N = 98* 74.5% female 91.8% White	**Professional quality of life** / ProQOL 4 (Stamm, 2005) **Workplace Factors** / Four subscales of Psychologist's Burnout Inventory (Ackerley et al., 1998) measuring control, over-involvement, support and negative clientele	CS was significantly associated with: Years of clinical experience (p < .05) Trauma history (p < .05) Overinvolvement (p < .05) Control (p < .01) Personal trauma history (β = 0.198, p < 0.29), years of experience (β = 0.133, p = NS), and control (β = −0.445, p < .001) significantly contributed 26% to the total variance in CS.	 r = .223 r = .243 r = -.250 r = -.467 R^2 = .540

	compassion fatigue		**Personal Trauma History** / Stressful Life Experiences Short Form (Stamm, 1997)		
Ray et al. (2013) / Canada	Cross-sectional / Determined relationships among compassion satisfaction, compassion fatigue, work life conditions and burnout	Frontline mental health care professionals *N = 169* *M* age = *43.8* (±11.61) years 81.7% female	**Compassion satisfaction and compassion fatigue** / Subscales of ProQOL 4 (Stamm, 2005) **Work Life** / AWS (Leiter & Maslach, 2011) **Burnout** / MBI (Maslach et al., 1996)	CS was significantly associated with: CF ($p < .01$) Areas of Work Life ($p < .01$) (Workload, control, reward, community, values, fairness) Emotional Exhaustion ($p < .01$) Cynicism ($p < .01$) Personal Efficacy ($p < .01$) CS predicted: Emotional exhaustion Cynicism	 $r = -.230$ $r = .520$ ($r = .420$, $r = .420$, $r = .540$, $r = .400$, $r = .290$, $r = .250$) $r = -.520$ $r = -.700$ $r = .610$ Adjusted $R^2 = .275$ Adjusted $R^2 = .483$
Rossi et al. (2012) / Italy	Cross-sectional / Assessed burnout, compassion fatigue and compassion satisfaction	Community-based mental health staff *N = 260* Aged 18-50+ 66.7% female 60.3% married	**Professional Quality of Life** / Italian validated version of ProQOL 3 (Stamm, 2003; Palestini et al., 2009) **General Psychological Distress** / GHQ-12 (Piccinelli et al, 1993; Goldberg et al., 1997) **Stress Exposures** / Survey asking about eight negative life events (Freedy et al., 1993) and survey asking about eight lifetime traumatic events	CS was significantly associated with: Psychological distress ($p < .0001$) BO ($p < .0001$) CF ($p < .0001$) Distressed workers had significantly lower CS than non-distressed ones (t (245) = 3.99, $p < .0001$) Having a fixed-term contract over open-ended contract ($B = 5.449$, $p = .017$) and psychological distress ($B = -4.298$, $p < .0001$) significantly predicted CS.	 $r = -.287$ $r = -.422$ $r = -.159$ Cohen's $d = .510$ Adjusted $R^2 = .080$
Sodeke-Gregson et al. (2013) / UK	Cross-sectional / assessed the prevalence of, and identified predictor	Therapists working with adult trauma clients *N = 253* 71.9% female	**Coping Strategies** / CSI (Bober et al., 2006) **Professional Quality of Life** / ProQOL 5 (Stamm, 2010)	CS was significantly associated with: Age ($p < .01$) Qualification ($p < .01$) Number of years post qualification ($p < .05$) Days of training since qualification ($p < .01$)	 $r = .265$ $r = .181$ $r = .151$ $r = .201$

	variables for, compassion satisfaction, burnout and secondary traumatic stress			Leisure beliefs ($p < .01$) Supervision beliefs ($p < .05$) Time spent engaging in self-care ($p < .01$) Time spent engaging in supervision ($p < .01$) Time spent engaging in R&D activities ($p < .01$) Perceived support by management ($p < .01$) Perceived support of supervision ($p < .01$) Age ($\beta = 0.210$, $p < .05$), time spent engaging in R&D activities ($\beta = 0.170$, $p < .05$), perceived management support ($\beta = 0.140$, $p < .05$), and perceived supervision support ($\beta = 0.170$, $p < .05$) were significant predictors of CS (F (11,220) = 5.825, $p < .001$).	$r = .171$ $r = .153$ $r = .216$ $r = .196$ $r = .282$ $r = .214$ $r = .254$ Adjusted $R^2 = .187$
Somoray et al. (2015) / Australia	Cross-sectional / Examined the role of personality and workplace belongingness in predicting compassion satisfaction, secondary traumatic stress, and burnout	Mental health staff working in a counselling service *N = 156* *M* age = *44.60* (±12.42) years 79.5% female	**Professional quality of life** / ProQOL 5 (Stamm, 2010) **Personality** / NEO-FFI (Costa & McCrae, 1992) **Sense of belonging** / PSOM (Cockshaw & Schochet, 2010)	CS was significantly correlated with: Age ($p < .01$) Personal trauma ($p < .01$) Neuroticism ($p < .01$) Extraversion ($p < .01$) Openness ($p < .05$) Agreeableness ($p < .01$) Conscientiousness ($p < .01$) Workplace belongingness ($p < .01$) Age ($\beta = .260$, $p < .01$), conscientiousness ($\beta = .240$, $p < .01$) and workplace belongingness ($\beta = .350$, $p < .001$) significantly predicted the variance in CS.	 $r = .400$ $r = .270$ $r = -.320$ $r = .330$ $r = .170$ $r = .310$ $r = .290$ $r = .500$ Adjusted $R^2 = .420$
Sprang et al. (2007) / USA	Cross-sectional / Explored variables that might influence compassion satisfaction,	Mental health providers *N = 1121* *M* age = *45.22* (±10.84) years 69.6% female	**Professional Quality of Life** / ProQOL 3 (Stamm, 2003) **Personal and Professional characteristics** / Items aimed to identify characteristics soliciting	CS differed by licensure (F (7, 523) = 2.26, $p < .05$) CS differed by specialized training, with those having specialized training having greater CS (F (1, 1076) = 37.09, $p < .001$)	$\eta^2_p = .029$ $\eta^2_p = .033$

	compassion fatigue and burnout		information about age, gender, experience, discipline, training and practice methods	Older age (β = .194, p < .000) and clients with PTSD (β = .067, p < .01) predicted CS Seven variables jointly accounted for 59% of the variance in CS.	Adjusted R^2 = .590
Sukut et al. (2021) / Turkey	Cross-sectional / Determined the relationship between professional quality of life and psychological resilience	Psychiatric nurses *N = 100* *M* age = *32.46* (±8.60) years 82.4% female	**Professional Quality of Life** / Turkish validated version of ProQOL 4 (Stamm, 2005; Yeşil et al., 2010) **Resilience** / Turkish validated version of CD-RISC (Connor & Davidson, 2003; Karairmak, 2010)	Female psychiatric nurses had higher scores on CS than male psychiatric nurses (p =.0009). Job status impacted CS significantly (p = .019). CS was significantly related to: BO (p < .05) Resilience (p < .05) Linear regression demonstrated a positive association only between resilience and CS (β = 0.391, p < .001).	Effect sizes not reported, unable to calculate r = -.437 r = .424 Effect size not reported, unable to calculate
Tirgari et al. (2018) / Iran	Cross-sectional / Determined the relationship between PTSD and professional quality of life	Psychiatric nurses *N = 160* Aged 30-39 years, *M = 33.01* (±6.91) 75.6% female 80% married	**Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **PTSD** / PTSD Checklist (Weathers, et al., 1991)	There was a significant correlation between PTSD and CS (p < .001)	r = .610
Towey-Swift & Whittington (2019) / UK	Cross-sectional / Identified how person-job congruence is associated with compassion fatigue and compassion satisfaction and how these relate to staff recovery attitudes	Community Mental Health Team (CMHT) staff *N = 132* Aged 31-60 years 72% female	**Person-Job Congruence** / AWS (Leiter & Maslach, 2011) **Professional Quality of Life** / ProQOL 5 (Stamm, 2010) **Recovery Knowledge and Attitudes** / RKI (Bedregal et al., 2006)	CS was significantly associated with: Years worked in current setting (p = .020) Workload (p < .01) Control (p < .01) Reward (p < .01) Community (p < .01) Fairness (p < .01) Values (p < .01) BO (p < .01) STS (p < .01)	 r = -.203 r = .326 r = .333 r = .363 r = .288 r = .329 r = .326 r = -.784 r = -.441

				Workload remained significant in predicting CS in hierarchical regression (F (7,123) = 6.315, $p < .001$)	$R^2 = .222$
Xie et al. (2020) / China	Cross-sectional / Investigated the prevalence and factors of compassion fatigue	Psychiatric nurses *N = 352* Aged 18-50 *M = 29.68* (±7.08) 83.8% female 57.7% married	**Professional Quality of Life** / Chinese validated version of ProQOL 5 (Stamm, 2010; Shen, 2015)	Higher CS was presented in: Psychiatric nurses who were female (t (351) = -2.278, p = .023) Nurse supervisors or above (F (2, 349) = 3.334, p = .037) Head nurses (t (351) = -2.485, p = .013) Those who had children (t (351) = 2.670, p = .008) Those who worked day shift (t (351) = 0.389, p = .027) Those who did not smoke (t (351) = -2.767, p = .006) Job satisfaction (β = .530, p = .000), exercise (β = .141, p = .002), had children (β = -.196, p = .001) and age range from 36 to 50 years (β = -.133, p = .023) explained 30.7% of the variance in compassion satisfaction.	Cohen's d = .321 $\eta^2_p = .019$ Cohen's d = .544 Cohen's d = .284 Cohen's d = .314 Cohen's d = .888 $R^2 = .307$

Please note: GHQ-12 = General Health Questionnaire, ProQOL = Professional Quality of Life, NPVS-R = Nurse Professional Values Scale – Revised, GQ-6 = Gratitude Questionnaire – six item form, DSES = Daily Spiritual Experiences Scale, WPV = Work Place Violence, COPE = Coping Strategies, MBI = Maslach Burnout Inventory, CASES = Counselor Activity Self-Efficacy Scales, B-IRI = Brief Interpersonal Reactivity Index, PERMA = positive emotion, engagement, relationships, meaning and accomplishment, BRS = Brief Resilience Scale, SCAW = Self-Care Assessment Worksheet, ACE = Adverse Childhood Experience, TEQ = Toronto Empathy Questionnaire, IRI = Interpersonal Reactivity Index, WAI = Working Alliance Inventory, SOC-13 = Sense of Coherence, PTGI = Posttraumatic Growth Inventory, CiOQ = Changes in Outlook Questionnaire, PSS = Perceived Stress Scale, CSI-SF = Coping Strategies Inventory Short-Form, RS = Resilience Scale, PCL-5 = The PTSD Checklist for DSM-5, JSPE = Jefferson Scale of Physician Empathy, 5F-Wel = Five Factor Wellness Inventory, CSBQ = Career Sustaining Behaviours Questionnaire, MAAS = Mindfulness Attention and Awareness Scale, AWS = Areas of Work Life Scale, CSI = Coping Strategies Inventory, NEO-FFI = NEO Five Factor Inventory, PSOM = Psychological Sense of Organisational Membership, CD-RISC = The Connor-Davidson Resilience Scale, RKI = Recovery Knowledge Inventory, CS = compassion satisfaction, BO = burnout, CF = compassion fatigue, PT = perspective taking, EC = empathic concern, R&D = research and development, PTSD = Post Traumatic Stress Disorder

Table 3: Quality Appraisal of Studies

Study	1. Were the aims/objectives of the study clear?	2. Was the study design appropriate for the stated aim(s)?	3. Was the sample size justified?	4. Was the target/reference population clearly defined?	5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	7. Were measures undertaken to address and categorise non-responders?	8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	10. Is it clear what was used to determine statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	12. Were the basic data adequately described?	**13. Does the response rate raise concerns about non-response bias?**	14. If appropriate, was information about non-responders described?	15. Were the results internally consistent?	16. Were the results presented for all the analyses described in the method?	17. Were the authors' discussions and conclusions justified by the results?	18. Were the limitations of the study discussed?	**19. Were there any funding sources or conflicts of interest that may affect the authors interpretation of the results?**	20. Was ethical approval or consent of participants attained?	**Score**
Adeyemo Sunday et al. (2015)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	**DK**	No	No	Yes	No	Yes	**DK**	Yes	13
Başoğul et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	**No**	No	No	Yes	Yes	Yes	**No**	Yes	17
Bell et al. (2019)	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	13
Browning et al. (2019)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	**No**	No	Yes	Yes	Yes	Yes	**DK**	Yes	14
Cetrano et al. (2017)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**No**	No	No	Yes	Yes	Yes	**No**	Yes	14
Clark et al. (2021)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	16
Craig & Sprang (2010)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	15

Study	1. Were the aims/objectives of the study clear?	2. Was the study design appropriate for the stated aim(s)?	3. Was the sample size justified?	4. Was the target/reference population clearly defined?	5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	7. Were measures undertaken to address and categorise non-responders?	8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	10. Is it clear what was used to determine statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	12. Were the basic data adequately described?	**13. Does the response rate raise concerns about non-response bias?**	14. If appropriate, was information about non-responders described?	15. Were the results internally consistent?	16. Were the results presented for all the analyses described in the method?	17. Were the authors' discussions and conclusions justified by the results?	18. Were the limitations of the study discussed?	**19. Were there any funding sources or conflicts of interest that may affect the authors interpretation of the results?**	20. Was ethical approval or consent of participants attained?	**Score**
Dehlin & Lundh (2018)	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**No**	Yes	12
Itzhaki et al. (2018)	Yes	Yes	No	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	14
Killian (2008)	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**DK**	Yes	12
Lakioti, et al. (2020)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	12
La Mott & Martin (2018)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**DK**	Yes	13
Laverdière et al. (2019)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**DK**	Yes	14
Laverdière, Ogrodniczuk & Kealy (2019)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**No**	Yes	14

Study	1. Were the aims/objectives of the study clear?	2. Was the study design appropriate for the stated aim(s)?	3. Was the sample size justified?	4. Was the target/reference population clearly defined?	5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	7. Were measures undertaken to address and categorise non-responders?	8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	10. Is it clear what was used to determine statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	12. Were the basic data adequately described?	**13. Does the response rate raise concerns about non-response bias?**	14. If appropriate, was information about non-responders described?	15. Were the results internally consistent?	16. Were the results presented for all the analyses described in the method?	17. Were the authors' discussions and conclusions justified by the results?	18. Were the limitations of the study discussed?	**19. Were there any funding sources or conflicts of interest that may affect the authors interpretation of the results?**	20. Was ethical approval or consent of participants attained?	**Score**
Lawson & Myers (2010)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	15
Linley & Joseph (2007)	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**DK**	Yes	14
Litam et al. (2021)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	14
Mangoulia et al. (2015)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	14
Martin-Cuellar et al. (2018)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	14
McKim & Smith-Adcock (2013)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	14
Ray et al. (2013)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**Yes**	No	No	Yes	Yes	Yes	**No**	Yes	14

Study	1. Were the aims/objectives of the study clear?	2. Was the study design appropriate for the stated aim(s)?	3. Was the sample size justified?	4. Was the target/reference population clearly defined?	5. Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?	6. Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?	7. Were measures undertaken to address and categorise non-responders?	8. Were the risk factor and outcome variables measured appropriate to the aims of the study?	9. Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?	10. Is it clear what was used to determine statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)	11. Were the methods (including statistical methods) sufficiently described to enable them to be repeated?	12. Were the basic data adequately described?	**13. Does the response rate raise concerns about non-response bias?**	14. If appropriate, was information about non-responders described?	15. Were the results internally consistent?	16. Were the results presented for all the analyses described in the method?	17. Were the authors' discussions and conclusions justified by the results?	18. Were the limitations of the study discussed?	**19. Were there any funding sources or conflicts of interest that may affect the authors interpretation of the results?**	20. Was ethical approval or consent of participants attained?	**Score**
Rossi et al. (2012)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**No**	No	Yes	Yes	Yes	Yes	**No**	Yes	15
Sodeke-Gregson et al. (2013)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	16
Somoray et al. (2015)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**DK**	Yes	12
Sprang, et al. (2007)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	**Yes**	No	No	Yes	Yes	Yes	**DK**	Yes	11
Sukut et al. (2021)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**No**	No	Yes	Yes	Yes	Yes	**No**	Yes	16
Tirgari et al. (2018)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	**Yes**	No	Yes	Yes	Yes	Yes	**No**	Yes	15
Towey-Swift & Whittington (2019)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**No**	No	Yes	Yes	Yes	Yes	**DK**	Yes	15
Xie et al. (2020)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	**No**	No	Yes	Yes	Yes	Yes	**No**	Yes	16

*Note: **Bold** indicates items reverse scored (i.e. 1 point for "no"); DK: Don't Know*

Figure 1: Diagram of Professional Quality of Life (Stamm, 2010)

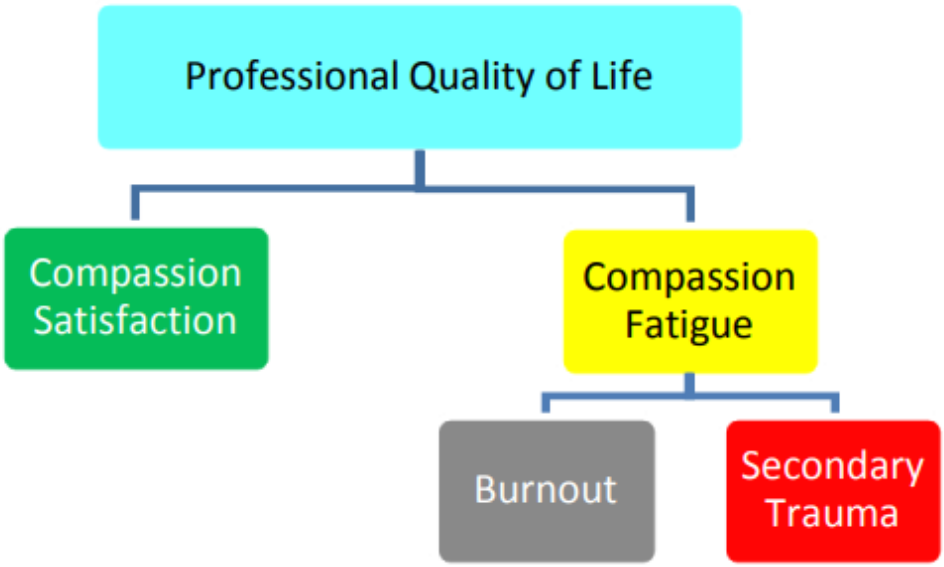
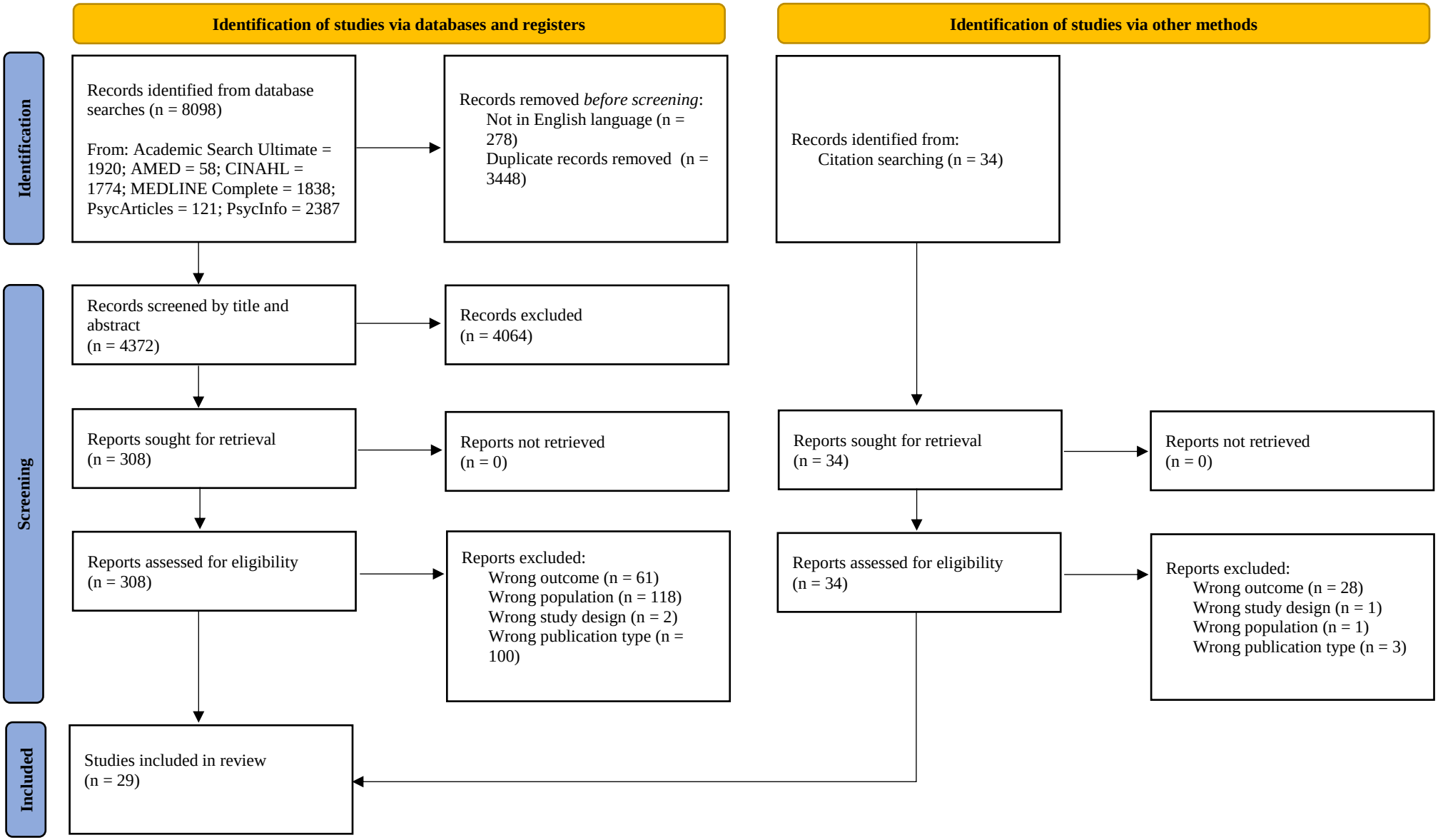


Figure 2: PRISMA flow chart for selection process, adapted from Page et al. (2021)



Appendices

Appendix A: Journal of Mental Health Author Guidelines

DESCRIPTION

Journal of Mental Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Journal of Mental Health accepts the following types of article:

- Original Articles; Research and Evaluation Articles
- Review article
- Book and Web Reviews

PREPARATION

Review Articles:

- Should be written with the following elements in the following order: Title page (to be uploaded separately and must not appear on the Main Document); Abstract (Background, Aims, Methods, Results, Conclusions); Keywords; Main text introduction; Materials and methods; Results; Discussion; Acknowledgments; Declaration of interest statement; References (in the correct format); Appendices (where appropriate - to be uploaded separately); Table(s) and caption(s) (on individual pages) - to be uploaded separately; Figures and figure captions (as a list) - to be uploaded separately.
- Should be no more than 6000 (excluding abstracts, tables and references)
- Should contain a structured abstract of 200 words.
- Should contain between 3 and 7 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- When submitting a Review, please confirm that your manuscript is a systematic review and include a statement that researchers have followed the PRISMA guidance – if this is not the case, please say why.
- Please confirm whether the review protocol has been published on Prospero and provide a date of registration – if this is not the case, please say why.
- Manuscripts are limited to a maximum of 4 tables and 2 figures to be uploaded separately – please advise where in your manuscript these are to be located.
- Please ensure that author details are not on the Main Document.
- Please ensure that author details are not included in the file name.
- Participants: language must be in the style of the APA. Our policy therefore is to refer to study participants as opposed to patients or subjects.
- Please note we do not accept pdf's. Please save your documents in the .doc format. in the .doc format.

