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RESEARCH PAPER

Wellbeing Matters in IAPT Practitioners: Identity vs System

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Ethical statement

All authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the APA. No ethical approval was required for this study because it was a non-sensitive survey where the participants were not defined as "vulnerable" and participation was voluntary on an opt-in basis.

Abstract

Background/Aims/Objectives: The importance of wellbeing has been well documented in recent years. This study explored the professional identity and wellbeing of psychological professionals working within Improving Access to Psychological Therapy services.

Methods/Methodology: An annual measure of staff wellbeing for psychological professionals was disseminated to a range of professional networks by the New Savoy Partnership (NSP) and British Psychological Society (BPS) between 2014 and 2018. The online survey encouraged quantitative and qualitative responses in addition to demographic and professional details. This study focuses on analysing the qualitative responses (n = 1543 across the five years).

Results: Thematic analysis revealed common themes across perceived identities in regards to the professional (desired and achievable) and the patient. The data explores how these identities align with the workplace system and the impact that agreement and conflict has upon wellbeing. Professionals have identified both barriers and protective factors which would support their professional identity and wellbeing. Changes across the five years have been examined. The ability to achieve our desired professional identity in the workplace has an effect on health and wellbeing.

Discussion: Current workplace systems could be utilised to improve the balance between the desired and achieved professional identity and health and wellbeing. Change across the years demonstrates the impact of systemic and corporate decision making.

Conclusion: Wellbeing was poor resulting from continuing identity, systemic and economic pressures. Wellbeing improved through enhanced clinical supervision and the prioritisation of personal identity. Future plans should include the development of training opportunities and a review of IAPT's systematic design.

Key words: Professional Wellbeing & Identity, IAPT, Qualitative, Perceptions

Abstrait

Contexte / Buts / Objectifs: *L'importance du bien-être a été bien documentée ces dernières années. Cette étude a exploré l'identité professionnelle et le bien-être des professionnels de la psychologie travaillant dans le cadre de l'amélioration de l'accès aux services de thérapie psychologique.*

Méthodes / Méthodologie: *Une mesure annuelle du bien-être du personnel des professionnels de la psychologie a été diffusée à divers réseaux professionnels par le New Savoy Partnership (NSP) et la British Psychological Society (BPS) entre 2014 et 2018. en plus des détails démographiques et professionnels. Cette étude se concentre sur l'analyse des réponses qualitatives (n = 1 543 sur cinq ans).*

Résultats: *L'analyse thématique a révélé des thèmes communs à travers les identités perçues en ce qui concerne le professionnel (souhaité et réalisable) et le patient. Les données explorent la façon dont ces identités s'alignent sur le système du lieu de travail et l'impact de l'accord et du conflit sur le bien-être. Les professionnels ont identifié à la fois des barrières et des facteurs de protection qui soutiendraient leur identité professionnelle et leur bien-être. Les changements au cours des cinq années ont été examinés. La capacité à atteindre l'identité professionnelle souhaitée sur le lieu de travail a un effet sur la santé et le bien-être.*

Discussion: *Les systèmes de travail actuels pourraient être utilisés pour améliorer l'équilibre entre l'identité professionnelle souhaitée et acquise et la santé et le bien-être. Le changement au fil des ans démontre l'impact de la prise de décision systémique et d'entreprise.*

Conclusion: *le bien-être était médiocre en raison de pressions identitaires, systémiques et économiques persistantes. Le bien-être s'est amélioré grâce à une supervision clinique renforcée et à la priorisation de l'identité personnelle. Les plans futurs devraient inclure le développement d'opportunités de formation et un examen de la conception systématique de l'IAPT.*

Mots clés: *Bien-être professionnel et identité, IAPT, Qualitatif, Perceptions*

BACKGROUND

Healthcare staff wellbeing has been of paramount importance over the past decade (Boorman, 2009; Brand et al., 2017; Clarke & Hyatt, 2009) with greater ill-health and suicide rates than other occupations. Stress, depression and anxiety accounted for over 25% of sickness absence (Boorman, 2009; Hacker Hughes, 2016). With Mental Health professionals having higher absence rates and dissatisfaction (Department of Health [DH], 2002; Edwards & Taunt, 2015), policy drivers focused on supporting wellbeing (Health Education England [HEE], 2019; The NHS Long Term Plan, 2019).

The Improving Access to Psychological Therapies (IAPT) programme, aimed to increase accessibility to psychological therapy (Layard, 2016; Farmer & Stevenson, 2017) and support people to remain or become employed. It offers five NICE recommended therapies: Cognitive Behaviour Therapy, Interpersonal Therapy, Brief Psychodynamic Therapy, Counselling for Depression and Behavioural Couples Therapy (National Collaborating Centre for Mental Health, 2018), although not all are accessible everywhere (Liness et al., 2017). IAPT's economic ambitions coincided with the Global Financial Crisis increasing the urgency of the rollout (Knapp, 2012).

Phase One (2008-2013) scaled up capacity rapidly, built the outcomes measurement infrastructure, and trained the new workforce. National Audits (Royal College of Psychiatrists, 2011, 2013) reported this phase as successful.

Phase Two (2014-2019) found workforce growth lagging behind access and waiting times targets. Despite IAPT's oft-proclaimed transparency as an evidence-based programme (Clark et al., 2018), neither service funding nor workforce numbers are open to public scrutiny. If targets for expanding the workforce are achieved, it assumes productivity and caseload levels that are considerably higher than IAPT's original modelling. Further investigation will identify if this contributes to reduced retention due to an unrealistically high workload.

Emphasis on key performance indicators (KPIs) enabled IAPT to achieve its recovery, access and waiting time targets. IAPT's invest-to-save business case focused upon helping people remain or become employed. Emphasis has shifted to a focus on long-term conditions without reporting impact on employment.

Staff wellbeing within IAPT is crucial for service sustainability and meeting targets. Mental health Minister, Rt. Hon. Alistair Burt MP recognised this, responding to staff wellbeing survey findings with: *"… something is going badly wrong. I can't be standing on platforms day in, day out, talking about a world - leading service if I'm standing on something that's rusting away beneath me...".(New Savoy Conference, 2016).*

The absence of staff wellbeing in IAPTs' KPIs is a serious omission (Clark et al., 2018). Training investment where the majority of the funding has been spent, does not tell us about workforce retention. High workforce retention for High Intensity Therapists is reported but based on less than 200 responses (Liness et al., 2017). In contrast, concerns are documented regarding Psychological Wellbeing Practitioners retention, attributed to poor career prospects, high and complex caseloads, perceived lack of value and support, burnout and unmet expectations (Centre for Outcomes Research & Effectiveness, 2015; Kell & Baguley, 2018). Given limited and conflicting findings, it is timely to explore the wellbeing of IAPT psychological professionals, if the expansion plan for IAPT is to be sustained.

AIMS

Since 2014, the NSP and the BPS Division of Clinical Psychology (DCP) conducted an annual survey to assess the general and workplace wellbeing of psychological professionals. Quantitative responses have been analysed annually, suggesting some consistencies across years e.g., high levels of depression, feelings of failure, increasing levels of work related stress. Within each survey respondents had opportunities to provide qualitative information concerning wellbeing. This paper looks at the qualitative data to explore the wellbeing of psychological professionals working within IAPT (2014-2018).

METHOD

An online wellbeing questionnaire was disseminated to psychological professionals annually between 2014 and 2018. Minor changes to the questionnaire were made to facilitate continued improvement and relevance. Across the years the open-ended questions invited qualitative responses across three areas; a) general comments b) key issues impacting staff wellbeing c) key changes perceived to improve wellbeing. Demographic and professional occupation information allowed results to be interpreted in different working contexts (IAPT and other). All responses were exported into Excel and anonymised. This paper focuses on the responses of IAPT psychological professionals.

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Participants

Demographic overview

Across the five years, 1543 IAPT professionals provided qualitative data. Respondents were largely female (79.2%), white (85.2%) and aged between 25 and 60 years (For detailed demographic information per year see Appendix 1: Tables 1a-e).