STYLE GUIDELINES

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation".

Please note that long quotations should be indented without quotation marks.

FORMATTING AND TEMPLATES

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

REFERENCES

Please use this reference guide when preparing your paper. An EndNote output style is also available to assist you.

CHECKLIST

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. **Graphical abstract** (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .tiff. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.
3. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
4. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:
   For single agency grants
   This work was supported by the [Funding Agency] under Grant [number xxxx].
   For multiple agency grants
   This work was supported by the [Funding Agency #1] under Grant [number xxxx];

[Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

5. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
6. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
7. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
8. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.
9. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
10. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
11. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
12. **Units.** Please use SI units (non-italicized).

Appendix B: Appraisal tool for Cross-Sectional Studies (AXIS, Downes et al., 2016)

	Question	Yes	No	Don't know/ Comment
Introduction				
1	Were the aims/objectives of the study clear?			
Methods				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results presented for all the analyses described in the methods?			
Discussion				
17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
Other				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

Chapter Two: Empirical Paper

Compassion, Workplace Demands and Psychological Safety with IAPT Therapists

Word count (excluding references, tables and appendices): 7999

Abstract: 299 words

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March 2022

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[2] See Appendix A for submission guidelines

Abstract

Background: Mental health staff often experience high levels of work-related stress and poor professional quality of life (PQoL). The Job Demands-Resources model suggests employee wellbeing is predicted by job and personal demands and resources. Improving Access to Psychological Therapies (IAPT) services are expanding in response to increased demands for mental health services. To do so without undermining the delivery of compassionate care, it is important that practitioner wellbeing is given appropriate priority.

Aims: The aims of this study were to explore IAPT practitioners' levels of PQoL, as defined through their levels of compassion satisfaction (CS) and compassion fatigue (CF), and whether CS reduced and CF increased during the Coronavirus pandemic. Additionally, the study aimed to examine potential demands and resources associated with IAPT practitioner PQoL.

Methods: 169 IAPT practitioners completed a survey utilising validated measures of professional quality of life (ProQOL-21), general wellbeing (SWEMWBS), team psychological safety (TPSQ) and workload (QWI). Data was analysed using independent and paired samples t-tests, Pearson's correlation and cross-sectional regression.

Results: Practitioners reported average levels of CS and average-high levels of CF. CF, SWEMWBS and TPSQ significantly contributed to 41% of the variance in CS, however only SWEMWBS was independently associated with CS indicating improved wellbeing was related to higher CS. CS, SWEMWBS, TPSQ and QWI significantly contributed to 30% of the variance in CF, however only QWI and SWEMWBS were independently related to CF, indicating higher perceived workload and reduced wellbeing were associated with higher CF.

Conclusions: IAPT services should mitigate high workload demands placed on staff by promoting a focus on wellbeing and psychologically safe team environments to prevent job

strain and promote job engagement. Further research examining demands and resources within the IAPT environment is necessary to examine how factors undermining IAPT practitioner PQoL interact in the unique IAPT context.

Keywords: compassion satisfaction, compassion fatigue, psychological practitioner, IAPT

Introduction

It is well documented that staff working in caring roles experience stress (Moore & Cooper, 1996), burnout (BO) (Johnson et al., 2018) and fatigue (Figley, 1995) related to their role. In the UK, the National Health Service (NHS) staff survey (Survey Coordination Centre, 2021) documented that 44.0% of staff experienced work-related stress and 46.4% of staff reported attending work despite feeling unwell. This can present challenges for practitioners and service users because it is associated with increased BO, poorer quality of care delivery and increased likelihood of error and neglect (Homrich et al., 2020). Recent statistics show overall absence from work rates of 5.4% (NHS Digital, 2022). This can also be problematic, resulting in staff shortages, interruption to service delivery, and creating work overload for remaining staff (Kisakye et al., 2016). These concerning statistics and the consequences for employees' welfare, patient safety, and patient experience highlight the importance of gaining a full understanding of occupational wellbeing and workplace stressors for people providing therapeutic care.

Job Demands-Resources (JD-R) Model

The JD-R model is the most widely accepted and adopted framework of occupational wellbeing (Lesener et al., 2019). The model implies each occupation has risk factors divided into job demands and job resources (Demerouti et al., 2001). Typical job demands include high workload, poor physical environment, and demanding interactions with clients, while common job resources include interpersonal and social relationships, and role- and task-specific resources, for example role clarity, autonomy, and feedback (Bakker & Demerouti, 2007). An interaction between job demands and resources predict occupational wellbeing, with job demands leading to exhaustion and job resources leading to work engagement (Bakker et al., 2014). High job resources can reduce the strain of high job demands leading to

improved overall engagement (Bakker et al., 2007; Hakanen et al., 2005). The model was subsequently expanded to include personal resources, which have a reciprocal relationship with job resources, with both then predicting levels of work engagement (Xanthapoulou et al., 2007, 2009). This model is particularly resonant for mental health professionals (MHPs) because they are often managing competing demands of caseload management, administration, and supervision, whilst being exposed to the highly emotive experiences of their clients and others.

Professional Quality of Life (PQoL)

PQoL has been found to be primarily driven by the positive aspects an individual feels in relation to their role as a helper, known as compassion satisfaction (CS), balanced with the negative aspects an individual experiences in being able to effectively make their contribution to the wellbeing of clients, known as compassion fatigue (CF) (Stamm, 2010).

CS is defined as the pleasure derived from being able to do one's work well, leading to positive feelings about one's work and the motivation to continue doing it (Stamm, 2010). By contrast, CF describes the general experience of psychological and emotional fatigue professionals may experience as a result of displaying and experiencing empathy when helping suffering individuals (Figley, 1995; Stamm, 2005). CF is broken down into two components of BO and secondary traumatic stress (STS). BO refers to difficulties in dealing with work or doing one's role effectively and is often associated with feelings of dissociation or hopelessness (Stamm, 2010). STS is defined as the behavioural and emotional consequences of knowing about traumatizing events experienced by others and the stress associated with wanting to help them (Figley, 1995). Newell et al. (2016) noted exposure to clients' trauma information and material, often experienced in mental health care, can lead to both STS and CF.

Many years of research and development have resulted in the Professional Quality of Life scale (ProQOL: Stamm, 2002, 2005, 2010), which measures the value an individual feels in relation to their role as a helper by assessing both CS and CF. Given the risks associated with STS, ProQOL is a suitable tool to measure occupational wellbeing amongst MHPs, who are at greater risk of experiencing poor PQoL (Moore & Cooper, 1996).

Conceptual similarities between the components of PQoL and the processes of the JD-R model suggest CF is synonymous with job strain and exhaustion, while CS parallels engagement and motivation. Consequently, it is prudent to consider job demands and resources in mental health care, which may impact one's PQoL.

Job Demands and Resources in Mental Health Care

Examining job demands in relation to the time and resources afforded to staff, authors have found correlations of moderate effect between workload, CS and CF (Ray et al., 2013; Towey-Swift & Whittington, 2019). Turgoose and Maddox (2017) identified caseload factors, such as number of patients seen per week and working with victims of trauma**,** were related to CF in MHPs. More recently, Singh et al. (2020) systematically reviewed job demands in MHPs, concluding the most common demands associated with reduced PQoL to be workplace trauma, workload, and therapeutic setting. Although many workload factors have been found to be related to PQoL, quantitative workload has repeatedly featured as a significant factor.

On the other side of the equation, several factors have been found to act as potential resources. Singh et al. (2020) identified support from co-workers, support from supervisors and organisational sources (e.g., training, use of evidence-based practice) to be common job resources. Driven by supportive leadership, team dynamics and co-worker relationships, and relating to positive team outcomes (Newman et al., 2017), team psychological safety also acts

as a potential job resource. This relates to the safety individuals feel in taking interpersonal risks in the workplace (Edmondson, 1999), for example having the ability to express themselves and their ideas without fear of negative consequences such as judgment or retribution (Detert & Edmondson, 2011). Consistent with the JD-R model of occupational wellbeing, Edmondson and Lei (2014) reported high levels of psychological safety increased job engagement.

Psychological safety is particularly important within mental healthcare, empowering staff, patients and families to voice concerns and opinions, and promoting staff wellbeing by giving staff the confidence to speak up when they may be struggling (Hunt et al., 2021). Johnson et al. (2020) highlighted the importance of high quality and supportive supervision also in creating safe and open spaces for supervisees, which improved psychological therapists' engagement. Little research has considered the relationship between team psychological safety and employee wellbeing in mental health settings; however, it has been recognised that developing a trusting and psychologically safe workplace can lead to positive emotions, which leads to increased productivity and employee satisfaction (Coates & Howe, 2015).

In terms of personal resources, authors have identified age, experience, gender and religion are associated with PQoL, although a systematic review of this research suggests the relationship is negligible (Turgoose & Maddox, 2017). Coping styles and trauma history have also been noted to be associated with wellbeing outcomes in MHPs (Turgoose & Maddox, 2017; Simionato & Sampson, 2018). With findings suggesting high levels of psychological wellbeing predict job satisfaction and performance (Wright et al., 2007), Güler and Çetin (2019) identified a significant positive relationship between personal resources and subjective wellbeing. This suggests it would be reasonable to utilise measures of general mental

wellbeing to assess the association of multiple personal resources incorporating personality, coping style and resilience.

The NHS have published their *Long-Term Plan* (NHS England, 2019a) to highlight funding priorities and improved and expanded services, and to focus on NHS staff. The *Long-Term Plan* prioritises, amongst other services, the national Improving Access to Psychological Therapies (IAPT) Services. It also recognised a need to focus on improving workplace wellbeing to enable staff to deliver high levels of compassionate care, while facing rising demands and pressures. Consistent with the implications of the JD-R model, which suggests different occupations will have their own job-specific demands and resources (Bakker & Demerouti, 2007), if the *Long-Term Plan* is to achieve its maximum effect, it is clearly important to understand the risk factors affecting workplace wellbeing in IAPT services.

Improving Access to Psychological Therapies (IAPT) Services

IAPT services were introduced in 2008, in response to rising public costs imposed by absence from work and welfare benefits (Clark, 2018). Using a stepped care model, IAPT services deliver “Step 2” and “Step 3” interventions for anxiety and depression, as recommended by the National Institute of Health and Care Excellence (NICE, 2011) guidelines. The workforce is predominantly made up of Psychological Wellbeing Practitioners (PWPs) at Step 2, and High Intensity Therapists (HITs) and Counsellors at Step 3, as well as other management, administrative, and support staff. Practitioners undertake a range of clinical and non-clinical duties. Clinical contact includes face-to-face, telephone, online and group work. The remaining non-clinical work includes maintaining patient records, making referrals, liaising with other professionals and caseload management.

As with many public agencies, IAPT services are governed by national standards and targets. However, the growth of the workforce has lagged behind these targets and there is a lack of transparency on service funding and workforce numbers (Harper et al., 2020). The *NHS Mental Health Implementation Plan 2019/20-2023/24* (NHS England, 2019b) proposed that by 2023/24 1.9 million people would be provided with evidence-based, high quality mental health care through IAPT services. This required an additional 2,940 members of staff to the then existing workforce (NHS England, 2019b). Harper et al. (2020) argued that even if expansion of the workforce was achieved, productivity and caseload levels would need to be considerably higher than the original IAPT model proposed which could have a negative impact on staff wellbeing.

The *IAPT Manual* (National Collaborating Centre for Mental Health [NCCMH], 2021) also recognised that a challenging target-driven environment could have negative effects on both staff and patients and suggested there should be levels of support to match this. Health Education England's (HEE, 2020) results of the IAPT workforce census suggested staff turnover rates of 15%. Promotion and progression may account for some of this figure; however, evidence suggests that poor occupational wellbeing leads to high staff turnover, which may also play a role here. Further, literature exploring the impact of BO on patient care and safety has found that higher BO in IAPT staff has a negative impact on patient outcomes (Delgadillo et al., 2018).

Early research reported that almost 30% of IAPT staff experienced high levels of stress (Walklet & Percy, 2014). Qualitative exploration revealed high volume workloads, demanding service targets, resource issues, team dynamics, responsibility for managing distress and risk, and poor work-life balance as key sources of stress in this population. While this study provided some useful insights into the stresses on IAPT personnel, this mixed-

methods study was based on a single IAPT site, raising issues of generalisability to the wider workforce.

Multi-site research suggested IAPT practitioners experienced high levels of emotional exhaustion and low levels of depersonalisation and personal accomplishment (Steel et al., 2015). Further, high work demands were significantly associated with emotional exhaustion, while resources of an active coping style, increased training and increased autonomy related to higher levels of personal accomplishment. Results from a cross-sectional survey within 15 IAPT sites indicated that both PWPs (68.8%) and HITs (50%) experienced BO (Westwood et al., 2017). Higher BO was associated with increased overtime, telephone contact hours and patient contact, while increased supervision was related to lower BO.

A qualitative examination of IAPT practitioner wellbeing indicated practitioners felt unvalued, unheard and micromanaged due to the chain of pressure to achieve targets and demands imposed from Clinical Commissioning Groups (CCGs) to managers, and from managers to practitioners (Harper et al., 2020). Consequently, practitioners were less likely to seek support or to admit when they were struggling. Further, practitioners identified supervision to be focused on risk, case management and target compliance resulting in a lack of quality and reflective supervision (Harper et al., 2020).

Taken together, these studies suggest that reduced occupational wellbeing in IAPT practitioners is associated with high volume workloads, lack of quality supervision and training, and reduced autonomy. The JD-R model may be applied to understand these risks by exploring the job demands of time pressures, high workload, pressure to meet targets, and difficult team dynamics, offset by job resources including support from co-workers, regular supervision, and supportive leadership. Personal resources including coping style, personality factors and general wellbeing may also buffer the impact of high job demands. These job-

specific demands and resources have not yet been fully investigated amongst IAPT practitioners who are expected to consistently and sustainably provide high quality care to a large proportion of the population.

The Present Study

With IAPT service teams set to expand in line with the NHS *Long Term Plan* (NHS England, 2019a), it is important that staff are supported to deliver compassionate care, while maintaining their own wellbeing. It is essential to identify and address the implications of reduced PQoL in order to avoid detrimental consequences for the individual staff members, service users and the IAPT model.

Using the JD-R model of employee wellbeing, this original and timely exploratory study aimed to examine, within the IAPT context, whether PQoL changes over time in the context of a global pandemic, and the demands and resources associated with IAPT practitioner CS and CF. The study approached this by considering the relationships between job demands measured by occupational characteristics and quantitative workload, job resources in terms of occupational factors and team psychological safety, and personal resources measured as general mental wellbeing.

Hypotheses

Hypotheses have been made regarding the nature of the relationships between these variables, see figure 1.

H1: IAPT practitioners will experience high levels of CF and low levels of CS

H2: CS will decrease and CF will increase between data collection time points

H3: Personal factors (for example age, experience and gender) will not have a significant relationship with CS or CF

H4: Occupational factors (for example job role and awareness of targets) will have a significant effect on CS and CF

H5: CS will be significantly associated with CF, quantitative workload, general wellbeing, team psychological safety, and job characteristics (for example weekly hours, clinical contact and supervision)

H6: CF will be significantly associated with CF, quantitative workload, general wellbeing, team psychological safety, and job characteristics (for example weekly hours, clinical contact and supervision)

[FIGURE 1 ABOUT HERE]

Materials and Methods

Design

This study initially adopted a quantitative, longitudinal panel design. It was anticipated data would be collected at three time points, but due to drop out, data was collected only at two time points. Due to challenges recruiting and the non-significant findings from longitudinal data analyses, participant data from both time points was pooled to create cross-sectional data of all participants who completed Time 1 and the additional unique participants who completed Time 2 (N = 169). Consequently, the study adopted a combined longitudinal/cross-sectional design.

Participants

Participants were practitioners recruited via IAPT services in the Northwest of England between 15th January and 30th July 2021. Staff were eligible to participate if they were trainee or qualified PWP, HIT or Counsellors. Service leads, managers, employment

advisors, administration staff, and individuals on secondment to IAPT services were excluded from the study.

Procedure

Managers of participating services distributed the survey advertisement with a link to an anonymous online survey to all target staff within their services. The researcher also attended team meetings to aid recruitment and snowballing techniques were utilised, for example the survey link being shared between colleagues within other services. Reminder emails were sent out during each recruitment period.

The participant information sheet was accessed online via the survey link. Participants were presented with a series of consent statements to indicate they had read and understood the information fully and consented for their data to be used in the research. They were then asked to provide a 3-digit unique identifier to enable their responses from repeat time points to be matched. Participants then completed the survey and were finally presented with the debrief sheet which included signposting to supportive resources in case they experienced any distress.

The first data collection took place over 12 weeks between 15th January and 9th April 2021 and the second over 8 weeks from 4th June to 30th July 2021. Once data sets had been linked, the original identifiers provided by participants were deleted and replaced with a randomised unique identifier.

Materials and Measures

Participants were asked to provide demographic information, including age, gender, job role, region, average weekly working hours, clinical contact, and supervision, and whether they were aware of their services' targets.

Professional Quality of Life Scale

The ProQOL-21 (Heritage et al., 2018) measuring CS and CF was developed to overcome issues relating to the construct validity of the ProQOL-V (Stamm, 2010). CS is measured using ten items; CF is measured with five items assessing BO and six assessing STS. The measure requires individuals to rate items such as "I like my work as a helper" for CS, "I feel worn out because of my work as a helper" for BO and "as a result of my helping, I have intrusive, frightening thoughts" for STS. Participants are asked to reflect on their experiences in the last 30 days and choose one of five responses from "never" to "very often". The modified response approach (Heritage et al., 2018) was used to code scores. Stamm (2010) recommended cut-off scores for CS and CF using the 25^{th} and 75^{th} percentile. On this basis, Heritage et al. (2018) identified cut-off scores for the modified ProQOL-21 of 21 and 30 for CS, and 16 and 25 for CF, which were used to establish prevalence of CF and CS. Higher scores indicated participants reported higher CS and CF. The ProQOL-21 demonstrates high Cronbach reliability for CF ($\alpha = 0.90$) and CS ($\alpha = 0.92$) (Heritage et al., 2018).

Shortened Warwick-Edinburgh Mental Wellbeing Scale

The Shortened Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS, Stewart-Brown et al., 2009) measures general wellbeing, demonstrating high Cronbach reliability ($\alpha = 0.85$; Stewart-Brown et al., 2009). This shorter version was found to have more robust psychometric properties than the original, longer version and has demonstrated high internal consistency among adult populations (Haver et al., 2015; Koushede et al, 2019) and the general population (Ng Fat et al., 2017). In addition, it has been found to be sensitive to change over time (Shah et al., 2018), which is important within this longitudinal study. Mental wellbeing is measured using seven items, such as "I've been feeling relaxed" and

"I've been dealing with problems well". Participants are asked to choose from five responses, how often they have experienced each item in the last two weeks from "none of the time" to "all of the time". Higher scores indicate better wellbeing.