Data Analysis

Data was analysed using Braun and Clarke's (2006) Thematic Analysis.

Comments were read repeatedly by three members of the research team. Codes were identified by the Lead Researcher and discussed with a research colleague ensuring validity and reliability. Upon agreement, the codes were combined into themes. Thematic maps were generated to consider relationships between themes, new themes and sub-themes. This process was repeated until the themes were an accurate representation of the data. Themes were discussed again with a research colleague and an experienced qualitative researcher independent of the project.

RESULTS

A main domain was identified (The Person behind the Professional: Health & Wellbeing) wherein professionals commented upon the impact of four over-arching themes and 18 sub-ordinate themes upon wellbeing (see Figure 1, page 4).

OVER-ARCHING THEME 1: IDENTITY

'**Identity**' contained two sub-ordinate themes '***Professional Identity***' and '***Seeking Balance: Professional & Personal Identity***'. Questions focused on the workplace potentially affecting the prominence given to the 'professional identity'.

Initially, there was a united sense and conviction for '***Professional Identity***', founded upon pride and satisfaction for being "*instrumental in helping people recover and find their own answers*" (Participant 688, 2014) and alignment with the perceived identity of IAPT.

'***Professional Identity***' was originally prioritised at the expense of a compromised personal identity (i.e., '***Seeking Balance: Professional & Personal Identity***') embodied by neglected relationships, their consequential breakdowns and limited outside interests. Conflict between identities resulted in vulnerability, exhaustion, stress, anxiety and helplessness. Professionals sought balance through reducing working hours and requesting flexible working.

'***Professional Identity***' diminished in 2016 but greater balance was achieved in 2017, attributed to professionals taking responsibility for their own wellbeing, whilst utilising coping strategies for the anxieties and pressures placed upon professional identity. This challenge re-emerged in 2018.

OVER-ARCHING THEME 2: SYSTEMIC DESIGN: A THREAT TO PROFESSIONAL IDENTITY

'**Systemic Design: A Threat to Professional Identity**' contained five sub-ordinate themes, '***The Failing Professional***', '***Employee First, Person Second***', '***The Restricted Professional***', '***Inter-professional Rivalry***' and '***Misunderstood Practitioners***'.

Discrepancies arose between the desired professional identity and what was considered realistically achievable within systemic limitations, illustrated in the theme '***The Failing Professional***'. Service priorities (administration, targets, outcome measures) obstructed delivery of adequate patient care leading to an oppressed, negative and frustrated workforce.

"All around me I see staff burning out and struggling to cope with ever rising targets. Since our service was contracted on a payment by results basis, the culture has been transformed to one where the financial side is prioritised over sound clinical decisions." (Participant 333, 2015)

Therapeutic limitations compromised values and raised feelings of failure as professionals felt accountable for contributing to a revolving door of patients, who were offered inappropriate therapies and knowingly discharged too early. Pressures of failure challenged integrity as professionals disclosed manipulating recovery figures. Increasing concerns were raised regarding failing patients presenting with complexities outside their training and capacity.

"*…I feel I cannot work at my best without the time to prepare for disorders I may not have been trained in. This leads to frustration at not offering the best and low confidence in ability to help people.*" (Participant 665, 2016)

Despair, guilt, perceived incompetence and self-doubt intensified towards 2017 and professionals desired work which would complement their professional identity.

By 2018, whilst theme content and context remained stable, the emotional distress reduced.

Professionals identified feeling dehumanised and treated like slaves and objects in order to meet systemic priorities as they reflected being '***Employee First, Person Second***'.

"*I've lost my enthusiasm for doing this job, have little job satisfaction*

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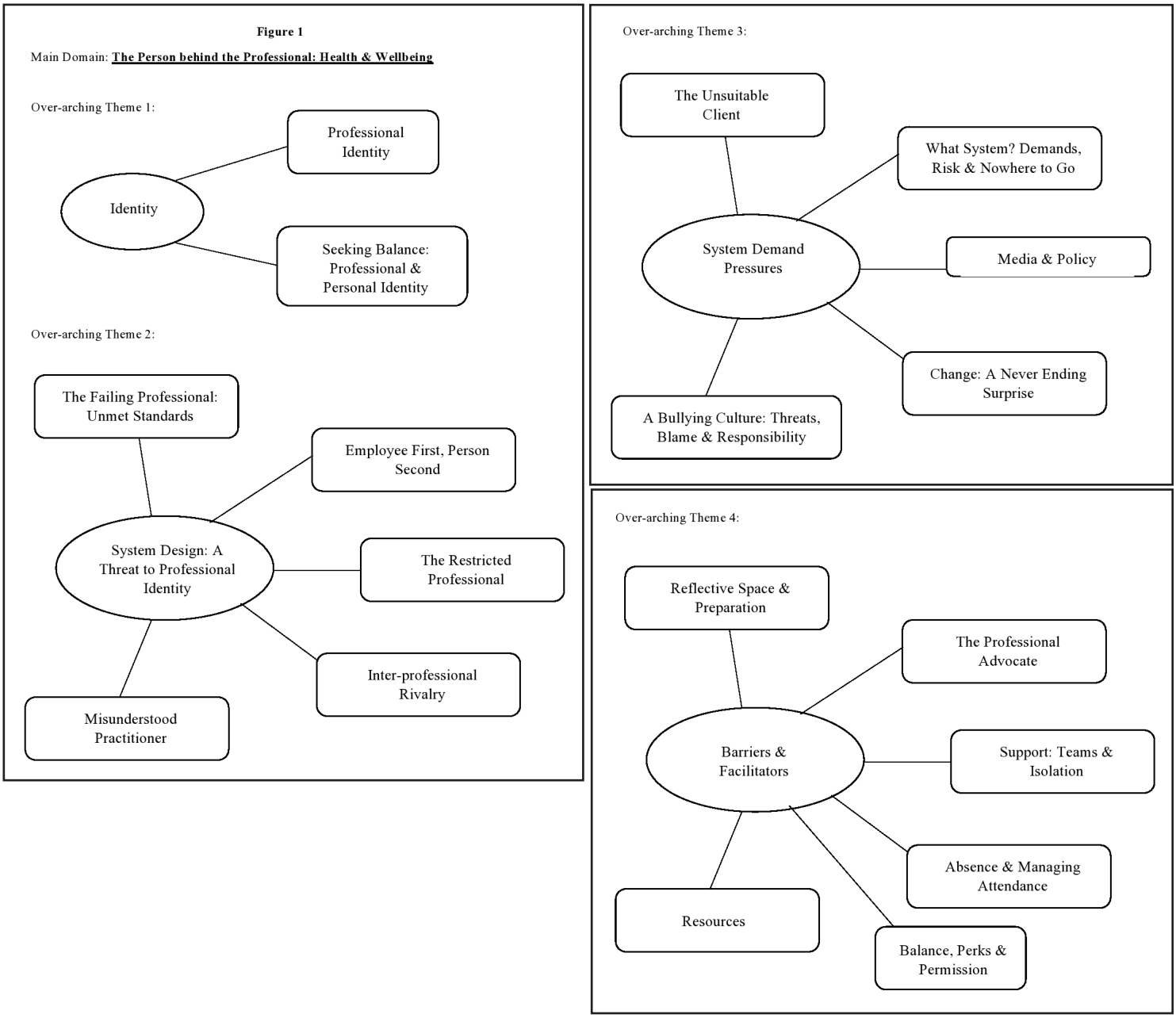

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and feel like we are treated as robots, made of stone, just a number underperforming against other numbers, have been mechanised and dehumanised, made to feel I have no control over my faith, colleagues are leaving this organisation, and I'm filled with envy for being stuck here ... this job made me doubt my decision of entering this profession…" (Participant 1033, 2016)

Professionals felt unvalued and unheard as work went unacknowledged, positions were 'down-banded', wellbeing approaches were tokenistic and staff felt replaceable, potentially with someone cheaper and less skilled. Professionals were left demoralised, emotionally exploited, burnt-out and stressed. Impressions of powerlessness rose.