Team Psychological Safety Questionnaire

The Team Psychological Safety Questionnaire (TPSQ, Edmondson, 1999) measures psychological safety, the extent to which members of a team feel able to take interpersonal risks. The scale has demonstrated good validity and reliability with Cronbach's alpha of 0.82 (Ramalho & Porto, 2021). A systematic review of psychological safety concluded the TPSQ was the measure of choice (Newman et al., 2017). This measure asks participants to rate how much they agree with each of the seven items, from one, "strongly disagree" to five, "strongly agree". Items include "in this team, it is easy to discuss difficult issues and problems" and "when someone makes a mistake in this team, it is often held against him or her". Items were reverse scored where necessary, with higher scores indicating higher psychological safety.

Quantitative Workload Inventory

The Quantitative Workload Inventory (QWI, Spector & Jex, 1998) measures workload in terms of perceived volume and pace. Participants are asked to rate five items such as "how often does your job require you to work very fast?" and "how often does your job require you to work very hard?". Individuals select one of five responses from "less than once per month or never" to "several times per day". Higher scores indicate participants perceive their workload to be higher. The QWI showed good internal consistency (Cronbach's alpha = 0.82) in a meta-analysis of 18 studies including a diverse range of professions (Spector & Jex, 1998).

Ethical Approval

The Lancaster University Faculty of Health and Medicine Research Committee granted ethical approval (FHMREC20004). Research and development oversight and approval was also obtained through the Health Research Authority (HRA) Integrated Research Application System (Project ID: 287800). Subsequently, applications to conduct the study were submitted to seven NHS Research and Development (R&D) departments. Four expressed interest but were unable to proceed due to lack of capacity. This resulted in the participation of four IAPT services across three Trusts. Feedback on design was obtained from managers of a local IAPT service, which was used to refine the participant information sheet and survey and understand the potential time burden of participation.

Statistical Analysis

Descriptive statistics of demographics and study variables were examined to understand sample characteristics at Time 1 and Time 2. Next, a paired samples t-test was used to explore differences in the raw data between those who completed the survey at both time points to identify any changes over time. A further independent samples t-test was used to explore whether there were any differences in raw scores between those who only completed Time 1 and only completed Time 2.

Further descriptive statistics were examined for cross-sectional data to understand sample characteristics of cross-sectional data. Cronbach's alphas for each of the main study variables were also calculated to assess their internal consistency for the sample.

Independent samples t-tests were used to determine whether there were differences in CS and CF based on gender, job role and awareness of targets. Next, the nature of the relationships between demographic characteristics, occupational variables, CS, CF, wellbeing, team psychological safety and workplace demands were explored using Pearson's correlational analyses. Variables that did not demonstrate a statistically significant

relationship with CS or CF were excluded from regression analysis. Finally, two separate multiple linear regression analyses were carried out to explore predictor variables for CS and CF. An a priori power analysis was computed using G* power. For multiple linear regression with four predictor variables at an alpha level of 0.05 and power of 0.80, a sample size of 129 was required to identify medium effect sizes ($f^2 = 0.15$).

Results

Participant Characteristics

A total of 132 complete participants responses were recorded at Time 1, and 87 at Time 2. Of those, 50 participants fully completed the survey at both time points, with a total of 169 unique cross-sectional responses across both data sets, see Figure 2. Participant characteristics are summarised in Table 1.

[FIGURE 2 ABOUT HERE]

Participants' mean age was 40.82, ranging from 23 to 67, and 87.0% of participants were female. Recruitment took place within three Trusts, with 77.5% of participants recruited from Trust 1. Participants working as trainee, qualified or senior PWPs at Step 2 accounted for 43.2% of the sample, while those working as trainee or qualified HITs or counsellors at Step 3 made up the remaining 56.8%. 90.5% of participants identified being aware of their services targets. On average, participants reported having 1 to 240 months of experience, with an average of 55.93 months. Participants mean weekly working hours were 33.29, with a minimum of 8 and a maximum of 48, and mean weekly clinical contact hours were 17.53, ranging from 0 to 39. Participants indicated they received an average of 2.63 hours of supervision per week, varying from 0 to 12.

[TABLE 1 ABOUT HERE]

Statistical Assumptions

Prior to conducting analyses, assumptions were tested. For independent and paired samples t-tests, box plots were examined to detect extreme outliers. Assumption of normality was assessed by examining results of Kolmogorov-Smirnov's tests and skewness and kurtosis values. And, for independent samples Levene's test was used to assess the assumption of homogeneity of variance. Inspection of values of identified outliers did not reveal them to be extreme and they were kept in the analysis. Although some variables failed the Kolmogorov-Smirnov test, skewness and kurtosis were within acceptable parameters of ±1.96 (George & Mallery, 2010), therefore the assumptions of normality were not violated. There was homogeneity of variances for all measures.

For correlational analyses the data was statistically and visually inspected to determine whether it met the appropriate assumptions. Scatterplots, histograms, and Q-Q plots were examined. There were no extreme outliers and assumptions of linearity were met. Further, although not all variables were normally distributed as assessed by Kolmogorov-Smirnov, skewness and kurtosis were within acceptable parameters.

For multiple regression, assumptions of independence of residuals, homoscedasticity and linearity were met as assessed by Durbin-Watson statistics (1.960 for CS and 1.846 for CF) and residual scatterplots. There was no evidence of multicollinearity, assessed by tolerance values greater than 0.1, and the distribution of residuals was approximately normally distributed assessed by visual inspection of histograms and Q-Q plots. Further, case wise diagnostics outlier analysis was run for each multiple regression. No participants were identified as having standardised residuals above or below three.

Hypothesis 1

Descriptive statistics and Cronbach's alpha are presented in Table 2. The averages at Time 1, Time 2 and cross-sectionally were similar. Considering the cross-sectional data, participants had a mean CS score of 24.16, ranging from 12 to 34. The mean score for CF was 24.29 (minimum 13, maximum 42). Using cut-off scores for the modified ProQOL-21 (Heritage et al., 2018), this suggests participants had average levels of CS and moderate to high levels of CF. All measures demonstrated high internal consistency with Cronbach's alphas of 0.80 and above.

[TABLE 2 ABOUT HERE]

Hypothesis 2

A paired samples t-test was used to identify any statistically significant changes in CS and CF scores in participants who completed both Time 1 and Time 2. Amongst those who completed the survey at both time points, results revealed that there were no significant changes between Time 1 and Time 2 in CS ($t(49) = -.044$, $p = .965$) or CF ($t(49) = .520$, $p = .605$).

Independent samples t-tests were used to examine differences in main study variables in those who only completed the survey at Time 1 ($N = 82$) and those who only completed at Time 2 ($N = 37$), excluding participants who completed both. Results revealed that there were no significant differences in any of the study variables between time points.

Hypothesis 3

Independent samples t-tests revealed that there were no significant differences in CF and CS scores across gender. Additionally, age and experience were not significantly correlated with CS or CF. Consequently, these were not included in multiple regression models.

Hypothesis 4

Independent samples t-tests indicated that there was no significant difference in CS and CF scores across job role and between those who were aware of targets and those who were not. These were excluded from regression analysis.

Hypothesis 5

Results of correlation analyses are displayed in Table 3. CS was strongly positively correlated with SWEMWBS (r = .643, p <.01), weakly positively correlated with TPSQ (r = .246, p < .01), and moderately negatively correlated with CF (r = -.340, p < .01). Moderate relationships were also observed between SWEMWBS and TPSQ (r = .334, p < .01) and QWI (r = -.305, p < .01).

[TABLE 3 ABOUT HERE]

The results of multiple linear regressions are summarised in Tables 4A-B. The model significantly explained 40.6% of variance in CS (F (3,165) = 39.237, p < .001, R = .645, R^2 = .416, adjusted R^2 = .406), a large effect size according to Cohen (1988). When taking all other variables into account, SWEMWBS (β = .613, p < .001, 95% CI [.657, 1.037) was significantly independently associated with CS. These findings indicated that higher general mental wellbeing was related to higher CS.

[TABLE 4A ABOUT HERE]

Hypothesis 6

CF was moderately positively correlated with QWI (r = .402, p < .01), moderately negatively with SWEMWBS (r = -.471, p < .01) and weakly negatively correlated with TPSQ (r = -.251, p < .01).

Overall, the regression model significantly accounted for 29.9% of the variance in CF (F (4,164) = 18.897, p < .001, R = .562, R^2 = .315, adjusted R^2 = .299). According to Cohen (1988) this demonstrates a large effect size. When holding all other variables constant, SWEMWBS (β = -.272, p = .003, 95% CI [-.635, -.128]) and QWI (β = .303, p < .001, 95% CI [.220, .574]) were significantly independently associated with CF. These results suggested lower general mental wellbeing and higher perceived workload were related to higher CF.

[TABLE 4B ABOUT HERE]

Discussion

To date, there have been no published, peer-reviewed studies examining PQoL amongst IAPT practitioners. This study explored how IAPT practitioners experienced PQoL, utilising an evidence-based framework to examine the relationships between PQoL, wellbeing, psychological safety, and workplace demands. Overall, 169 participants took part in the study. The mean age of participants was 40.82 years, 87.0% were female, 43.2% worked at Step 2, and 56.8% worked at Step 3. This is not dissimilar to the profile of the national workforce, with females making up most of the workforce (81%) and a ratio of 40:60 Step 2 and Step 3 practitioners (HEE, 2020). Figure 3 depicts a summary of the relationships found between study variables.

[FIGURE 3 ABOUT HERE]

Hypothesis 1

Those who participated had average levels of CS and average-high levels of CF. It is difficult to compare these findings to other IAPT literature, as CS and CF have not been measured in this population, however they mirror findings that IAPT practitioners experience high levels of stress and BO (Steel et al., 2015; Walklet & Percy, 2014; Westwood et al., 2017). As with other physical healthcare staff, high CS with high CF was not an unexpected

finding. This suggests that although practitioners derived satisfaction from helping others, they also experienced BO and STS. Stamm (2002) identified a relationship between CF and CS, suggesting there may be a balance between feeling satisfied that the work individuals are doing is helpful to others, but continuing to experience CF. In line with the JD-R model, this supports the notion of two independent processes (Bakker et al., 2014), with job and personal resources facilitating a motivational process leading to CS, and job demands triggering the health impairment process leading to CF.

Hypothesis 2

There were no significant differences found in CS or CF between participants completing the survey at Time 1 and Time 2, which indicated that PQoL remained stable between the two time points. This was surprising as data collection took place during the ongoing 2019 Coronavirus (COVID-19) pandemic, between 15th January and 30th July 2021, coinciding with a third national lockdown and subsequent lifting of restrictions. Although caseloads appeared to remain the same between the two time points, many services had decreased provision during the lockdowns so overall staff may have experienced reduced caseloads. Remote working also resulted in clients receiving therapy at home which increased non-attendance of appointments and may have given therapists more time to complete other work duties. Finally, staff may have become accustomed to or preferred the changes associated with lockdown restrictions and managed to strike a better work/home balance with reduced commuting time.

Hypotheses 3-6

In line with existing literature, and in support of the third hypothesis, personal factors such as age, experience and gender experience were not significantly correlated with ProQOL (Turgoose & Maddox, 2017).

In relation to the fourth hypothesis considering occupational factors, there were no significant relationships between ProQOL and weekly hours, clinical contact, supervision, or awareness or targets. This is contrary to previous findings that increased hours, patient contact and supervision were strongly related to BO and CF (Singh et al., 2020; Westwood et al., 2017). This may be explained by the fact that weekly hours and clinical contact were not the primary measures of workload, or that workloads had reduced as a result of the COVID-19 lockdowns. Additionally, supervision was measured quantitatively, rather than measuring the quality of supervision. It may be useful to explore this in more depth, utilising tools to measure the quality of supervision received by IAPT practitioners as used elsewhere with psychological therapists (Johnson et al., 2020).

It was surprising that awareness of targets did not influence CS, as this has been reported elsewhere (Walklet & Percy, 2014). However, almost all participants (92.4%) were aware of their targets, so there was only a very small "non-aware" group to use as a comparator. Additionally, in this study, awareness was measured using a single (yes/no) item. Further research exploring the relationship between PQoL and working to targets should be undertaken

It was hypothesised that CS and CF would be significantly related to each other. This hypothesis was supported. A significant moderately negative correlation suggested that as CS increased, CF decreased, and vice versa. This fits with the tenets of the JD-R model, which identified an interaction between job strain and job engagement, impacting on organisational outcomes (Bakker et al., 2014).

The JD-R framework suggested that job resources (psychological safety), personal resources (general wellbeing) and job demands (quantitative workload) would be related to each other, and in turn, these would trigger the motivation (CS) and exhaustion (CF)

processes (Bakker et al., 2014). Significant correlations were found between CS, CF and general wellbeing. Results suggested higher SWEMWBS scores were strongly associated with higher CS, and moderately associated with lower CF. This is consistent with the results of a small number of other studies that have examined the relationship between general wellbeing and PQoL. Wright et al. (2007) examined psychological wellbeing amongst customer services managers, finding that wellbeing moderated the relationship between job performance and satisfaction. Further, employees with higher wellbeing had higher job satisfaction. Although not a direct comparison with the findings of this study, Güler and Çetin (2019) also concluded that personal resources positively related to subjective wellbeing suggesting SWEMWBS was an appropriate measure to examine the role of personal resources in predicting PQoL.

TPSQ was significantly weakly associated with both CS and CF. Although these findings were expected, it is difficult to compare with existing research as to whether the relationships demonstrated comparable strengths to previous findings. Little research has explored these concepts in IAPT practitioners, or in MHPs more generally. A climate of psychological safety enables teams to work collaboratively, perform well and learn (Edmondson & Lei, 2014), and is often influenced by positive relationships with leaders and other co-workers (Newman et al., 2017). In line with this, previous research has highlighted positive relationships between CS, team dynamics and social support (Singh et al., 2020; Walklet & Percy, 2014). Further, in a review of psychological safety, Edmondson and Lei (2014) identified a relationship between psychological safety and work engagement. From a JD-R perspective, this suggests psychological safety may act as a job resource, further evidenced by the relationship found here between CS and TPSQ. However, Edmondson (1999) recognised that psychological safety can vary between groups within organizations, so these findings may not be an accurate representation of levels of psychological safety more

generally within IAPT services. Additionally, it is likely a combination of individual and group factors impacts psychological safety, therefore focusing on the team level may not give a complete understanding of the processes taking place (Edmondson & Lei, 2014).

Accounting for 41% of the variance in CS, as hypothesised, multiple regression revealed that higher general wellbeing was significantly independently associated with improved CS. It was surprising that psychological safety was not independently related to CS, though higher general wellbeing was. Expansions of the JD-R model suggested that personal resources mediated the relationship between job resources and work engagement (Xanthopoulou et al., 2007). Additionally, longitudinal research exploring the reciprocal relationships between job and personal resources and work engagement concluded that job resources can predict personal resources and work engagement (Xanthopoulou et al., 2009). Indeed, there were a significant correlations between TPSQ and SWEMWBS, and TPSQ and CS. These were moderately positive and weakly positive, respectively, indicating that an increase in one led to an increase in the other. It might be that psychological safety was indirectly related to CS through general wellbeing. It could be worth exploring this potential mediation relationship further. Although unexpected, the fact that team psychological safety as a job resource was not independently associated with CS does not rule out the influence of job resources on engagement and CS, but perhaps indicated that other job and personal resources may have been present.

Quantitative workload was moderately and significantly independently associated with CF, supporting the sixth hypothesis. Regression analysis indicated that increased perceived workload and reduced general wellbeing were significantly independently related to increased CF, explaining 30% of the variance. This was expected as many factors including caseload variables (Turgoose & Maddox, 2017), congruence between expected and actual workload (Ray et al., 2013; Towey-Swift & Whittington, 2019), and quantitative and

qualitative workload (Singh et al., 2020; Walklet & Percy, 2014) have all been explored amongst MHPs and highlighted significant relationships of comparable strengths between high levels of workload and reduced wellbeing. This indicates the need to focus on balancing workload demands with organisational targets and reinforces the needs to expand work forces to meet these demands as recognised in the *Long Term Plan* (NHS England, 2019a). The IAPT environment is recognised as fast-paced and high-volume (NCMMH, 2021), therefore high workload may be an unavoidable demand. Exploring other factors which may also mediate the impact of high workload on employee wellbeing, for example autonomy, coping style (Steel et al., 2015), and supervision (Westwood et al., 2017) may help services better care for their staff.

Interestingly, CS was not independently associated with quantitative workload. Studies in other occupational groups have demonstrated that the relationship between workload and CS is a complicated one. High workload can lead to higher CS, where it is coupled with high job resources (Bakker et al., 2014). For example, Hakanen et al. (2005) examined job demands and resources in a sample of dentists, finding that the presence of many job resources mitigated the impact of high workload, and boosted engagement. Similarly, amongst Finnish teachers, job resources, in particular supervisor support, appreciation, and team climate, enhanced engagement despite high demands (Bakker et al., 2007). The findings from this study indicated that workload was not associated with CS. This might be because higher workload was not matched with higher job resources, the levels of workload were not high enough to contribute independently to the variance in CS, or IAPT practitioners are not like other occupational groups in this respect.

Clinical implications

These findings revealed important relationships between PQoL, wellbeing, job demands and psychological safety for IAPT practitioners. These findings are significant as little research has considered these relationships amongst MHPs, and less still amongst IAPT practitioners.

Using the JD-R framework to understand these findings, high personal resources, in relation to high job resources, were associated with engagement, while high job demands were related to job strain. This study has demonstrated a relationship between general wellbeing and CS and the importance of nurturing a psychologically safe team environment which may be indirectly associated with CS through general wellbeing. Furthermore, quantitative workload was associated with CF, therefore suggesting that a certain amount or type of workload may be beneficial, but there may be a limit beyond which additional workload, if not matched with additional job resources, leads to symptoms of CF.

As discussed previously, high workloads, if they are matched with high levels of job resource, can have a positive relationship with CS and CF. Guidance has presented examples of better and worse performing services, implying inconsistent expectations depending on the provider, with better performing services offering job resources of staff feedback, wellbeing programmes, and appropriate supervision compared to worse performing ones which do not (NCMMH, 2021). Given that occupational wellbeing is significantly impacted by job-specific demands and resources (Bakker & Demerouti, 2007), there is a strong case to argue for clear, standardised principles of best practice to be generated, implemented, and evaluated to afford staff the best chances of maintaining their wellbeing and providing quality services to clients.

To maintain a healthy workforce, IAPT services should endeavour to promote a psychologically safe environment within teams and support reasonable workloads. The interpretation of IAPT targets and the visibility of performance metrics are also factors here.

Clinical Commissioning Groups (CCGs) are responsible for performance and hold the threat of decommissioning and retendering over providers, who then put pressure on service managers and then staff. This undoubtedly affects team dynamics (Harper et al., 2020). Services with concerns about capacity and performance should use the IAPT manual (NCMMH, 2021) and evidence to date to push back on CCGs and Trusts who are far too removed from the work to understand the challenges staff experience. Considering team psychological safety, any changes to service design should incorporate consultation with IAPT practitioners who are on the front line. This will empower staff and reduce the gap between systemic priorities and the realities of working in such a challenging environment.

IAPT services and those who deliver them are coming under increasing pressure in terms of workload and management expectations. If quality of provision is not to suffer, these services need to maintain or increase the PQoL of their staff. Within this sample participants continued to feel satisfied by their work despite experiencing the negative costs of caring. In line with previous research, CS and CF were associated with each other (Singh et al., 2020; Stamm, 2010), suggesting that strategies to improve CS may reduce CF, and vice versa. Workload, psychological safety and general wellbeing are related to these concepts. The evidence on factors associated with PQoL is equivocal, therefore it would be prudent to explore further variables which may be related to PQoL in specific contexts to devise interventions to improve outcomes.

Limitations

Within this study, recruitment was challenging, exacerbated by the COVID-19 pandemic. During the pandemic, a very large number of internal and external wellbeing surveys were sent out to staff. It is possible staff experienced survey fatigue and were therefore less inclined to take part in additional research or that they became confused about

which they had participated in. Challenges to participant recruitment were managed by frequent contact with service managers and prompts to participate, which led to a total sample of 169, the largest sample thus far specifically in relation to IAPT practitioner PQoL. Additionally, services became increasingly stretched and the demands on staff time increased, with clinical contact and work duties becoming more of a priority than engaging in research. Notwithstanding these pressures, significant results were found, and the study was adequately powered statistically.

It is also possible that data collection during a global pandemic may have influenced findings. For example, some staff may have been experiencing high levels of stress outside work due to the restrictions or anxiety and loss associated with COVID-19. These factors may have affected their perceptions of general wellbeing and PQoL. Further, staff experienced significant and rapid changes to their working practice, being required like others to work from home. This may have led to significant changes in team dynamics and the need to balance workload with home life. It may also have impacted on individuals' perceptions of team psychological safety and quantitative workload.

Initially this study was designed to collect and analyse longitudinal data. However, due to difficulties with recruitment during the pandemic with high dropout rates between time points, the main analyses were cross-sectional in nature. This does not allow determination of causality. Additionally, only four IAPT sites within three NHS Trusts in the Northwest of England took part in the study, with most participants (77.5%) from one of these Trusts. As such, the results may not generalize to the wider IAPT workforce.