'***The Restricted Professional***' developed over the years related to being 'micromanaged' and limited professional development. Professionals felt prohibited from utilising and developing a varied skillset and consequently controlled, dispirited, unconfident and trapped.

"*Meeting targets and the demands of the Clinical Commissioning Groups are causing management to micro-manage the team. This creates anxiety, feelings of failure, anger and depression amongst the team. There is no autonomy, which we used to enjoy…[Everybody's] looking for a way out of the job.*" (Participant 676, 2016)

By 2016, '***The Restricted Professional***' was angry, humiliated and looking to leave due to perceptions of unvalued professional judgment. Anger dissipated in 2017 as restrictions resulted in hopelessness. By 2018 participants reported feeling untrusted as professionals.

Between 2014 and 2016, the "*seemingly socially acceptable pecking order that has been encouraged or at best ignored*" (Participant 685, 2014) and perceived workload discrepancy between disciplines created '***Inter-professional Rivalry***' resulting in blame, frustration, and defensiveness. Low morale derived from perceived discrimination linked to professional title and qualifications. PWPs and Counsellors felt underappreciated in comparison to CBT Therapists. '***Inter-professional Rivalry***' was not observed in 2017 but, rose again in 2018 as professionals requested equality of pay and progression with other disciplines.

"*…The training and skills of counsellors are discounted and devalued. CBT therapists are [privileged] above counsellors in many ways including getting more regular supervision, professional development and a higher salary.…*" (Participant 559, 2015)

Between 2014 and 2016, IAPT professionals expressed discontent at being managed by staff from differing professions citing their lack of understanding and respect (i.e., '***Misunderstood Practitioner***'). Frustration and boredom increased as skills were "dumbed down", attributed to limited comprehension of roles and training.

OVER-ARCHING THEME 3: SYSTEM DEMAND PRESSURES

'**System Demand Pressures**' contained five sub-ordinate themes, '***The Unsuitable Client***', '***What System? Demands, Risk & Nowhere to Go***', '***Media & Policy***', '***Change: A Never Ending Surprise***' and '***A Bullying Culture***'.

Professionals suggested clients were unsuitable for the treatment available "*in a system that is set up to benefit commissioners rather than users of service*" (Participant 817, 2014) (i.e., '***The Unsuitable Client***'). Service designs were associated with repeated referrals, lack of treatment choice and patients too complex for the service.

Professionals felt encouraged to place patients on the shortest, not the most appropriate, waiting lists (to spread caseloads and manipulate statistics) and assign patients to treatment groups regardless of potential benefits. Disillusioned and stressed, professionals felt they were setting patients up to fail.

"*… the targets have an adverse effect on delivering a decent service. Figures are massaged in order to achieve the semblance of achievement which ironically stops us achieving. We do not have enough staff and as the focus is on assessment and getting people into service, our efforts are forced in that direction which means, once assessed, patients are left on waiting lists for months as we have no staff to deliver the promised treatments…*" (Participant 1024, 2017)

By 2016, professionals felt inadequate as environmental factors (financial problems, poverty, poor housing), resistant to therapeutic interventions, increasingly contributed to presenting distress, and widened the gap between the patients IAPT was designed to treat and '***The Unsuitable Client***' IAPT was receiving.

"*…People are depressed because they are cold, poor and hungry- 6 sessions of low intensity CBT isn't going to do much about that!*" (Participant 982, 2016)

Professionals in underprivileged areas expressed concerns regarding a system design without consideration for social and economic deprivation. Frustration heightened as professionals were restricted to the therapeutic limitations offered to affluent areas with no adjustment for deprivation. Concerns regarding '***The Unsuitable Client***' were not identified in 2017, but emerged again in 2018.

Professionals queried systemic efficacy and consequential impact upon individual services ('***What System? Demands, Risk & Nowhere to Go***') as secondary services' cuts increased the

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presentation of complexity being referred to services which lacked the training and structures to manage the additional risk.