The sample self-selected, and the study may have attracted individuals experiencing more negative feelings about their work or people with more time to complete a survey, therefore biasing results. Unfortunately, due to the scale of the project, it was not possible to

gather data on non-responders (both individuals and services) and whether non-participation indicated a more, or less, suffering workforce with lower PQoL.

Despite these limitations, however, this novel data provides evidence that IAPT practitioners are at risk of reduced occupation wellbeing, influenced by many of the same factors as practitioners in other mental health contexts. The findings provide an insight into IAPT practitioners' experiences and are sufficiently robust to serve as a catalyst for further exploration.

Future Research

To build upon the findings of this innovative study, it would be beneficial to replicate this research, with the same and/or additional measures, once services have returned to business-as-usual or services have put successful protocols in place for the adapted practices that staff have become accustomed to during the pandemic. Further longitudinal research on a larger scale, capturing a greater number of IAPT sites, would provide more information regarding the wellbeing and PQoL of IAPT practitioners and identify any factors that might be unique to the IAPT context. This could be complemented with qualitative data to gain a more complete understanding of the relevant risk factors and ways of mitigating them, and would enable strategies and interventions to be implemented and evaluated to target these.

This study has analysed outcomes related to staff PQoL and wellbeing in IAPT settings. The JD-R model highlights the potential positive and negative outcomes at both the individual and organisational level (Bakker et al., 2014). Future research could assess organisational outcomes by integrating client measures of outcome and/or satisfaction alongside staff outcomes as the main variables. This would extend understanding and whether, in fact, high levels of CF with average levels of CS are even a problem requiring intervention.

Conclusion

Previous literature has highlighted the need to focus on staff wellbeing and recognised the detrimental consequences of poor PQoL and wellbeing both for MHPs and their clients. The findings of this study suggested that IAPT practitioners experienced average levels of CS, with average-high levels of CF. CS was associated with wellbeing, a potential personal resource, while CF was associated with quantitative workload, a source of job demands. Team psychological safety, as a measure of job resources, but may be indirectly associated with CS.

Further research should be undertaken to consider other potential sources of job demands, job resources, and personal resources, to ensure staff remain motivated to deliver IAPT assessments and interventions with compassion and care, while avoiding job strain and exhaustion. This will lead to improved outcomes for clients and, equally importantly, an environment which properly protects staff engaged in supporting service users experiencing difficulties with their mental health.

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Tables and Figures

Table 1: Participant characteristics

Demographics		***Time 1*** *(N = 132)*	***Time 2*** *(N = 87)*	***Cross-Sectional*** *(N = 169)*
Gender				
	Male	15 (11.4%)	9 (10.3%)	22 (13.0%)
	Female	117 (88.6%)	78 (89.7%)	147 (87.0%)
NHS Trust				
	Trust 1	98 (74.2%)	79 (90.8%)	131 (77.5%)
	Trust 2	22 (17.6%)	7 (8.0%)	25 (14.8%)
	Trust 3	0 (0.0%)	1 (1.2%)	1 (0.6%)
	Other	12 (9.1%)	0 (0.0%)	12 (7.1%)
Role				
	Step 2 (Trainee PWPs, PWPs)	60 (45.5%)	35 (40.2%)	73 (43.2%)
	Step 3 (Trainee HIT, HIT, Trainee Counsellor, Counsellor)	72 (54.5%)	52 (59.8%)	96 (56.8%)
Aware of Targets				
	Yes	122 (92.4%)	78 (89.7%)	153 (90.5%)
	No	10 (7.6%)	9 (10.3%)	16 (9.5%)
Age (years)		39.77 ± 11.05	42.36 ± 11.37	40.82 ± 11.23
Experience (months)		53.30 ± 55.08	65.93 ± 62.67	55.93 ± 55.41
Weekly hours (hours)		33.61 ± 6.69	33.24 ± 6.96	33.29 ± 7.21
Weekly Clinical Contact (hours)		17.48 ± 8.32	18.70 ± 7.17	17.53 ± 8.25
Weekly administration (hours)		12.07 ± 11.18	10.74 ± 5.48	11.62 ± 10.22
Weekly Supervision (hours)		2.45 ± 2.08	2.74 ± 2.13	2.63 ± 2.23

Note: PWP = Psychological Wellbeing Practitioner, HIT = High Intensity Therapist

Table 2: Descriptive statistics and Cronbach's alpha for study variables

Variable	Time 1 *(N = 132)*	Cronbach's alpha	Time 2 *(N = 87)*	Cronbach's alpha	Cross-Sectional *(N = 169)*	Cronbach's alpha
CS	24.27 ± 5.59	0.86	23.69 ± 5.57	0.87	24.16 ± 5.66	0.87
CF	24.23 ± 5.90	0.82	24.69 ± 5.97	0.83	24.29 ± 5.75	0.81
SWEMWBS	24.08 ± 3.96	0.84	24.22 ± 4.24	0.87	24.11 ± 4.09	0.86
TPSQ	27.02 ± 5.10	0.85	26.87 ± 5.13	0.85	26.91 ± 4.96	0.84
QWI	19.13 ± 4.25	0.87	19.67 ± 4.45	0.87	19.38 ± 4.38	0.87

Note: CS = Compassion Satisfaction, CF = Compassion Fatigue, SWEMWBS = Shortened Warwick-Edinburgh Mental Wellbeing Scale, TPSQ = Team Psychological Safety Questionnaire, QWI = Quantitative Workload Inventory

Table 3: Correlation coefficients amongst all study variables

Variables	1	2	3	4	5	6	7	8	9	10	11
1. Age	-										
2. Experience	**.424****	-									
3. Hours	**-.304****	**-.257****	-								
4. Contact	**.198***	**.181***	**.196***	-							
5. Supervision	-.103	**-.342****	-.009	.052	-						
6. Administration	.006	-.017	**.224****	**.184***	**.263****	-					
7. CS	.082	-.028	-.037	.090	-.053	-.011	-				
8. CF	-.060	.069	-.032	.125	.011	-.102	**-.340****	-			
9. SWEMWBS	**.212****	.014	-.005	.178	-.042	.149	**.643****	**-.471****	-		
10. TPSQ	-.089	**-.158***	**.203****	.177	-.074	.150	**.246****	**-.251****	**.334****	-	
11. QWI	-.069	.011	.022	.031	.077	-.082	-.105	**.402****	**-.305****	-.045	-

Note: * $p < .05$, ** $p < .01$, CS = Compassion Satisfaction, STS = Secondary Traumatic Stress, BO = Burnout, SWEMWBS = Shortened Warwick-Edinburgh Mental Wellbeing Scale, TPSQ = Team Psychological Safety Questionnaire, QWI = Quantitative Workload Inventory

Table 4A: Multiple regression results for compassion satisfaction

CS		*B*	95% CI for *B*		*SE B*	*β*	R^2	ΔR^2
			LL	*UL*				
Model							.416	.406***
	Constant	3.861	-3.414	11.136	3.685			
	CF	-.043	-.175	.089	.067	-.044		
	SWEMWBS	.847***	.657	1.037	.96	.613		
	TPSQ	.034	-.109	.177	.072	.030		

Note: Model = "Enter" method in SPSS Statistics, *B* = unstandardized regression coefficient, CI = confidence interval, *LL* = lower limit, *UL* = upper limit, *SE B* = standard error of the coefficient, β = standardized coefficient, R^2 = coefficient of determination, ΔR^2 = adjusted $R.^2$, CS = Compassion Satisfaction, CF = Compassion Fatigue, SWEMWBS = Shortened Warwick-Edinburgh Mental Wellbeing Scale, TPSQ = Team Psychological Safety Questionnaire

*** $p < .001$

Table 4B: Multiple regression results for compassion fatigue

CF		*B*	95% CI for *B*		*SE B*	*β*	R^2	ΔR^2
			LL	*UL*				
Model							.315	.299***
	Constant	32.119	25.202	39.036	3.503			
	CS	-.105	-.276	.065	.086	-.104		
	SWEMWB	-.381**	-.635	-.128	.129	-.272		
	TPS	-.141	-.298	.017	.080	-.121		
	QWI	.397***	.220	.574	.090	.303		

Note: Model = "Enter" method in SPSS Statistics, *B* = unstandardized regression coefficient, CI = confidence interval, *LL* = lower limit, *UL* = upper limit, *SE B* = standard error of the coefficient, β = standardized coefficient, R^2 = coefficient of determination, ΔR^2 = adjusted $R.^2$, CF = Compassion Fatigue, CS = Compassion Satisfaction, SWEMWBS = Shortened Warwick-Edinburgh Mental Wellbeing Scale, TPSQ = Team Psychological Safety Questionnaire, QWI = Quantitative Workload Inventory

** $p < .01$, *** $p < .001$

Figure 1: Hypothesised relationships between subscales, based on the JD-R model (Bakker et al., 2014)

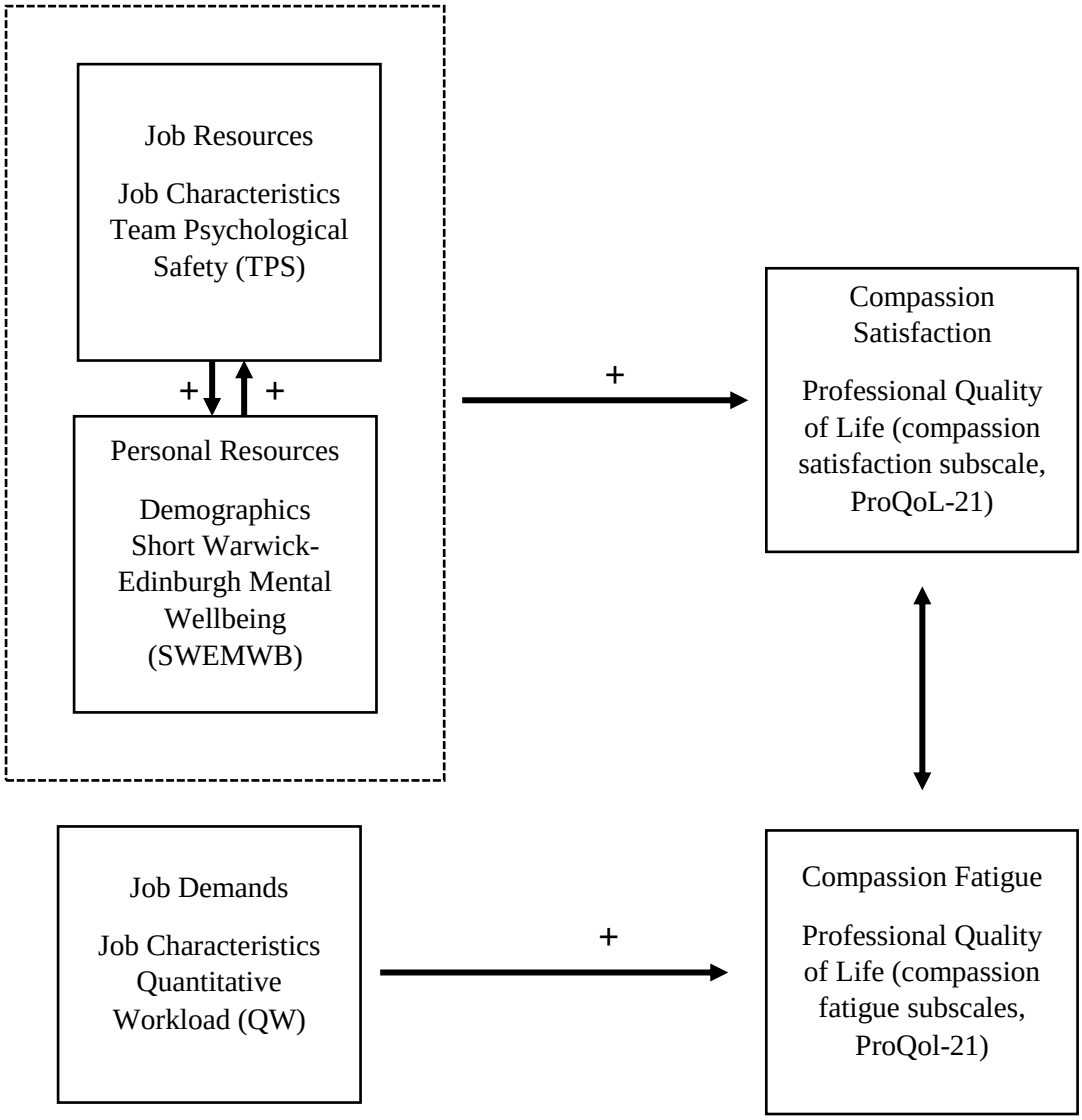


Figure 2: Participant numbers across the study

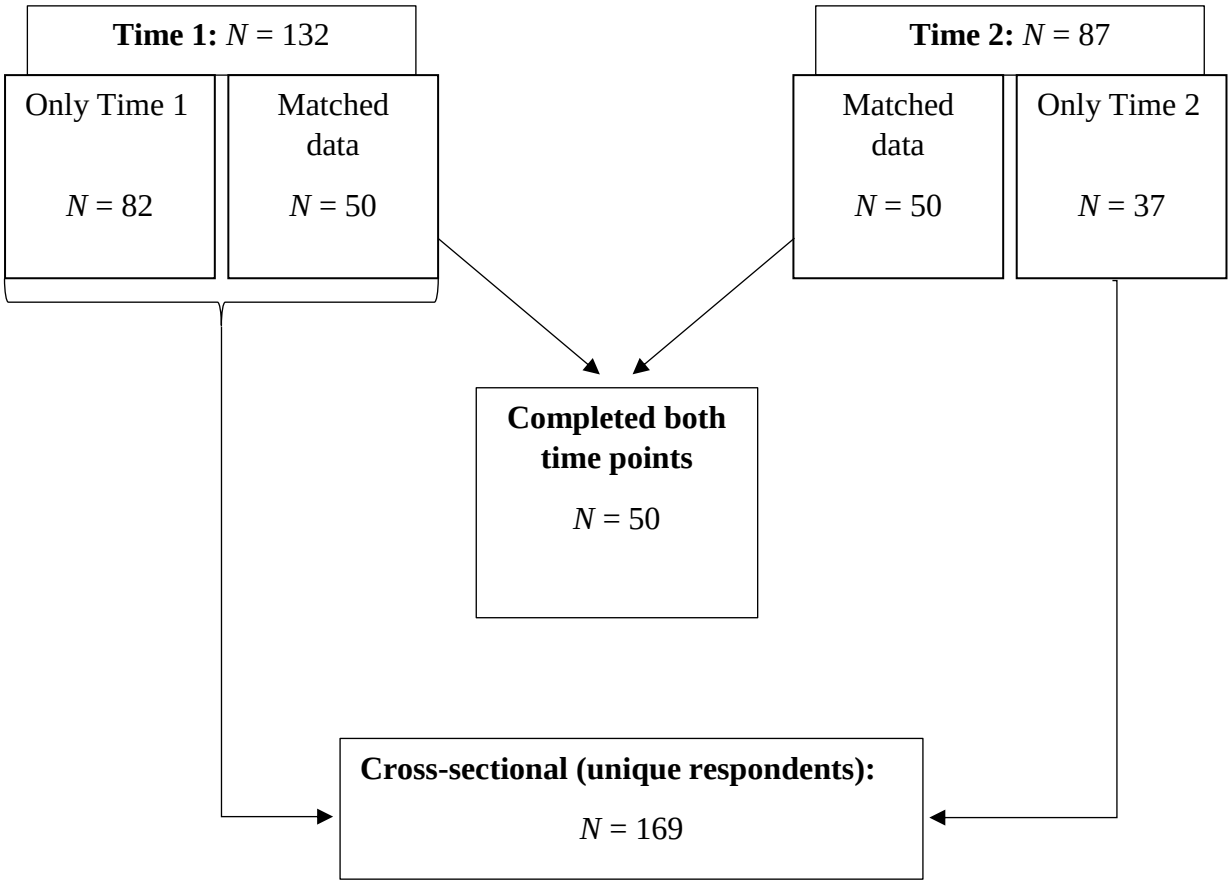
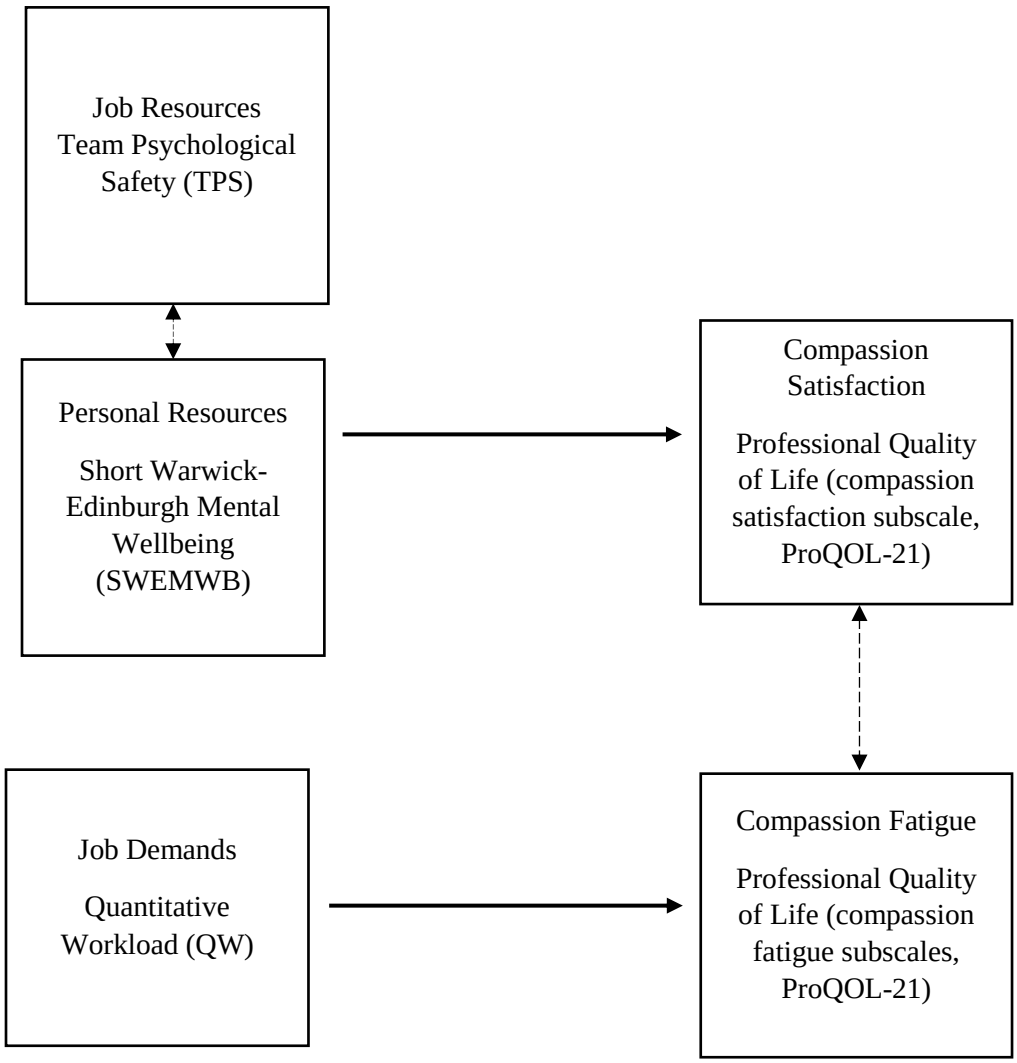


Figure 3: Actual relationships between subscales



Appendices

Appendix A – Journal for Mental Health Submission Guidelines

Journal of Mental Health is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

PREPARING YOUR PAPER

Original Articles; Research and Evaluation Articles

- Should be written with the following elements in the following order: Title page (to be uploaded separately and must not appear on the Main Document); Abstract (Background, Aims, Methods, Results, Conclusions); Keywords; Main text introduction; Materials and methods; Results; Discussion; Acknowledgments; Declaration of interest statement; References (in the correct format); Appendices (where appropriate - to be uploaded separately); Table(s) and caption(s) (on individual pages) - to be uploaded separately; Figures and figure captions (as a list) - to be uploaded separately.
- Should be no more than 4000 words (excluding abstracts, tables and references)
- Should contain a structured abstract of 200 words.

- Should contain between 3 and 7 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
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- Please include a sentence to confirm that participants have given consent for their data to be used in the research. If consent has not been necessary, please say why.
- Manuscripts are limited to a maximum of 4 tables and 2 figures to be uploaded separately – please advise where in your manuscript these are to be located.
- Please ensure that author details are not on the Main Document.
- Please ensure that author details are not included in the file name.
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Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

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Checklist

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors’ affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
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3. You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.
4. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants
This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

5. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.
6. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
7. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
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9. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
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11. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
12. **Units.** Please use SI units (non-italicized).

Chapter Three: Critical Appraisal

Professional Quality of Life and Wellbeing with Mental Health Professionals: Reflections on Decisions and Challenges

Word count (excluding references, tables and appendices): 3999

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Critical Appraisal

The aim of this critical appraisal is to present a summary of the findings and provide further context to the literature review and empirical research discussed in Chapters One and Two. Reflections will be offered on the key decision-making points and challenges in the research process, which will highlight the strengths and limitations of the projects. The implications for practice and future research will expand upon those discussed in the aforementioned chapters.

Research Focus

I chose to embark on this research having worked in an Improving Access to Psychological Therapies (IAPT) service before my clinical psychology training. As a psychological wellbeing practitioner, I derived immense satisfaction from helping those experiencing difficulties with their mental health. However, there were several challenges in doing this work. The target driven environment meant I was responsible for a high caseload, holding back-to-back appointments whilst also dealing with high volumes of administration, supervision and liaison with other professionals. Although clinical guidelines stressed the frequency and importance of supervision, this was often not prioritised by my managers. As a result I was unable to properly reflect on the difficulties that service users were experiencing or the emotional impact this had on me. Later, in a more senior position, I had line manager and supervisory responsibilities which gave me a greater sense of the challenges staff were facing and of the impact these had both on staff wellbeing and on the experience of clients.

Given the risk of such subjective experience impacting on the research process (Jones & Bartunek, 2021), I have sought to use my knowledge and experience to enrich the research process while ensuring objectivity through a reflective journal and through supervision discussions. This connection has also been helpful in maintaining my interest in the project,

which has been emotionally challenging at times due to managing the competing demands of training and sustaining a personal life throughout a global pandemic.

Summary of Findings

The systematic literature review (SLR) sought to identify potential factors associated with the levels of compassion satisfaction (CS) experienced by mental health professionals (MHPs). Results from 28 cross-sectional studies were synthesised.

The findings suggested a complex network of organisational and personal factors were related to CS for MHPs. In terms of organisational factors, 39% of the studies established an association between workload and CS. CS was higher when employees' expectations matched the realities of their work, duties and client caseload were varied and manageable, and employees felt equipped to do their work through training and resources. Team-working was related to higher CS in 21% of the studies, enabling employees to feel a sense of belonging and support from colleagues. Access to regular supervision was associated with higher levels of CS in 11% of the studies.

With regards to personal factors, higher wellbeing and the use of self-care strategies were related to higher CS in 39% of the studies. Helpful self-care strategies included; accessing personal therapy; spending time with friends and family; and engaging in exercise. MHP personal trauma was associated with reduced CS in 14% of studies and with improved CS in 7% of studies. These contradictory findings suggest that the impact of trauma on practitioners may depend on either the nature of their personal experience or their response to it.

The SLR also identified several psychological characteristics that are related to CS, such as empathy, conscientiousness, and mindfulness, although fewer studies have focused on these. Such skills can be taught, but further exploration of the wide range of psychological

characteristics associated with CS would be necessary to determine their impact and where teaching should be focused. Additionally, individual preferences should be considered in teaching such skills.

The empirical paper explored professional quality of life (PQoL) amongst IAPT practitioners and whether this changes over time. The study explored relationships between PQoL, wellbeing, team psychological safety and workload using the Job Demands-Resources (JD-R) model (Bakker et al., 2014) as an evidence-based framework. The JD-R model suggests that an interaction between job demands, job resources and personal resources predicts occupational wellbeing (Bakker et al., 2014). Figure 1A shows a representation of the study variables in relation to the JD-R model. Multiple regression analyses were performed to examine variables significantly associated with PQoL.

[FIGURE 1A ABOUT HERE]

The sample of IAPT practitioners experienced average CS and average-high compassion fatigue (CF). This remained stable between the two time points. Higher CS was independently associated with higher general wellbeing. Higher CF was independently associated with higher perceived workload and lower general wellbeing (see Figure 1B). Team psychological safety was weakly correlated with both. Personal and occupational characteristics measured via a demographics questionnaire were not significantly associated with IAPT practitioners' PQoL.

[FIGURE 1B ABOUT HERE]

These findings are not dissimilar to comprehensive reviews regarding the predictors of CF for MHPs more generally. Workplace trauma, workload, therapeutic setting (Singh et al., 2020), and personal trauma history and caseload (Turgoose & Maddox, 2017) have all

been implicated in the development of CF. These factors were also highlighted in the SLR in relation to CS.

Cross-sectional research and multi-site research have identified that IAPT practitioners are at risk of developing burnout (BO), a component of CF (Steel et al., 2015; Westwood et al., 2017) and stress (Walklet & Percy, 2014), with higher levels of occupational stress related to high workload and poorer team dynamics. Further, higher levels of BO are associated with reduced wellbeing (Hall et al., 2016; Johnson et al., 2017). This finding was replicated in the empirical paper with wellbeing associated with both CF and CS. A parallel was also identified in the SLR with higher levels of CS associated with higher levels of wellbeing.

Uniquely, this is the first research in this field to focus specifically on PQoL with the IAPT practitioner occupational group. It found that very much the same factors interact in affecting PQoL amongst members of the IAPT practitioner specialism as have been found to affect PQoL in other occupational groups in the mental health field. Management interventions have been developed in other areas in the mental health field to protect and strengthen the mental health of practitioners and to improve the quality of outcomes for clients through more effective management of the wellbeing of staff. This research suggests that similar approaches and interventions may have positive effects also for IAPT practitioners and their clients. This is an important conclusion for the management of IAPT services throughout the NHS.

Systematic Literature Review (SLR) Reflections

Scope of the Review and Search Strategy

The intention of the SLR was to examine research relevant to the main study variable of PQoL. Initial scoping searches were taken over a wide field, following which the focus

was narrowed to identify significant gaps in the literature and to ensure a novel contribution. The initial search revealed that existing literature considering PQoL for MHPs tended to focus on the negative consequences of providing therapeutic care, such as CF. Less attention has been paid to the positive experiences of MHPs when helping others by focusing on CS. Additionally, it was clear that there was scope to consider whether the factors implicated in CF are also implicated in levels of CS. This was a major strength of the SLR, since it was the first systematic review to focus on CS in MHPs.

An initial search using broad search terms produced too many results to manage. Expert support from a librarian is crucial for systematic reviews to help develop comprehensive search strategies across multiple relevant sources (Harris, 2005). Recognising this, I sought guidance from an academic librarian. This helped me to concentrate my search terms, making the results more specific to the research question.

Entering search terms based on occupation and service setting excluded too many relevant results. Therefore, at the screening stage I had to carefully consider the inclusion and exclusion criteria, deciding which occupations would be included. For example, social work was excluded on the grounds that it was too broad and non-specific. Similarly, students and unqualified professions were also excluded as, although students also experience performance anxiety and course-related stress, they tend to receive higher levels of support and structure (Ronnestad & Skovholt, 1993).

Reducing the scope of the review in this way limited the search results that needed to be reviewed to a manageable number. It excluded reviews which explored CS in a wider range of occupations and may, therefore, have missed some potential read-across from other occupational fields. Overall, however, it has strengthened the value of the SLR by ensuring

that it was focused very clearly on the MHP, which means that the conclusions are both specific to the field and uncluttered by potentially confounding factors in other occupations.

Quality Appraisal

In considering which tool to use in critically appraising papers, I noted that the Joanna Briggs Institute (JBI) critical appraisal tool (Moola et al., 2017) is the normally preferred checklist for assessing the quality of analytical cross-sectional studies (Ma et al., 2020). I also noted, however, that the critical appraisal tool to assess the quality of cross-sectional studies (AXIS: Downes et al., 2016) developed using previously published critical appraisal tools, included a more comprehensive help text and assessed both quality and bias. As such, I felt the AXIS tool would give a more thorough picture of the quality of included studies. Quality was assessed by one author. This may represent a limitation of the SLR. However, to mediate this and to ensure consistency and objectivity, a colleague independently reviewed a selection of included papers. Their assessments were taken into account in determining the quality of the papers that were included in the review.

Synthesising Data

From the initial scoping search, it was clear the review would cover a wide breadth and depth of factors associated with CS. I therefore concluded that the data would best lend itself to a narrative review. The narrative synthesis of quantitative data has been criticised for lacking transparency in the reporting of methods and presentation of data (Campbell et al., 2019). I wanted to ensure I was as transparent as possible throughout data synthesis. Although high levels of statistical and methodological heterogeneity within the included studies meant meta-analysis was not possible, I utilised effect sizes to highlight findings that were most clinically meaningful. I believe this led to a comprehensive, transparent, and objective synthesis of the literature, representing a strength of the research.

Empirical Paper Reflections

Survey Design

At the start of this project, it was challenging to narrow the research focus for the empirical paper due to the lack of existing research within the IAPT context as compared to the wealth of occupational stress research in other populations. Here, my experiences of working in IAPT were useful as I had some knowledge of the factors which might impact on practitioners' wellbeing. I was aware of measures for examining the overall experience of practitioner burnout (BO), for example the Maslach Burnout Inventory (MBI: Maslach et al., 1996). The MBI captures the emotional exhaustion, depersonalization and reduced personal accomplishment developed in those having a professional relationship with others (Maslach & Leiter, 1997). This validated tool not only quantifies levels of BO, but also acknowledges potential positive aspects of helping others via personal accomplishment. However, it has been noted that it does not capture the traumatic experiences professionals may experience in helping others (Newell & MacNeil, 2010), termed secondary traumatic stress (STS).

It was important to utilise measures which encompassed the direct experiences practitioners might face in providing therapeutic care to individuals who were seeking support for their mental health. I therefore chose to use the professional quality of life (ProQOL) scale. This has been widely used across healthcare populations and in those providing therapeutic care, as revealed in the SLR. The ProQOL-V (Stamm, 2010) has demonstrated good construct validity amongst professionals working with trauma survivors (Geoffrion et al., 2019) and factorial validity amongst direct support professionals (Keesler & Fukui, 2020). Thus, it seemed appropriate for use with IAPT practitioners who would share similar experiences to these professions. However, analyses of the psychometric properties of the ProQOL-V indicated sound results for the CS subscale but concerns regarding the

construct validity of the BO and STS subscales (Hemsworth et al., 2018). Consequently, Heritage et al. (2018) developed the ProQOL-21 which overcame the issues described previously making it more suitable for the empirical study.

I decided to measure general wellbeing using the Shortened Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS: Stewart-Brown et al., 2009) due to the links between wellbeing and productivity at work (Knapp et al., 2011; Wright et al., 2007). Both the longer and shorter versions of this measure have demonstrated similarly robust psychometric properties (Stewart-Brown et al., 2009). I opted for the shorter version to reduce the time burden on staff completing the survey.

My experiences of IAPT and discussions with my supervisors led me to consider psychological safety and its relationship with PQoL. National targets mean managers are constantly pressurised to report against and meet specific performance indicators. This pressure is passed down and felt by staff working with the service users. Qualitative exploration of this dynamic indicated that some staff feel micromanaged, bullied, and compelled to provide inadequate care beyond their training remit (Harper et al., 2020). This can create an environment in which it feels unsafe and invalidating to express personal vulnerability and raise any concerns. The Team Psychological Safety Questionnaire (TPSQ: Edmondson, 1999) captures these experiences. This also seemed particularly topical considering the coronavirus (COVID-19) pandemic and a move to remote working which would likely impact communication between teams and the support available to staff.

Whilst working in IAPT, I also found the quantitative workload challenging. I considered it important to review how this might impact PQoL. I chose to utilise the quantitative workload inventory (QWI; Spector & Jex, 1998), which measures perceived workload, recognising that the individual's perception of occupational stressors has a greater

impact on professional wellbeing than the objective presence of stressors (Bowling et al., 2015). Previous studies, suggesting IAPT practitioner stress and BO are related to workload, have utilised hours worked as an objective, although non-validated, measure (Walklet & Percy, 2014; Westwood et al., 2017). This does not, however, fully assess the amount and pace of work.

I also gathered demographic and occupational information, including gender, age, experience, job role, and awareness of targets. Participants were asked to indicate their average weekly working hours, clinical contact hours by type, supervision received, and supervision provided. This provided a mine of useful information to describe the sample and consider and rule out potential confounding variables.

Although the questionnaire was designed in consultation with service managers, during data collection I received feedback that these figures were difficult and time-consuming to calculate. This may have affected recruitment. In hindsight, it may have been more valuable to exclude questions about workload as this was covered by the QWI (Spector & Jex, 1998). There would then have been scope to focus more explicitly on regularity and quality of supervision and the impact of working to targets, i.e. factors which have been linked to poorer wellbeing outcomes (Johnson et al., 2020; Westwood et al., 2017).

Recruitment

Recruitment was a challenge throughout this study. Due to COVID-19, research priorities had shifted towards those projects considering managing the impact of the pandemic. Several services expressed interest but did not have capacity to proceed due to extra workloads and changing working practices associated with COVID-19. Although there are approximately 140 providers nationwide (NHS Digital, 2019) a central database of service providers and their contact details does not exist which made it difficult to invite

services to participate. For those whose contact details were obtained many attempts to make contact went unanswered. Four IAPT sites across three NHS Trusts took part in the study. The challenges in recruiting sites were discussed in supervision in terms of whether the project was viable. It was agreed that, given enthusiastic support from managers to encourage participation, an appropriate sample would be obtained.

During data collection I received several emails from potential participants and service managers stating that although it was felt the research topic was valuable, staff just did not feel they had the time to participate. Additionally, there were high levels of attrition between Time 1 and Time 2, resulting in only 50 matched responses. Retention strategies in longitudinal research often include financial incentives and tracking methods (Abshire et al., 2017). It might have been helpful to utilise these strategies to improve recruitment and retention. In discussion with my research and field supervisors, it was agreed that it was unlikely sufficient participant numbers would be reached at a third time point and a period of planned long-term sickness created further time pressures. As such, data collection was stopped after two time points, instead of the planned three.

Recruitment was frustrating and disappointing at times, particularly since services and individuals within them expressed interest and value in the research topic. For those services interested in participating in future research, it would be beneficial to strengthen the network of communication between IAPT providers and to consider designating research leads and a central database of contact details to improve access to research opportunities.

The small number of participating sites and overall sample size limit the extent to which results can be generalised to the larger IAPT workforce and preclude cross-sectional analyses that allow examination of causes and effects. However, the analyses were

appropriately powered and significant results were found. That these replicated previous findings in other similar settings reinforces confidence in the conclusions drawn.

Analyses

Hypotheses were made based on the JD-R framework (Bakker et al., 2014). Ideally, structural equation modelling (SEM) would have been utilised to analyse data. However, given data limitations and the lack of existing literature within the IAPT context, the study was more exploratory in nature. As such, correlation and regression analyses were appropriate.

It was surprising psychological safety was not significantly independently associated with CS. The addition of personal resources to the JD-R model may explain this finding. Xanthopoulou et al. (2007) explored the role of personal resources in predicting job strain and engagement. Results suggested that job resources promoted development of personal resources, indicating a mediation relationship may exist between the two. This was explored retrospectively but excluded from the empirical paper to avoid biasing the results and conclusions through data fishing (Erasmus et al., 2020)

To assess the indirect effects of psychological safety on CS, a mediation regression analysis (see Figure 2) was conducted using Hayes' Process Tool (Hayes, 2017), utilising 5000 bootstrap samples to estimate confidence intervals. The outcome variable was CS, predictor variable was TPSQ, CF and QWI were entered as covariates, and SWEMWBS was tested as the mediating variable. If the 95% bootstrap interval did not contain zero, the indirect effect of SWEMWBS was deemed significant.

[FIGURE 2 ABOUT HERE]

The 95% confidence interval for the completely standardised indirect effect (.1521) was above zero (.0534 to .2567), indicating that psychological safety indirectly effected CS

through general wellbeing (see Table 1). Higher psychological safety was associated with higher wellbeing and higher wellbeing was related to higher CS. This indirect effect accounted for 78.6% of the total effect of psychological safety on CS. These findings may indicate that job resources (TPSQ) predicted personal resources (SWEMWBS) which, in turn, predicted CS. Further research exploring this mediation relationship is warranted.

[TABLE 1 ABOUT HERE]

Clinical Implications

A systems approach to job stress suggests preventative strategies which reduce potential risk factors before employees' experience work-stress are more effective than attempts to change how individuals respond to stress (Lamontagne et al., 2007). Individuals should be encouraged to take reasonable steps to maintain their own wellbeing by making time for social support and engaging in self-care strategies. It should also be recognised however that wellbeing, personal growth and the ability to engage in self-care may be affected by organisational demands.

Taken together, the findings from both the SLR and the empirical research suggest that commissioners and services should prioritise: (i) staffing levels that enable manageable workloads; (ii) development opportunities for staff to access training and to bring variability to their role, for example by engaging in research and development or utilising alternative therapeutic models; (iii) regular access to quality supervision and peer-support; and (iv) a commitment to engaging in research and ensuring practitioners have time to participate in it. These steps should lead to improved engagement, while reducing strain and exhaustion (Bakker et al., 2014). Meetings have been arranged with managers of participating IAPT services to disseminate these recommendations and encourage systemic change.

Future Research

These findings have generated some important research questions. It is important to clarify levels of PQoL and wellbeing amongst MHPs and the factors influencing these. All the studies included in the SLR adopted cross-sectional designs. This prevents determination of causality. Although the empirical paper was intended to gather longitudinal data, challenges to recruitment and time pressures also limited the research to cross-sectional analyses. Future research utilising longitudinal research designs would give rise to a more thorough understanding of the factors influencing PQoL and wellbeing for MHPs.

Using existing knowledge of factors influencing these concepts, prospective studies could use confirmatory analyses to test, on the basis of a hypothesized model such as the JD-R model, how constructs relate to each other. Consequently, robust explanatory models of PQoL and employee wellbeing will be generated. Based on the findings of the SLR and empirical research, factors worth exploring further for MHPs generally and for clearly defined populations within mental health services are depicted in Figure 3 utilising the JD-R framework of occupational wellbeing (Bakker et al., 2014).

[FIGURE 3 ABOUT HERE]

There is also scope for further research using a mixed methods approach to data collection, including interviews and focus groups. This would provide qualitative data to deepen understanding of staff experiences and perhaps generate further exploration of new or existing constructs which are not currently captured by validated measures of occupational wellbeing. In addition, strategies to promote CS and reduce CF should be implemented and evaluated.

The benefits of further research are five-fold: researchers could understand the job-specific resources and demands and unique experiences of staff working in different contexts; policymakers who are distanced from the realities of working within services would gain

evidence-based guidance for funding priorities and workforce expansion needs, while facilitating cost-effective strategies to reduce the costs associated with reduced PQoL such as staff turnover and absenteeism; service managers would get a real sense of employee wellbeing, could implement strategies to improve service design and delivery, and provide evidence to push back against the targets laid out by policymakers; staff would have a voice and opportunities to share their personal experiences in a safe and open manner; and service users would experience compassionate care in which they are recognised as individuals, as opposed to being reduced to a number with their care governed by systemic issues and national targets.

Conclusions

Service providers need to recognise the risk factors associated with job and personal demands and resources within their specific context to maintain a healthy workforce that can deliver effective mental health assessment and intervention. Despite the challenges and transparent limitations described, these novel and timely findings have highlighted organisational and personal demands and resources for MHPs. For example, high workload and lack of resources are potential job demands. Supervision and team psychological safety are possible job resources. Meanwhile, self-care strategies and a focus on general wellbeing which meet individuals' needs and preferences are likely personal resources. Focusing on these to reduce demands and maximise resources should be prioritised within service design and delivery.

COVID-19 is likely to have longstanding effects on the mental health of the whole population. Therefore, it is important that PQoL and staff wellbeing remain on the agenda to enable staff to retain the emotional availability required to deliver therapeutic interventions while maintaining their own wellbeing. These projects have also highlighted gaps in the

existing literature and will hopefully act as a catalyst for further research to bring about a cohesive understanding of PQoL for MHPs and inform systemic change.

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Tables and Figures

Table 1: Mediation Analysis

	Y = compassion satisfaction, X = team psychological safety, M = general wellbeing
a[1]	.1977**
b[1]	.8773**
c’	.0201
c	.1936*
ab (CI)	.1735^ (.0640, .2883)
CSIE (CI)	.1521^ (.0534, .2567)

* $p < .05$, ** $p < 0.001$, ^ Significant indirect effect with 95% CI
Note: X = predictor, M = mediator, Y = outcome, c’ = direct effect of X on Y, controlling for M, c = total effect of X on Y, ab = mediated effect, CI = confidence interval, CSIE = completely standardised indirect effect.