"*We are all under pressure to the point it is dangerous. Today we made a referral to crisis team who said they [don't] have the capacity to see anybody in the next two days. This is a lady who was on a train line*." (Participant 775, 2017)

The struggling and pressurised workforce felt accountable for dynamics outside their control. Increased demand upon primary services and restrictions upon eligibility criteria for other services resulted in *"services [fighting] between themselves NOT to take certain patients"* (Participant 474, 2015).

In 2016, professionals identified '***Media & Policy***' impacting upon wellbeing with "*media portrayal of a system in crisis*" (Participant 721, 2016) and outsourcing services to third parties causing distress and uncertainty.

Professionals reported being scapegoated by the Government whom they perceived to blame staff for systemic problems as opposed to accepting that shortfalls are a consequence of little funding and poorly integrated systems.

Minimal opportunity for inclusion and consultation upon service development and decision making created a culture of '***Change: A Never Ending Surprise***'. Exclusion and rapid change successions (roles, locations, service structure, service redesign, management) without any stabilisation left professionals exhausted, stressed and feeling incompetent. With limited effective communication and insufficient thinking about resource vs demand, professionals become disempowered.

"*The senior management team within my service does not involve me in [decisions] which have a direct impact on my clinical work - this is usual [sic] communicated by a directive email! I am leaving the service due to this culture change*." (Participant 315, 2015)

By 2017 effects of prior changes presented conflicting results. Some professionals believed changes would create improvements, whilst others anticipated greater service divisions. In 2018 professionals reiterated frustrations regarding lack of consultation and involvement.

System design was held partially responsible for '***A Bullying Culture***' as professionals felt pressurised to provide substandard care *"that I would not feel good enough for friends and family"* (Participant 566, 2014) to meet targets. Widespread competition between IAPT services left professionals concerned about employment security. Failure was personalised as professionals felt bullied and shamed into using techniques which encouraged individualistic competition.

Demoralised, anxious and threatened professionals believed competency was continually questioned, reinforced by negative feedback, as they worked in fear of decommissioning or investigation. Data manipulation became a survival technique to avoid punishment.

By 2016, professionals were leaving after discovering that voicing concerns was unproductive and at times "*career suicide*" (Participant 1180, 2016). This reduced significantly in 2018.

OVER-ARCHING THEME 4: WORKPLACE CULTURE & CONTEXT

'**Workplace Culture & Context**' contained six sub-ordinate themes, '***Reflective Space & Preparation***', '***The Professional Advocate***', '***Support: Teams & Isolation***', '***Absence & Managing Attendance***', '***Resources***' and '***Balance, Perks & Permission***'.

Limited '***Reflective Space & Preparation***' was a barrier to wellbeing. Initially, professionals identified minimal clinical supervision, of poor quality, focussed on risk, case management and target compliance and attributed to management shortages and increases in task demand. Supervision was required to enhance resilience, reduce burn-out and create feelings of value.

Inadequate supervision left overwhelmed professionals struggling to manage client distress. This was understood to be, at best, a consequence of little understanding and value from those above them regarding the emotional burdens and challenges of their work or at worst, plainly, a need ignored.

"*… there is nothing built into our system to protect us from our patients. We are willingly absorbing the misery of service users for countless hours each week, month after month, year [after] year. Supervision is all about seeing if you've met your targets and is often oppressive for supervisees and is invidious and soul destroying for supervisors.*" (Participant 858, 2016)

Equally, time restraints due to target demands and administration impacted clinical session preparation as professionals reflected failing patients through limitations to produce notes and treatment plans.

In 2017 clinical supervision and support increased, but professionals remained emotionally exhausted and unable to fulfil self-care due to inadequate reflection and preparation opportunities. By 2018 requests for more supervision, reflection and preparation continued.

In 2015 and 2016, professionals requested support from '***The Professional Advocate***' (professional bodies) to create a stronger, unified psychological voice. Greater promotion relating to parity

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of esteem, career development and advice regarding safe caseloads and targets was identified as an indispensable contribution towards wellbeing.