Figure 1A: Study variables in relation to the Job Demands-Resources Model (Bakker et al., 2014)

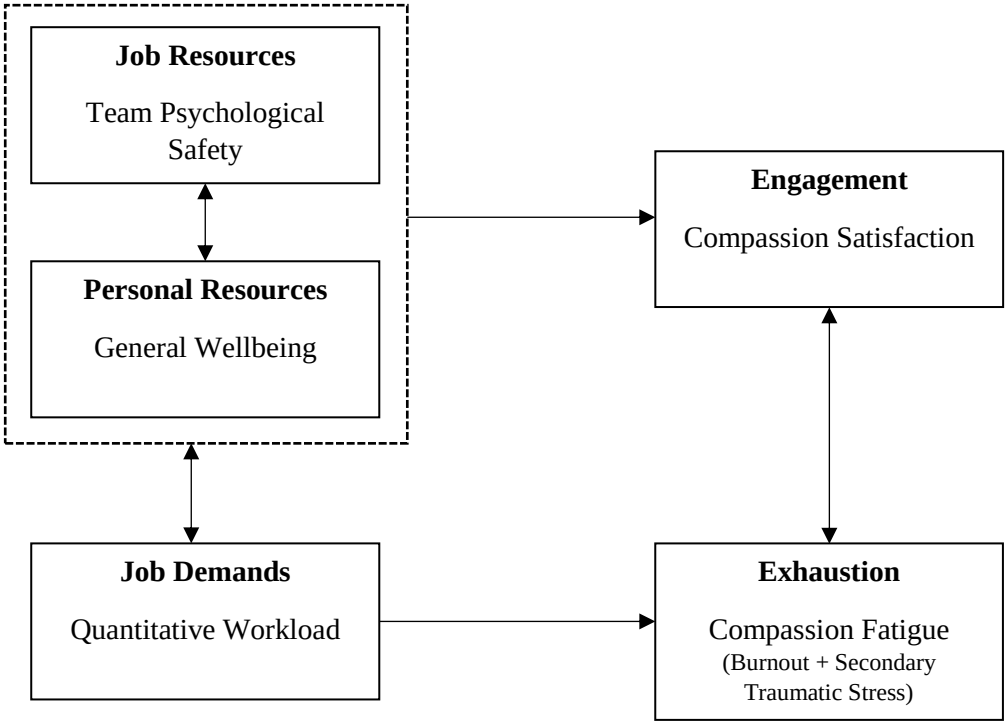


Figure 1B: Empirical research findings

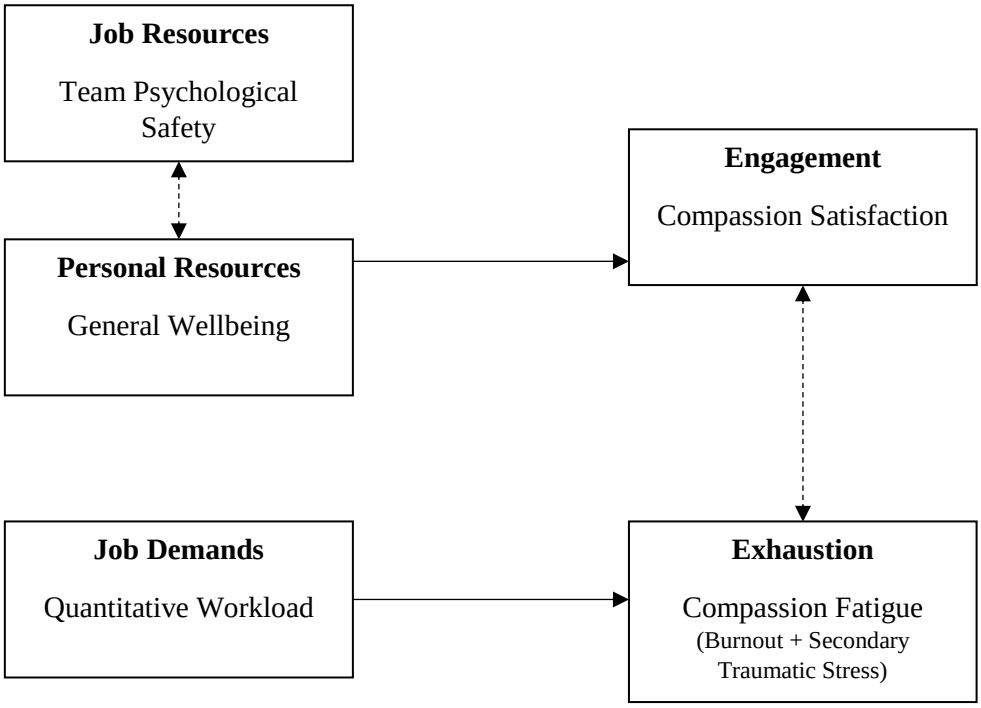
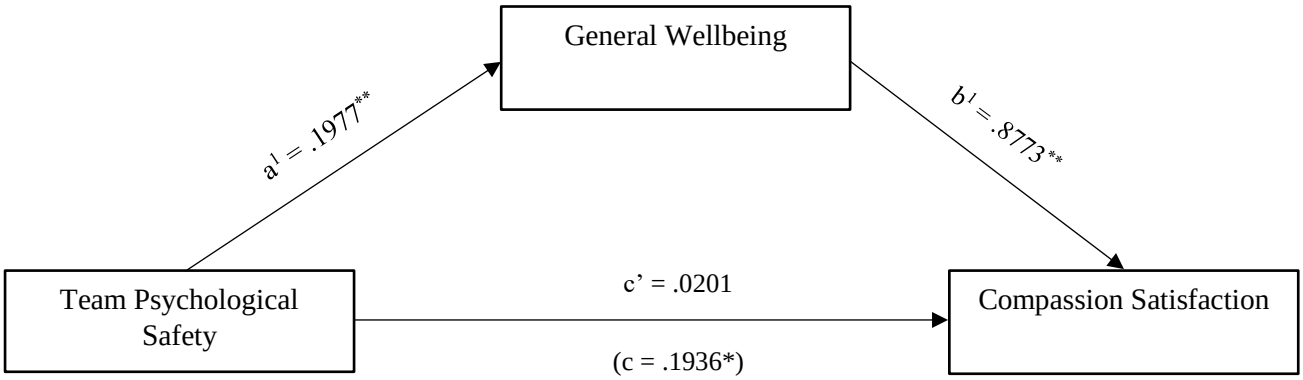
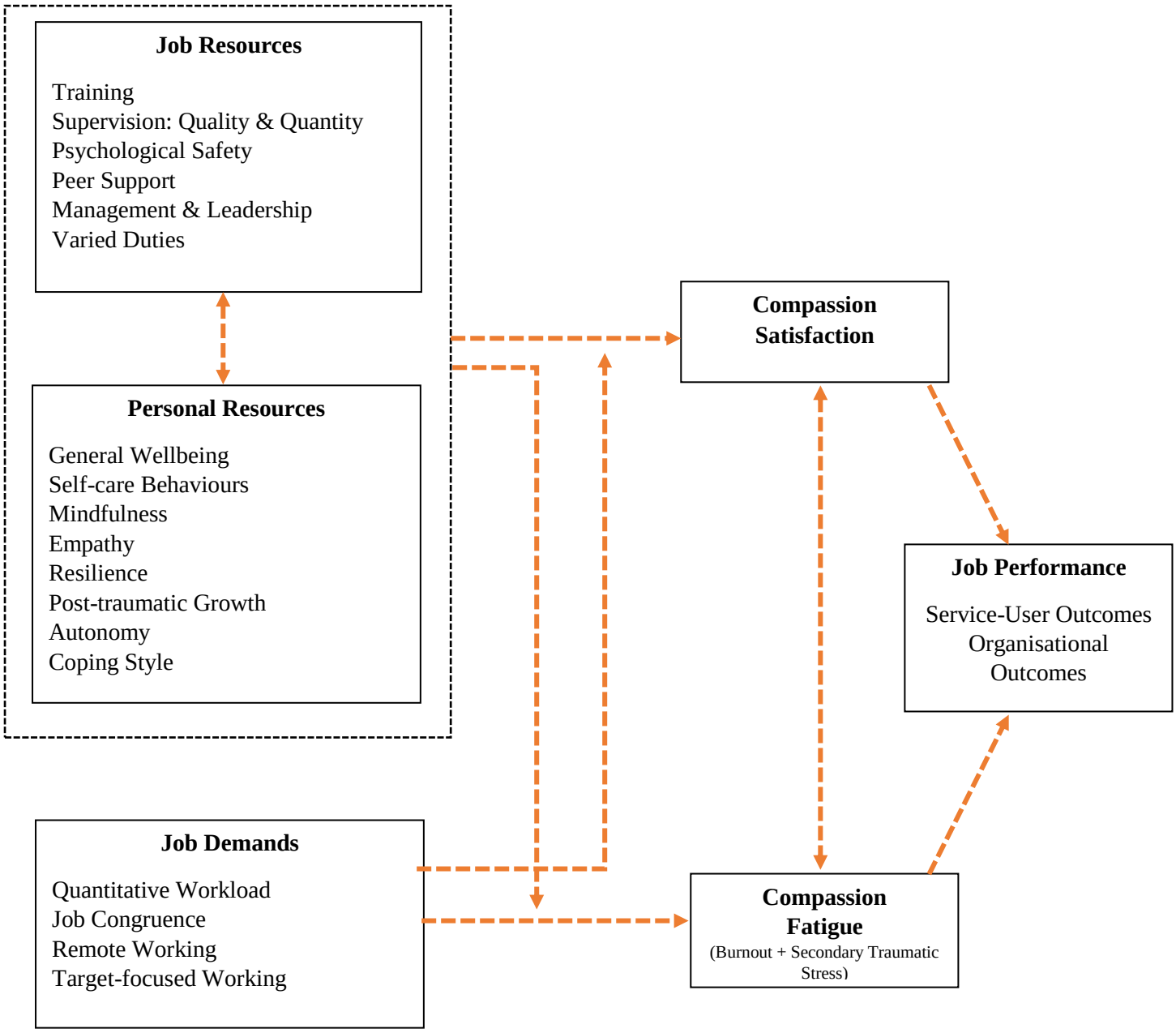


Figure 2: Mediation Model



Note: * $p < .05$, ** $p < 0.001$

Figure 3: Potential factors affecting professional quality of life utilising the JD-R framework of occupational wellbeing (Bakker et al., 2014).



Note: Dashed line indicates relationships to be explored using structural equation modelling in general mental health care and clearly defined samples within mental health care

Chapter Four: Ethics

Ethics proposal for the empirical study: *"Compassion, Workplace Demands and Psychological Safety with IAPT Therapists"*

Word count (excluding references, tables and appendices): 4350

Rebecca Wright

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

March 2022

IRAS Form | Reference: 20/HRA/6116 | IRAS Version 5.17

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
IAPT Staff Wellbeing and Compassion

1. Is your project research?

(•) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product

( ) Clinical investigation or other study of a medical device

( ) Combined trial of an investigational medicinal product and an investigational medical device

( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

( ) Basic science study involving procedures with human participants

(•) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

( ) Study involving qualitative methods only

( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

( ) Study limited to working with data (specific project only)

( ) Research tissue bank

( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(•) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(•) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(•) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[x] England

☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
◯ Scotland
◯ Wales
◯ Northern Ireland
◯ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ◯ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ◯ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or Medtech and In Vitro Diagnostic Cooperative in all study sites?

Please see information button for further details.

◯ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The study is being undertaken as part of a Doctorate in Clinical Psychology. The student's supervisor will be the chief investigator, however the student will be the main researcher, carrying out research duties and activities and writing the report under supervision of the chief investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project

(including identification of potential participants)?

◯ Yes ◉ No

IRAS Form | Reference: 20/HRA/6116 | IRAS Version 5.17

Integrated Research Application System
Application Form for Research administering questionnaires/interviews for quantitative analysis or mixed methodology study

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
IAPT Staff Wellbeing and Compassion

Please complete these details after you have booked the REC application for review.

REC Name:
Non-REC Studies: England

REC Reference Number:
20/HRA/6116

Submission date:
10/12/2020

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Compassion, Workplace Demands and Psychological Safety in IAPT Therapists

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Rebecca	Wright
Address	37 Windsor Avenue		
	Lancaster		
Post Code	LA1 4BE		
E-mail	becky.m.wright30@gmail.com		
Telephone	07867416435		
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:

Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Address	Lancaster University		
	Lancaster		
Post Code	LA1 4AG		
E-mail	i.j.fletcher@lancaster.ac.uk		
Telephone	01524593301		
Fax			

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	Sabir	Giga
Address	Lancaster University		
	Lancaster		
Post Code	LA1 4AG		
E-mail	s.giga@lancaster.ac.uk		
Telephone	01524594033		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Rebecca Wright	☑ Dr Ian Fletcher ☐ Dr Sabir Giga

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Senior Lecturer		
Qualifications	PhD		
ORCID ID	0000 0002 1000 9581		
Employer	Lancaster University		
Work Address	Lancaster University		
	Lancaster		
Post Code	LA1 4AG		
Work E-mail	i.j.fletcher@lancaster.ac.uk		
* Personal E-mail	i.j.fletcher@lancaster.ac.uk		
Work Telephone	01524593301		
* Personal Telephone/Mobile	07854834898		
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Mrs	Becky	Gordon
Address	Head of Research Quality and Policy		
	Lancaster University		
Post Code	LA1 4YT		
E-mail	sponsorship@lancaster.ac.uk		
Telephone	01524592981		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	FHMREC20004
Sponsor's/protocol number:	N/A
Protocol Version:	0.3
Protocol Date:	16/11/2019
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	https://lancasteruni.eu.qualtrics.com/jfe/form/SV_dijH0Ou6lK6Wmvb

Additional reference number(s):

Ref.Number Description	Reference Number
N/A	N/A

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open

access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

◯ Yes ◉ No

Please give brief details and reference numbers.
N/A

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Compassion and wellbeing are important to maintain the health of the workforce and ensure efficient and effective patient care. Improving Access to Psychological Therapies (IAPT) services were originally designed to improve access to support for adults experiencing mild to moderate anxiety and depression. Several work factors specific to IAPT may lead to higher compassion fatigue and/or reduced compassion satisfaction and wellbeing. These include high caseloads, high levels of client complexity or distress, reduced opportunity for development, team dynamics, perceived lack of support from colleagues and reduced psychological safety. Very little research has considered compassion and wellbeing of IAPT staff. This study will investigate predictors of compassion and wellbeing in IAPT staff and will attempt to capture changes over time, particularly in light of changing work practices due to COVID-19, circumstances permitting.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

This study will adopt a quantitative longitudinal panel design to examine the relationship between compassion, wellbeing, psychological safety and job demands. The longitudinal design extends previous cross-sectional research within IAPT settings as it will allow identification of links between variables, as well as further exploration of the nature of these relationships and may allow for stronger claims to be made about causality.

In recent times, with COVID-19, working practices have had to rapidly change and may be likely to begin returning to business-as-usual during the study. The design of this study intends to capture these changes and may allow for recommendations to be proposed in supporting staff transitioning back to business as usual and when considering any future changes to working practices.

Managers of a local IAPT service were consulted in all aspects of the research, including design, materials, sample and feasibility of the study.

Participants will predominantly be recruited by gaining support of managers from specific IAPT services. Managers from four services have already been approached and shown enthusiastic support for the study [redacted]. The main researcher will attend team meetings to explain and advertise the study to aid recruitment, where appropriate. Managers and/or service leads will be sent the advert, Participant Information Sheet and a link to the online survey to disseminate within their teams. Other IAPT services across England will also be approached to gather a wider geographical sample.

Participants will be employed by an IAPT service within England as either (trainee or qualified) psychological wellbeing

practitioner, (trainee or qualified) high intensity therapist, or (trainee or qualified) counsellor. They will not be employed by IAPT but hold an alternative role to those mentioned, or be trained in alternative therapeutic approaches and be on secondment to IAPT services.

The survey will be hosted online via Qualtrics, which should be easily accessible by all participants via email link. Participants will be asked to use the last three digits of their postcode as a unique identifier for the purposes of matching data sets. Once the longitudinal data sets have been linked, identifier data will be deleted and substituted with a randomised unique identifier.

Anonymous data will be stored securely on the Qualtrics database before being transferred to SPSS software. All laptops being used for data analysis will be encrypted and password protected and will only be accessible by the main researcher and named supervisors. On completion of the thesis project, data will be securely transferred to the Lancaster DClinPsy research coordinator via OneDrive. Data will be stored for 10 years, in line with University procedures and it will be the research coordinators responsibility to destroy data in 10 years' time.

Lancaster University will fund any costs associated with the study, for example advertisements. Individual participants will not be reimbursed for taking part.

There are unlikely to be any major ethical issues with this project. All data will be anonymous and only the participant will be aware of their unique identifier. As mentioned previously, anonymous data will be stored securely on password protected computers, on the University's secure storage drive. In addition, participants will be informed their employer will not be made aware if they choose to participate or not.

All efforts will be taken to ensure participants are given adequate information to make an informed decision to take part in the study. Upon clicking the link, participants will be taken firstly to a participant information sheet which will provide information about the study, what is required of participants, the length of participation and any potential benefits and risks of participation. Participants will be encouraged to take the time to carefully consider this information before being presented with a series of consent statements. They will then be asked to proceed to the next page of the survey, and it will be made clear this indicates their consent to participate. All participants will be employed by IAPT sites in England. Given their roles, it will be assumed they have capacity to consent.

Participants will be informed of their right to withdraw at any time throughout the study. They can do this by exiting the questionnaire, which will prevent any data being saved. They can also contact the main researcher via email, providing their unique identifier, should they wish to withdraw at a later stage. This option will be available to participants up until data analysis begins, approximately November 2021.

There are no direct benefits to those taking part in the study. It is anticipated the findings will increase our understanding of compassion and wellbeing in IAPT staff. This may indirectly benefit those who participate by making recommendations around the design of future services, gaining additional resources from commissioners and that participating services would be mentioned in any publication. Further, services would be offered an anonymised summary of the findings as a whole, as well as for their individual service, where possible. The risks of participation appear low. There will be minimal additional distress as a consequence of completing the questionnaires and participants thinking about their wellbeing and job role. This has been discussed with service managers and all questionnaires have been reviewed. It has been determined none of the items are likely to lead to disclosures of risk (to self or others). In addition, the absence of a free text box within the questionnaires will further reduce disclosures of risk. Participants will be provided with general advice (e.g. contact clinical supervisor, services specific employment support, general practitioners) as part of the participant information sheet and debrief information. The main researchers email address will be given as a point of contact. Should participants make contact to disclose a concern for their wellbeing or the wellbeing of others, they will be advised to contact their supervisor/manager, employment support and/or general practitioner. If the research team is concerned for the safety of the participant or those they work with, they will be advised that their contact details may be shared with their supervisor/manager. Participants will also be provided with the contact details of an independent member of the Lancaster University staff team should they wish to discuss any concerns or make a complaint.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation

- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☐ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☑ Other (please specify)

Longitudinal panel design

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The objective of the study is to explore relationships between compassion, job demands and psychological safety among IAPT staff in order to make recommendations for design of future services and potentially gain further resources from commissioning.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Secondary objectives include exploring whether changes in working practices due to COVID-19 impact on staff compassion and wellbeing.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

There has been significant focus on the implications of poor compassion and staff wellbeing in health care settings, including higher rates of sickness and absence (absenteeism), higher incidence of staff working despite physical or mental illness (presenteeism), reduced patient safety and patient experience, higher rates of staff turnover and less effective patient care (Department of Health, 2009). A wealth of research exists exploring compassion and staff wellbeing amongst several professional groups with much of the research focusing on indicators of staff wellbeing that are measurable, for example stress levels, job satisfaction and burnout. While findings vary, it is apparent that a combination of organisational and personal factors can increase an individuals' vulnerability to reduced wellbeing and compassion.

The Improving Access to Psychological Therapies (IAPT) workforce is a relatively new, and expanding, team within adult mental health. Previous literature into workplace compassion and wellbeing highlights many aspects of working within IAPT services as potential risk factors for compassion fatigue, reduced wellbeing and reduced compassion satisfaction. It is fast-paced, high volume work where practitioners hold their own caseloads, have clinical responsibility and are often working with complex cases. This may lead to high levels of compassion fatigue which could, in turn, leader to higher levels of staff turnover, absences and reduced patient outcomes. This would suggest it is important to investigate staff wellbeing and compassion amongst this group of professionals.

Little published research has been carried out within IAPT services with regards to compassion and wellbeing. Walklet and Percy (2014) investigated stress and coping, with findings suggesting 30% of IAPT workers experienced high levels of stress. Steel, Macdonald, Schröder and Mellor-Clark (2015) explored the concept of burnout in IAPT staff, reporting high levels of emotional exhaustion with low levels of depersonalisation and personal accomplishment. Similarly, Westwood, Morison, Allt and Holmes (2017) reported Psychological Wellbeing Practitioners (68.8%) and High Intensity Therapists (50%) experienced burnout due to increased hours of overtime and increased telephone contact. Research has also found higher burnout can have a negative impact on patient outcomes (Delgadillo et al., 2018).
There are several inconsistencies within the existing literature regarding the nature of wellbeing and compassion within mental health staff and a paucity of research amongst IAPT professionals, a group who, based on the existing literature, would appear at risk of negative wellbeing and compassion outcomes.

This is relevant to clinical psychology in several ways. Lavender (2009) highlights the role of applied psychologists in

IAPT service design and delivery, as well as training and supervision of the existing and new workforce. Given their role in governance, management and leadership, it is important for clinical psychologists to understand the IAPT environment and needs of the workforce. Furthermore, IAPT services are designed to increase access to psychological therapies for common mental health disorders, as recommended by the National Institute of Health and Care Excellence [NICE] guidelines. This may reduce pressure on secondary and specialised mental health services who are now more able to work with more complex cases which suit the expertise of clinical psychologists.

It is important these services run efficiently and effectively to continue to allow services to provide for those they are designed for. In addition, with recent changes due to the COVID-19 pandemic, it is important for services to understand the impact on compassion and staff wellbeing as the situation progresses and working practices are changing. As such, this study aimed to explore the relationships between compassion, job demands and psychological safety amongst IAPT staff.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

This study will adopt a quantitative longitudinal panel design to examine the relationship between compassion, wellbeing, psychological safety and job demands. The longitudinal design extends previous cross-sectional research within IAPT settings as it will allow identification of links between variables, as well as further exploration of the nature of these relationships.

In recent times, with COVID-19, working practices have had to rapidly change and may be likely to begin returning to business-as-usual during the study. The design of this study intends to capture these changes and may allow for recommendations to be proposed in supporting staff transitioning back to business as usual and when considering any future changes to working practices.

Participants will predominantly be recruited by gaining support of services managers. If appropriate, the main researcher will attend team meetings to discuss the purpose, aims and benefits of the study to aid recruitment. Once a site has been recruited and appropriate ethical and research and development approval has been gained, managers will be emailed the study advertisement and a link to the online survey. This includes the participant information sheet, consent process and online questionnaires. The participant information sheet will be accessed online and participants will be encouraged to take time to consider the information before proceeding. They will be presented with a series of consent statements prior to completing the online survey and their consent will be indicated by moving on to the next page.

Participants will be asked to provide the last three digits of their postcode as a unique identifier, as this will be used to match responses at repeat time points. They will then be asked to complete a demographics questionnaire and several questionnaires relating to compassion, wellbeing, psychological safety and job demands, as described previously. The survey will take approximately 15 minutes to complete.

Participants will be asked to provide some demographic information, including age, gender, job role, length of time in service, region, hours of client contact, supervision and administration and awareness of targets. They will then be asked to complete a series of questions related to compassion (fatigue and satisfaction), personal wellbeing, psychological safety and quantitative workload. Participants will be asked to complete the following questionnaires: Professional Quality of Life Scale - 21 (Heritage, Rees & Hegney, 2018), the Shortened Warwick-Edinburgh Mental Wellbeing Scale (Tennant et al., 2007), Team Psychological Safety Questionnaire (Edmondson, 1999) and Quantitative Workload Inventory (Spector & Jex, 1998).

The online survey link will be sent to managers for distribution at a minimum of two, ideally three, time points throughout the total recruitment period. Each recruitment period will last approximately 4-8 weeks and will likely take place December 2020-January 2021, May-June 2021 and September-October 2021. In total, across three time points, it is anticipated the survey will take a total of 45 minutes to complete per participant.

It is anticipated correlation analyses will be performed to explore whether relationships exist between variables. Subsequently, regression analysis will be conducted and demographic variables will be controlled for, where appropriate.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research

- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [x] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
Managers of a local IAPT service have been consulted throughout the research process to date. Discussions have taken place around the design of the research and the benefits of longitudinal panel design. A thesis contract has been drawn up to cover management, undertaking and analysis of the results. In addition, managers have reviewed questionnaire items to determine their suitability for the research question and wellbeing of those taking part. These managers will have ongoing involvement with the research and will read draft copies of the research project and results.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [ ] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [x] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth
- [ ] Respiratory
- [ ] Skin
- [ ] Stroke

Gender: Male and female participants

Lower age limit: 18	Years
Upper age limit:	No upper age limit

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants will be employed by an IAPT service within England, be 18 years of age or older, be employed as any one of the following; trainee, qualified or supervising psychological wellbeing practitioner, trainee or qualified high intensity therapist, trainee or qualified counsellor.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Participants will not be employed within an IAPT service but hold an alternative role to those specified in the inclusion criteria, be trained in different therapeutic approaches and be on secondment to IAPT services

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Completion of an online survey asking questions around demographics, workload, compassion (satisfaction and fatigue), general wellbeing, psychological safety and perceived workload.	3	0	15 minutes	Participants will complete an online survey in their place of work using a laptop, computer or mobile device.

A21. How long do you expect each participant to be in the study in total?

It is estimated each participant will be in the study for no more than 12 months from start to finish.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

There will be minimal additional distress as a consequence of completing the questionnaires and participants thinking about their wellbeing and job role. This has been discussed with service managers and all questionnaires have been reviewed. It has been determined none of the items are likely to lead to disclosures of risk (to self or others). In addition, the absence of a free text box will further reduce disclosures of risk. Participants will be provided with general advice (e.g. contact clinical supervisor, services specific employment support, general practitioners) as part of the participant information sheet and debrief information. The main researchers email address will be given as a point of contact. Should participants make contact to disclose a concern for their wellbeing or the wellbeing of others, they will be advised to contact their supervisor/manager, employment support and/or general practitioner. If the research team is concerned for the safety of the participant or those they work with, they will be advised that their contact details may be shared with their supervisor/manager. Participants will also be provided with the contact details of an independent member of the Lancaster University staff team should they wish to discuss any concerns or make a complaint.

Participants will be informed of their right to withdraw at any time throughout the study. They can do this by exiting the questionnaire, which will prevent any data being saved. They can also contact the main researcher via email,

providing their unique identifier, should they wish to withdraw at a later stage. This option will be available to participant up until data analysis begins, approximately November 2021.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◯ Yes ◉ No

A24. What is the potential for benefit to research participants?

There are no direct gains to participants taking part in the study. However, the services involved will be offered an anonymised summary of the results pertaining to their staff to inform them of current levels of compassion (satisfaction and fatigue), psychological safety, general wellbeing and perceived workload demands. Further, the services will be acknowledged within any publications and the study aims to lead to a better understanding of compassion, psychological safety and workplace demands that may lead to improvements in working conditions and/or resources for staff.

A26. What are the potential risks for the researchers themselves? *(if any)*

It is not anticipated any member of the research team will come to any harm during the completion of this study as no members will be meeting one-to-one with participants. When advertising the study in team meetings, it is likely these will be held remotely, making risk of harm unlikely. Should these be held face-to-face, the main researcher will adhere to the Lancashire and South Cumbria NHS Foundation Trust lone working policy.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will predominantly be recruited by gaining support of managers from specific IAPT services. Managers from four services have already been approached and shown enthusiastic support for the study [redacted]. The main researcher will attend team meetings to explain and advertise the study to aid recruitment, where appropriate. Managers and/or service leads will be sent the advert, Participant Information Sheet and a link to the online survey to disseminate within their teams. Participants will be self-selecting. Other IAPT services across England will also be approached to gather a wider geographical sample.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

◯ Yes ◉ No

Please give details below:
Identifiable personal information will not be accessed for this study. Participants will be asked to provide information regarding their age, gender, job role and location, however these will not be used to identify potential participants.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ◯ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Managers of IAPT services will be sent an advert to email out to their team which will give brief information around the nature of the study. It will also contain the link to the survey should participants wish to take part and further information around what will be expected of participants.

A29. How and by whom will potential participants first be approached?

Potential participants will be approached via email from their service managers.

A30-1. Will you obtain informed consent from or on behalf of research participants?

(●) Yes ( ) No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

The participant information sheet will be accessed online and participants will be encouraged to take time to consider the information before proceeding. They will be presented with a series of consent statements prior to completing the online survey and their consent will be indicated by moving on to the next page.

If you are not obtaining consent, please explain why not.

N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

( ) Yes (●) No

If No, how will it be recorded?

Participants will indicate they have consented to take part by continuing on to the next page in the online survey, after taking time to digest the participant information sheet and reading the consent statements.

A31. How long will you allow potential participants to decide whether or not to take part?

There is no specific time given for potential participants to decide whether to take part. They will be sent the link to the survey and will be encouraged to take as much time as they need to read the participant information sheet and consent statements. Participants may be contacted again via a generic email to the entire team if recruitment becomes an issue, however this is intended as a reminder rather than to coerce participation.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Participants are employed by IAPT sites across England, therefore it is assumed all participants would have adequate understanding of written information given in English and do not have special communication needs.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

( ) The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

( ) The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

◯ The participant would continue to be included in the study.

◯ Not applicable – informed consent will not be sought from any participants in this research.

◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

All participants will be employed by IAPT sites in England. Given their roles, it will be assumed they have capacity to consent.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☐ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☐ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:

Anonymous survey data will be transferred from the secure Qualtrics survey software to the Statistical Package for the Social Sciences (SPSS) software package. Data will be stored on the University's secure storage drive and will only be accessed via password protected computers using the Virtual Private Network. On completion of the thesis project, data will be securely transferred to the Lancaster DClinPsy research coordinator via OneDrive. Data will be stored for 10 years, in line with University procedures and it will be the research coordinators responsibility to destroy data in 10 years' time.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Anonymised data will be stored on the main researchers secure Lancaster University drive. Data will only be

accessed via password protected laptops using the Virtual Private Network and will only be accessible by the main researcher and named supervisors.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Participants will be asked to provide a unique identifier. This will only be used to match their data at repeat time points. Once data sets have been linked, information will be destroyed and substituted with a randomised unique identifier. Only anonymised personal data will be stored and this will retain participant confidentiality.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the main researcher and named supervisors will have access to anonymous data.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be stored electronically on the Qualtrics database under password protection. Data will then be entered manually into the Statistical Package for the Social Sciences (SPSS) software package. Data will be analysed using SPSS software on the Lancaster University drive and any output will be stored on the Lancaster University secure drive.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Senior Lecturer		
Qualifications			
Work Address	Lancaster University		
	Lancaster		
Post Code	LA1 4AG		
Work Email	i.j.fletcher@lancaster.ac.uk		
Work Telephone	01524593301		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- (●) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10

Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

On completion of the thesis project, data will be securely transferred to the Lancaster DClinPsy research coordinator via OneDrive. Data will be stored for 10 years, in line with University procedures and it will be the research coordinators responsibility to destroy data in 10 years' time.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
Lancaster University uses Pure as the data repository which will hold, manage, preserve and provide access to anonymised datasets produced by Lancaster University research. Unique identifiers will be removed from the anonymised data set.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- [x] Peer reviewed scientific journals
- [x] Internal report
- [x] Conference presentation
- [ ] Publication on website
- [x] Other publication
- [ ] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- [ ] No plans to report or disseminate the results
- [ ] Other (please specify)

It is intended this study will be published as part of a Doctoral thesis paper. Services taking part in the study will be offered an anonymised summary of findings related to their service, upon request.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

All personal data will be anonymised prior to data analysis and publishing the results.

A53. Will you inform participants of the results?

(●) Yes ( ) No

Please give details of how you will inform participants or justify if not doing so.
The results of the study will be shared anonymously with participating sites, who may choose to share with the rest of the team. Individuals will be invited to contact the main researcher should they wish to be sent a copy of the final report.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- [ ] Independent external review
- [ ] Review within a company
- [ ] Review within a multi−centre research group
- [x] Review within the Chief Investigator's institution or host organisation
- [x] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The research proposal was reviewed by the Lancaster University research team. Following approval, the study has been discussed with the academic supervisors and field supervisors. Study materials have also been reviewed. The research, and all its materials, have also been reviewed by the Lancaster University Faculty of Health and Medicine Research Ethics Committee.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

- ☐ Review by independent statistician commissioned by funder or sponsor
- ☐ Other review by independent statistician
- ☐ Review by company statistician
- ☐ Review by a statistician within the Chief Investigator's institution
- ☐ Review by a statistician within the research team or multi−centre group
- ☑ Review by educational supervisor
- ☑ Other review by individual with relevant statistical expertise
- ☐ No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Department	Clinical Psychology, Division of Health Research		
Institution	Lancaster University		
Work Address	Clinical Psychology Division of Health Research		
Post Code	LA1 4YG		
Telephone	01524593301		
Fax			
Mobile			
E-mail	i.j.fletcher@lancaster.ac.uk		

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

The primary outcome measure is participants scores on compassion subscales (fatigue and satisfaction) using the Professional Quality of Life Scale - 21 (ProQoL, Heritage, Rees & Hegney, 2018)

A58. What are the secondary outcome measures? *(if any)*

Secondary outcome measures include scores on formal measures of mental wellbeing (Shortened Warwick-Edinburgh Mental Wellbeing Scale), team psychological safety (Team Psychological Safety questionnaire) and workload (Quantitative Workload Inventory)

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 130

Total international sample size (including UK):

Total in European Economic Area:

Further details:
A minimum sample size of 130 will be recruited for the study. There will be no maximum number of participants.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Green (1991) suggests a rule of thumb of N = 50 + 8 per predictor variable for multiple regression, however Harris (1985) suggests, with more than six predictors, the rule of thumb is N = 50 + 10 per predictor. As such, with 6-8 predictors, a minimum sample size of 130 will be recruited for the study.

A61. Will participants be allocated to groups at random?

○ Yes ◉ No

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Initially, descriptive statistics will be used to describe the sample. Following this, correlation analyses will be performed to explore whether relationships exist between variables. Subsequently, a hierarchical regression model will be conducted. The variables below will be used if correlation analyses suggest a significant relationship exists:
Outcome variables:
1. Compassion satisfaction (ProQoL)
2. Compassion fatigue (ProQol)
Predictor variables:
1. Demographic variables: age, gender, geographical location
2. Job related variables: perceived quantitative workload (QWI), job role, clinical contact hours by type
3. Social support: Psychological safety (TPSQ), supervision hours
4. Personal resources: general wellbeing (SWEMWBS)
Subsequently, if appropriate assumptions are met, mediation analyses will also be completed, in line with the hypothesised relationships between subscales discussed previously. Demographic variables will be controlled for within these analyses, where appropriate.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
	Dr [redacted] [redacted]
Post	Consultant Clinical Psychologist and Clinical Lead
Qualifications	Doctorate in Clinical Psychology
Employer	[redacted]
Work Address	[redacted]
Post Code	[redacted]
Telephone	[redacted]
Fax	
Mobile	[redacted]
Work Email	[redacted]

	Title Forename/Initials Surname
	Mr [redacted] [redacted]
Post	Psychological Wellbeing Practitioners Clinical Lead

Qualifications	BSc (Hons) Occupational Therapy PG Dip Cognitive Therapy
Employer	[redacted]
Work Address	[redacted]
Post Code	[redacted]
Telephone	[redacted]
Fax	
Mobile	[redacted]
Work Email	[redacted]

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ◯ NHS or HSC care organisation
- ◉ Academic
- ◯ Pharmaceutical industry
- ◯ Medical device industry
- ◯ Local Authority
- ◯ Other social care provider (including voluntary sector or private organisation)
- ◯ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Lancaster University
Town/city	Lancaster
Post code	LA1 4YT
Country	United Kingdom
Telephone	01524592981
Fax	
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project

◯ Project that is part of a programme grant

◯ Project that is part of a Centre grant

◯ Project that is part of a fellowship/ personal award/ research training award

◯ Other

Other – please state:
N/A

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

◯ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

◯ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname
	Ms [redacted] [redacted]
Organisation	[redacted]
Address	Research & Development
	[redacted]
	[redacted]
Post Code	[redacted]
Work Email	research.office[redacted]
Telephone	[redacted]
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/12/2020
Planned end date: 18/03/2022
Total duration:
Years: 1 Months: 3 Days: 18

A71-1. Is this study?

○ Single centre
◉ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 4

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	4
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☐ Educational establishments	
☐ Independent research units	
☐ Other (give details)	

Total UK sites in study: 4

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

This research will be supervised by the research supervisors and field supervisors. Principles outlined in the policy framework for health and social care research will be adhered to at all times and monitored by the supervisors.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:* in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland**

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

◉ Yes ○ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN1	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: [redacted] Address: [redacted] Post Code: [redacted] Country: [redacted]	Forename: [redacted] Middle name: N/A Family name: [redacted] Email: [redacted] Qualification (MD...): Doctorate in Clinical Psychology Country: United Kingdom
IN2	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: [redacted] Address: [redacted] Post Code: [redacted] Country: ENGLAND	Forename: [redacted] Middle name: N/A Family name: [redacted] Email: [redacted] Qualification (MD...): Country: United Kingdom
IN3	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name: [redacted] Address: [redacted]	Forename: [redacted] Middle name: Family name: [redacted] Email: [redacted] Qualification (MD...): Country:

[redacted]
Post Code [redacted]
Country ENGLAND

IN4

(•) NHS/HSC Site
( ) Non-NHS/HSC Site

Forename [redacted]
Middle name
Family name [redacted]
Email [redacted]

Organisation name [redacted]
Address [redacted]
Qualification (MD...)
Country

Post Code [redacted]
Country ENGLAND

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- (•) Chief Investigator
- ( ) Sponsor
- ( ) Study co-ordinator
- ( ) Student
- ( ) Other – please give details
- ( ) None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr Ian Fletcher on 30/11/2020 11:12.

Job Title/Post:	Senior Lecturer
Organisation:	Lancaster University
Email:	i.j.fletcher@lancs.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 27/11/2020 19:08.

Job Title/Post:	Head of Research Quality and Policy
Organisation:	Lancaster University
Email:	b.gordon@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Sabir Giga on 10/12/2020 10:41.

Job Title/Post:	Senior Lecturer
Organisation:	Lancaster University
Email:	s.giga@lancaster.ac.uk

Academic supervisor 2

This section was signed electronically by Dr Ian Fletcher on 30/11/2020 11:16.

Job Title/Post:	Senior Lecturer
Organisation:	Lancaster University
Email:	i.j.fletcher@lancs.ac.uk

Ethical Approval Letters

Lancaster University

Applicant: Becky Wright
Supervisor: Ian Fletcher, Sabir Giga
Department: Division of Health Research
FHMREC Reference: FHMREC20004

27 October 2020

Re: FHMREC20004
Compassion, Workplace Demands and Psychological Safety in IAPT Therapists

Dear Becky,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC).** The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Annie Beauchamp,
Research Ethics Officer, Secretary to FHMREC.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Ian Fletcher
Lancaster University
Lancaster
LA1 4AG

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

14 December 2020

Dear Dr Fletcher

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

Study title:	**Compassion, Workplace Demands and Psychological Safety in IAPT Therapists**
IRAS project ID:	**287800**
Protocol number:	**N/A**
Sponsor	**Lancaster University**

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 **287800**. Please quote this on all correspondence.

Yours sincerely,
Rekha Keshvara

Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Mrs Becky Gordon*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Faculty of Health and Medicine Research Ethics Committee Approval]	0.1	27 October 2020
Copies of materials calling attention of potential participants to the research [Study advert]	0.2	05 October 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Document]	0.1	26 June 2020
HRA Schedule of Events	1	10 December 2020
IRAS Application Form [IRAS_Form_10122020]		10 December 2020
Letters of invitation to participant [Email invitation for participants]	0.1	26 August 2020
Non-validated questionnaire [Survey questionnaire demographics]	0.2	26 November 2020
Organisation Information Document [Organisation Information Document]	2.0	11 December 2020
Other [Participant Debrief Sheet]	0.1	26 August 2020
Participant consent form [Consent Statements for Survey]	0.2	05 October 2020
Participant information sheet (PIS) [Participant Information Sheet]	0.2	05 October 2020
Research protocol or project proposal [Research Protocol]	0.3	16 November 2020
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		26 November 2020
Summary CV for student [Student CV]	0.1	16 November 2020
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol Flowchart]	0.1	16 November 2020
Validated questionnaire [Professional Quality of Life Scale]	0.1	16 November 2020
Validated questionnaire [Short Warwick-Edinburgh Mental Wellbeing Scale]	0.1	16 November 2020
Validated questionnaire [Team Psychological Safety Questionnaire]	0.1	16 November 2020
Validated questionnaire [Quantitative Workload Inventory]	0.1	16 November 2020

Appendices

Appendix A: Research Proposal v0.4

Compassion, Workplace Demands and Psychological Safety in IAPT Therapists

Rebecca Wright, Lancaster University

Dr Ian Fletcher, Lancaster University

Dr Sabir Giga, Lancaster University

Dr Olga Horgan, Mindsmatter

Kieran Fleck, Mindsmatter

A focus on staff wellbeing and compassion in health care settings has highlighted several implications when these are poor. Findings suggest staff with reduced levels of wellbeing and compassion are more likely to be absent from work or to work despite illness, both mental or physical. Additionally, there are implications for patient experience, safety and care and higher staff turnover rates (Department of Health, 2009). A wealth of research exists exploring compassion and staff wellbeing amongst several professional groups with much of the research focusing on indicators of staff wellbeing that are measurable, for example stress levels, job satisfaction and burnout. While findings vary, a combination of personal and organisational factors can impact an individuals' wellbeing and compassion.

The Job Demand-Resources model ([JD-R], Demerouti, Bakker, Nachriener & Schaufeli, 2001) is perhaps the most widely used and accepted model of occupational wellbeing. This framework recognises occupations will have their own risk factors related to job strain and exhaustion, which can be divided into job demands or job resources (Bakker & Demerouti, 2007). A lack of job resources may lead to staff disengaging from their work, while high job demands may lead to exhaustion (Demerouti et al., 2001). The JD-R model was subsequently expanded to include the role of personal resources in mediating the relationship between engagement, exhaustion and job demands, as well as influencing perceived job resources (Xanthopoulou, Bakker, Demerouti & Schaufeli, 2007). A growing body of literature has explored the concept of psychological safety and its role in mediating symptoms of compassion fatigue and burnout. Research has found high levels of psychological safety increase job engagement (Edmondson & Lei, 2014), which fits with the JD-R model of occupational wellbeing.

The Improving Access to Psychological Therapies (IAPT) workforce is a relatively new, and expanding, team within adult mental health. Previous literature into workplace compassion and wellbeing highlights many aspects of working within IAPT services as potential risk factors. These factors include the volume and pace of work, managing their own caseloads, holding clinical

responsibility and working with complex client presentations. This may lead to high levels of compassion fatigue and reduced compassion satisfaction and wellbeing, which could, in turn, lead to higher levels of staff turnover, absences and reduced patient outcomes. With this in mind, it is vital to consider staff wellbeing and compassion amongst IAPT professionals.

Little published research has been carried out within IAPT services with regards to compassion and wellbeing. Walklet and Percy (2014) investigated stress and coping, with findings suggesting high levels of stress in 30% of IAPT staff. Steel, Macdonald, Schröder and Mellor-Clark (2015) explored the concept of burnout in IAPT staff. Their findings indicated low levels of personal accomplishment and depersonalisation, and high levels of exhaustion. Similarly, Westwood, Morison, Allt and Holmes (2017) reported Psychological Wellbeing Practitioners (68.8%) and High Intensity Therapists (50%) experienced burnout due to increased hours of overtime and increased telephone contact. Research has also found higher burnout can have a negative impact on patient outcomes (Delgadillo et al., 2018).

Several inconsistencies exist within the current literature around wellbeing and compassion in staff working in mental health settings. Furthermore, there is a scarcity of research with IAPT professionals despite existing literature suggesting IAPT professionals are at risk of poor compassion and wellbeing outcomes.

It is important these services run efficiently and effectively to continue to allow services to provide for those they are designed for. In addition, with recent changes due to the COVID-19 pandemic, it is important for services to understand the impact on compassion and staff wellbeing as the situation progresses and working practices are changing. As such, this study aims to explore the relationships between compassion, wellbeing, job demands and psychological safety amongst IAPT staff. Hypotheses have been made regarding the nature of the relationship between these factors, see figure 1.

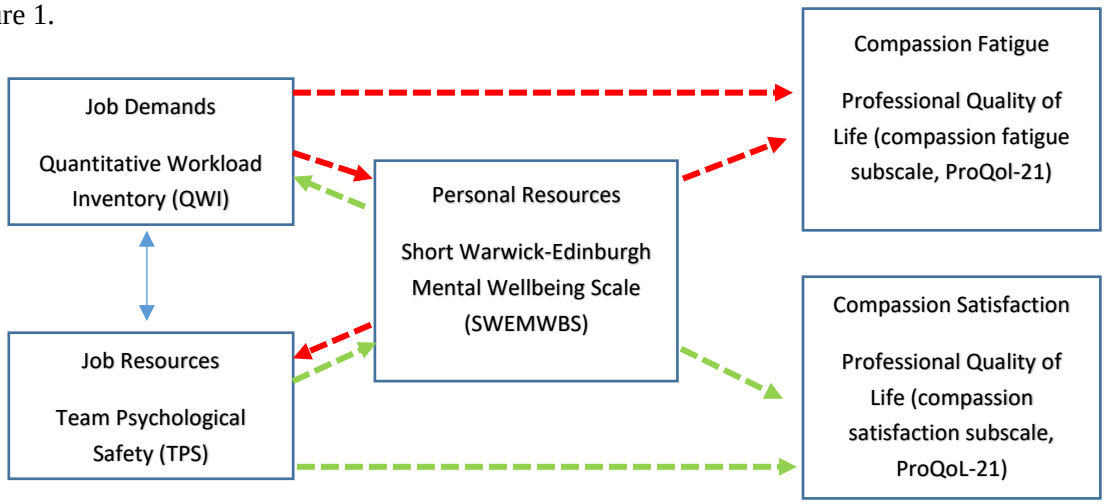


Figure 1: Hypothesised relationships between subscales

Method

Participants

Green (1991) suggests a rule of thumb of N = 50 + 8 per predictor variable for multiple regression, however Harris (1985) suggests, with more than six predictors, the rule of thumb is N = 50 + 10 per predictor. As such, with 6-8 predictors, a minimum sample size of 130 will be recruited for the study. There will not be a maximum number of participants. In order to gather longitudinal data there will be a minimum of two recruitment windows, ideally three, each lasting approximately four weeks. If the minimum number of participants has not been met by the end of the recruitment window, it will be extended to facilitate this. Further, while the study aims to be longitudinal, valuable information will still be gained by having cross-sectional data should attrition or staff turnover become an issue. The online survey will be closed at the end of each recruitment period.

Participants will predominantly be recruited by gaining support of managers from specific IAPT services. Managers from four services have already been approached and shown enthusiastic support for the study (Mindsmatter, Lancashire; italk, Hampshire; First Step, South Cumbria; Rotherham & Doncaster IAPT). The principal researcher will attend team meetings to explain and advertise the study to aid recruitment, where appropriate. Managers and/or service leads will be sent the advert, Participant Information Sheet and a link to the online survey to disseminate within their teams. Other IAPT services across England will also be approached to gather a wider geographical sample. Participants may be recruited via snowballing techniques, for example the link being shared between colleagues in other services.

Inclusion Criteria

Participants will:

- Be employed by an IAPT service within England
- Be aged 18 years or older
- Be either;
    - Trainee, qualified or supervising Psychological Wellbeing Practitioners
    - Trainee or qualified High Intensity Therapists
    - Trainee or qualified counsellors

Exclusion Criteria

Participants will not;

- Be employed within an IAPT service but hold an alternative role to those mentioned above, e.g. service leads, managers, employment advisors and administration staff
- Be trained in different therapeutic approaches and be on secondment to IAPT services, e.g. trainee clinical psychologists

Demographic data will be collected as part of the study in order to understand the sample population, for example age, gender, geographical location, however these will not determine eligibility for the study.

Design

This study will adopt a quantitative longitudinal panel design to examine the relationship between compassion, wellbeing, psychological safety and job demands. The longitudinal design extends previous cross-sectional research within IAPT settings as it will allow identification of links between variables, as well as further exploration of the nature of these relationships and may allow for stronger claims to be made about causality (Howitt & Cramer, 2011).

In recent times, with COVID-19, working practices have had to rapidly change and may be likely to begin returning to business-as-usual during the study. The design of this study intends to capture these changes and may allow for recommendations to be proposed in supporting staff transitioning back to business as usual and when considering any future changes to working practices.

Managers of a local IAPT service were consulted in all aspects of the research, including design, materials, sample and feasibility of the study.

Materials

Participants will be asked to provide some demographic information, including age, gender, job role, region, hours of client contact, supervision and administration and awareness of targets. They will then be asked to complete a series of questions related to compassion (fatigue and satisfaction), personal wellbeing, psychological safety and quantitative workload. Participants will be asked to complete the following questionnaires:

- Professional Quality of Life Scale - 21 ([ProQOL-21], Heritage, Rees & Hegney, 2018): this 20-item scale is used to measure compassion satisfaction and compassion fatigue. This version was developed from Stamm's (2010) ProQOL-5 scale after findings suggested inadequate measurement properties of the original scale (Heritage et al., 2018). Heritage et al. (2018) reported the modified measures of compassion satisfaction and compassion fatigue had good internal consistency (Cronbach's alpha = 0.90)
- The Shortened Warwick-Edinburgh Mental Wellbeing Scale ([SWEMWBS], Stewart-Brown et al., 2009): this 7-iteam scale is used to measure general wellbeing. This shorter version was

found to have more robust psychometric properties than the original, longer version. This scale has demonstrated high internal consistency among adult populations (Koushede et al, 2019; Haver et al., 2015) and the general population (Ng Fat et al., 2017). In addition, it has been found to be sensitive to change (Shah et al., 2018), which is important within this longitudinal study

- Team Psychological Safety Questionnaire ([TPSQ] Edmondson, 1999): this 7-item subscale is used to measure psychological safety, the extent to which members of a team feel able to take interpersonal risks. Edmonson (1999) demonstrated good validity and reliability of this measure. Further, Newman, Donohue & Eva (2017) completed a systematic review of literature around psychological safety and concluded this as the measure of choice
- Quantitative Workload Inventory ([QWI] Spector & Jex, 1998): this 5-item scale measures work in terms of perceived volume and pace. Findings indicate this measure has good internal consistency (Cronbach's alpha = 0.82)

Procedure

As mentioned previously, participants will predominantly be recruited by gaining support of service managers. If appropriate, the principal researcher will also attend team meetings, by invitation, to discuss the purpose, aims and benefits of the study to aid recruitment. Should recruitment become an issue, the principal researcher will attend a national Psychological Wellbeing Practitioner conference and will post on various social media platforms, including Twitter, Facebook and a Lancaster University hosted webpage. Participants may be recruited via snowballing techniques, for example the link being shared between colleagues in other services.

Once a site has been recruited and appropriate ethical and research and development approval has been gained, managers will be emailed the study advertisement and a link to the online survey which includes the participant information sheet, consent process and online questionnaires. The participant information sheet will be accessed online and participants will be encouraged to take time to consider the information before proceeding. They will be presented with a series of consent statements prior to completing the online survey and their consent will be indicated by moving on to the next page.

Participants will be asked to provide a 3-digit unique identifier made up of the last three digits of their postcode, as this will be used to match responses at repeat time points. Once longitudinal data sets have been linked, the information will be deleted and replaced with a randomised unique identifier. They will then be asked to complete a demographics questionnaire and several questionnaires relating to compassion, wellbeing, psychological safety and job demands, as described previously. The survey will take approximately 15 minutes to complete.

The online survey link will be distributed at a minimum of two, ideally three, time points throughout the total recruitment period in line with the proposed timescale documented later in this protocol. In total, across three time points, it is anticipated the survey will take a total of 45 minutes to complete per participant.

Data will be stored electronically on the Qualtrics database. Data will then be entered into the Statistical Package for the Social Sciences (SPSS) software package. Survey data will be stored securely for 10 years, in line with Lancaster University procedures, and then destroyed.

Proposed Analysis

Initially, descriptive statistics will be used to describe the sample. Following this, correlation analyses will be performed to explore whether relationships exist between variables. Subsequently, a hierarchical regression model will be conducted. The variables below will be used if correlation analyses suggest a significant relationship exists:

Outcome variables:

1. Compassion satisfaction (ProQoL)
2. Compassion fatigue (ProQol)

Predictor variables:

1. Demographic variables: age, gender, geographical location
2. Job related variables: perceived quantitative workload (QWI), job role, clinical contact hours by type
3. Social support: Psychological safety (TPSQ), supervision hours
4. Personal resources: general wellbeing (SWEMWBS)

Subsequently, if appropriate assumptions are met, mediation analyses will also be completed, in line with the hypothesised relationships between subscales discussed previously. Demographic variables will be controlled for within these analyses, where appropriate.

Dissemination

It is intended this study will be published as part of a Doctoral thesis paper. It will also be submitted to an appropriate peer-reviewed journal for publication. Services taking part in the study will be offered an anonymised summary of findings related to their service, upon request.

Practical Issues

The survey will be hosted online via Qualtrics, which should be easily accessible by all participants via email link. Should participants wish to take part via hard copy, these can be requested via email to the principal researcher who will post copies to the participants' work address.

Anonymous data will be stored securely on the Qualtrics database before being transferred to SPSS software. All laptops being used for data analysis will be password protected and will only be accessible by the principal researcher and named supervisors. On completion of the thesis project, data will be securely transferred to the Lancaster DClinPsy research coordinator via OneDrive. Data will be stored for 10 years, in line with University procedures and it will be the research coordinators responsibility to destroy data in 10 years' time.

Lancaster University will fund any costs associated with the study, for example advertisements or hard copy of questionnaires. Individual participants will not be reimbursed for taking part.

Ethical Concerns

There are unlikely to be any major ethical issues with this project. All data will be anonymous and only the participant will be aware of their unique identifier. As mentioned previously, anonymous data will be stored securely on password protected laptops, on the University's secure storage drive. In addition, participants will be informed their employer will not be made aware if they choose to participate or not.

All efforts will be taken to ensure participants are given adequate information to make an informed decision to take part in the study. Upon clicking the link, participants will be taken firstly to a participant information sheet which will provide information about the study, what is required of participants, the length of participation and any potential benefits and risks of participation. Participants will be encouraged to take the time to carefully consider this information before being presented with a series of consent statements. They will then be asked to proceed to the next page of the survey, and it will be made clear this indicates their consent to participate. All participants will be employed by IAPT sites in England. Given their roles, it will be assumed they have capacity to consent.

Participants will be informed of their right to withdraw at any time throughout the study. They can do this by exiting the questionnaire, which will prevent any data being saved. They can also contact the principal researcher via email, providing their 3-digit unique identifier, should they wish to withdraw at a later stage. This option will be available to participant up until data analysis begins, approximately November 2021.

There are no direct benefits to those taking part in the study. It is anticipated the findings will increase our understanding of compassion and wellbeing in IAPT staff. This may indirectly benefit those who participate by making recommendations around the design of future services, gaining additional resources from commissioners and that participating services would be mentioned in any publication. Further, services would be offered an anonymised summary of the findings as a whole, as

well as for their individual service, where possible. The risks of participation appear low. There may be some distress as a consequence of completing the questionnaires and participants thinking about their wellbeing and job role. This has been discussed with service managers and all questionnaires have been reviewed. It has been determined none of the items are likely to lead to disclosures of risk (to self or others). In addition, the absence of a free text box will further reduce disclosures of risk. Participants will be provided with general advice (e.g. contact clinical supervisor, services specific employment support, general practitioners) as part of the participant information sheet and debrief information. The principal researchers email address will be given as a point of contact. Should participants make contact to disclose a concern for their wellbeing or the wellbeing of others, they will be advised to contact their supervisor/manager, employment support and/or general practitioner. If the research team is concerned for the safety of the participant or those they work with, they will be advised that their contact details may be shared with their supervisor/manager. Participants will also be provided with the contact details of an independent member of the Lancaster University staff team should they wish to discuss any concerns or make a complaint.

Timescale

January-March 2021

Data collection time 1

June-July 2021

Data collection time 2

October-November 2021

Data collection time 3

December 2021 – January 2022

Data analysis and write up

February 2022 – March 2022

Complete final version of research paper

March 2022

Submit thesis

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Appendix B: Recruitment Advert version 0.2

Doctorate in Clinical Psychology | Lancaster University

How are YOU?

Are you a trainee or qualified Psychological Wellbeing Practitioner, High Intensity Therapist or Counsellor? We are interested in your views.

Can you spare some time to take part in an online survey looking at staff wellbeing and compassion in IAPT services?

The survey will take approximately 15 minutes to complete and you will be invited, via email, to complete it at three separate time points between now and October 2021.

Please feel free to participate, even if you are unsure whether you will still be in the same role for the duration of the study, as the data collected at each time point will be invaluable.

For further information and to access the survey:

https://lancasteruni.eu.qualtrics.com/jfe/form/SV_dijH0Ou6lK6Wmvb

Appendix C: Participant Information Sheet version 0.2

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Participant Information Sheet

Compassion, Workplace Demands and Psychological Safety in IAPT Therapists

My name is Becky Wright and I am conducting this research as a student in the Doctorate in Clinical Psychology at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to find out more about compassion and wellbeing in IAPT staff, in relation to job demands and psychological safety.

Why have I been approached?

You have been approached because you currently work within an IAPT service in England and your service have agreed to share the study with you. We are inviting all trainee and qualified Psychological Wellbeing Practitioners, High Intensity Therapists and Counsellors who can read and write in English. Please feel free to participate, even if you are unsure whether you will still be in the same role for the duration of the study, as the data collected at each time point will be invaluable.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. You may withdraw at any point before submitting your answers, or afterwards by contacting the main researcher using the details below and providing your unique 3-digit identifier. Your decision to take part or not will not be shared with your organisation.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to complete an online survey at three time points between now and October 2021. The survey will take approximately 15 minutes to complete each time. You will be asked to provide the last three digits of your postcode as a unique identifier. The survey includes a series of questions about yourself, such as your age, gender and job role. You will then be asked to complete some brief questionnaires about compassion, wellbeing, work load and psychological safety. Once you have submitted your responses you will not need to do anything else. You will then be invited to take part again, via email, sometime around April/May 2021 and September/October 2021.

Will my data be identifiable?

All answers collected from the survey will be anonymous and cannot be linked back to you. Once your data has been linked, your postcode will be deleted and replaced with a randomised unique identifier. All responses will be securely stored and only accessed by the research team involved in the study.

How will my information be stored?

The anonymous data collected for this study will be stored securely on the secure computer drive at Lancaster University, and only the researchers conducting this study will have access to this data. In line with policy and guidance from Lancaster University, your anonymous responses will be stored securely for 10 years, after which they will be destroyed.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?

The results will be summarised and reported in a thesis and may be submitted for publication in an academic or professional journal. Participating services will be offered an anonymised summary of the findings. If you wish, you will be able to request a summary of the findings by contacting the main researcher.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and speak with your clinical supervisor. There are some limits to confidentiality: if contact is made with a member of the research team which makes us think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher: Becky Wright, Trainee Clinical Psychologist, Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YG. Email: r.wright6@lancaster.ac.uk

You can also contact one of the project supervisors: Dr Ian Fletcher, Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YG. Email: i.j.fletcher@lancaster.ac.uk

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact: Professor Bill Sellwood, Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YG. Email: b.sellwood@lancaster.ac.uk

If you wish to speak to someone outside of the Lancaster Clinical Psychology Doctorate Programme, you may also contact:
Professor Roger Pickup, Faculty of Health and Medicine, Lancaster University, Lancaster, LA1 4YG, Email: r.pickup@lancaster.ac.uk

Should you feel distressed either as a result of taking part, or in the future, please contact your clinical supervisor, employee assistance programme or GP.

Thank you for taking the time to read this information sheet.

Appendix D: Consent Statements version 0.2

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The next page will take you to the survey. You will be asked 15 questions about yourself and your job role. You will then be taken to four short questionnaires about compassion, psychological safety, wellbeing and workload. It is likely this survey will take approximately 15 minutes in total.

By proceeding to the next page, you confirm that

- You have read the participant information sheet and understand what is expected of you within this study
- You understand your responses will remain anonymous, and only you will be aware of your unique identifier
- Your participation is voluntary and you may withdraw at any time by exiting the survey or contacting the main researcher with your unique identifier
- By submitting your answers, you consent to them being used for research purposes and please be aware that your answers cannot be withdrawn after November 2021
- You consent for the information you provide to be discussed with the research team
- You consent to Lancaster University storing the anonymized data securely for a period of 10 years after the study has finished
- By clicking NEXT, you consent to taking part in the study

Appendix E: Outcome Measures version 0.2

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Unique identifier:

Please provide the last three digits of your postcode as a unique identifier as this will be used to match data at repeat time points.

About you

Age:

Gender:

Job role:

Length of time in role:

Region:

About your work

Thinking about the last month, how much time in an average week did you spend doing the following (in hours and/or minutes):

Working hours:

Client contact by telephone:

Client contact face-to-face:

Client contact by video conference:

Client contact online (e.g. cCBT):

Client group contact:

Providing supervision:

Receiving supervision:

Completing administration tasks:

Are you aware of your service's targets? Yes/No

Professional Quality of Life (ProQoL) - 21

Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

	1	2	3	4	5
I get satisfaction from being able to help people.					
I feel invigorated after working with those I help.					
I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.					
I think that I might have been affected by the traumatic stress of those I help.					
I feel trapped by my job as a helper.					
Because of my helping, I have felt "on edge" about various things					
I like my work as a helper.					
I feel depressed because of the traumatic experiences of the people I help.					
I feel as though I am experiencing the trauma of someone I have helped.					
I am pleased with how I am able to keep up with helping techniques and protocols.					
My work makes me feel satisfied.					
I feel worn out because of my work as a helper.					
I have happy thoughts and feelings about those I help and how I could help them.					
I feel overwhelmed because my case work load seems endless.					
I believe I can make a difference through my work.					
I avoid certain activities or situations because they remind me of frightening experiences of the people I help.					
I am proud of what I can do to help.					
As a result of my helping, I have intrusive, frightening thoughts.					
I feel "bogged down" by the system.					
I have thoughts that I am a "success" as a helper.					
I am happy that I chose to do this work.					

Team Psychological Safety Questionnaire

Please rate the following seven statements on a scale of 1-5
(1 strongly disagree, 2 disagree, 3 neutral, 4 agree, and 5 strongly agree).

1. When someone makes a mistake in this team, it is often held against him or her
2. In this team, it is easy to discuss difficult issues and problems.
3. In this team, people are sometimes rejected for being different
4. It is completely safe to take a risk on this team.
5. It is difficult to ask other members of this team for help
6. Members of this team value and respect each others' contributions.

The Short Warwick-Edinburgh Mental Wellbeing Scale, SWEMWBS

Below are some statements about feelings and thoughts. Please select the box that best describes your experience of each over the last 2 weeks

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

Quantitative Workload Inventory, QWI

	Less than once per month or never	Once or twice per month	Once or twice per week	Once or twice per day	Several times per day
1. How often does your job require you to work very fast?					
2. How often does your job require you to work very hard?					
3. How often does your job leave you with little time to get things done?					
4. How often is there a great deal to be done?					
5. How often do you have to do more work than you can do well?					

Appendix F: Debrief Information version 0.1

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Participant Debrief Sheet

Thank you for taking the time to complete this survey.

This research is exploring the relationships between compassion, workload demands and psychological safety in IAPT staff. The intention is that findings will allow for recommendations to be made regarding the resources and support made available to staff working in IAPT services. Findings of the study will be available on the Lancaster University research website and participating services will be sent anonymised findings, on request.

If you feel you would benefit from support, following participating in this study please consider the following:

- Contact your clinical supervisor or service manager
- Contact your employee assistance support
- Contact your GP

If you have any questions or concerns about the study, please contact the main researcher using the details below:

Rebecca Wright, Trainee Clinical Psychologist
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r.wright6@lancaster.ac.uk