"*The government needs to show more investment into the wellbeing of staff who look after the patients. To this end, there needs to be lobbying from relevant organisations such as BPS, BABCP.*" (Participant 1042, 2016)

Adequate support was identified as a key facilitator to wellbeing, ('***Support: Teams & Isolation***'). Supported individuals felt valued and cared for. Isolated working prohibited team working and cohesion, negatively impacted morale, reduced the chance to add perspective to client sessions and negated the use of humour as a source of personal protection and resilience.

"*…we often work in isolation from each other, seeing clients alone. The isolation can be unhelpful when sometimes the only people you see during the day are mentally unwell clients. There is a lack of banter and humour that you would usually expect to experience when you're part of a proper team.*" (Participant 606, 2015)

By 2016 anxious, stressed and exhausted professionals requested support and understanding, overwhelmed by containing patient distress within an isolated environment.

2017 suggested improvements as professionals reported positive experiences which improved team relationships and compassion. However, professionals believed that the system design could not maintain this and in 2018 the majority of professionals requested more support and less isolation.

"*At the moment I have a supportive line manager but I am concerned that as the service has to deliver national targets more pressure will be put on the clinicians. I think our service is doing its best to try to support staff but the problem is the system.*" (Participant 540, 2017)

'***Absence & Managing Attendance***' contributed to stress, burnout and depression. High workload, demanding targets and unpaid overtime left professionals "*paying for IAPT with their health*" (Participant 416, 2015). As absence increased, colleagues were under pressure to meet targets with decreasing resource, giving rise to further burnout, absence and blame as colleagues lacked compassion for absentees.

"As our workload has increased to meet targets, more team members need time off sick - and so everyone else's workload increases to try to compensate, and more staff go off sick. In the end, the pressure to meet targets seems to be precisely the thing that stops us having enough staff in the office to have any chance of meeting said targets!" (Participant 90, 2014)

Ill professionals felt pressurised to attend work due to 'unsupportive' and 'punitive' attendance policies.

Decreasing '***Resources***', alongside increasing patient complexity and demand, was a barrier to wellbeing. Staff shortages contributed to exhaustion, low morale and helplessness as care standards reduced and unpaid overtime increased to meet targets.

Frustration rose through perceptions that management refused to acknowledge the inadequate workforce, replace those who left and blamed inefficiencies upon staff.

"*I feel that problems are not addressed and validated that the emphasis of blame is on you as the worker and get SICK!!!!!!! of hearing "Well maybe its your time management that needs to improve" as I feel this is disrespectful and unhelpful and a cop out."* (Participant 360, 2015)

By 2016, concerns rose regarding the impact of a reduced senior workforce as the newly qualified were left vulnerable and overwhelmed.

Poor environmental resources contributed to a frustrated, inefficient workforce as professionals competed for desks and rooms. Teams fragmented and without available space to take breaks, team dynamics failed to improve and breaks were neglected. Professionals attributed additional stress to reduced administration resource and poor IT access.

Professionals identified the need for '***Balance, Perks & Permission***' (2016-2018) requesting activities to be introduced into the working day to increase balance and wellbeing. Activities needed to be accessible during the working day, outside of lunch hours and within protected time. Professionals who were offered activities, without explicit permission to attend within a protected time, felt offended at the empty gesture.

"*But it feels like the commissioners and government, and some NHS management do not realise that a great deal of good will and unpaid overtime has kept things going for many years. When ones service decides to offer staff one hour of 'personal well-being time' each week. To be taken off and used as you wish. One would like to ask, which of the many hours of unpaid over time that I put in, so to attend to the needs of clients who otherwise would slip between services, should I choose to take off…*" (Participant 958, 2016)

DISCUSSION

This study explored IAPT psychological professionals' wellbeing, identifying barriers and facilitators during a time of change and expansion (2014-2018). One main domain, four over-arching themes and 18 sub-ordinate themes were identified exploring the

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effects of identity, systemic structure and economic factors. Initially, professional identity was prioritised above a meaningful personal life. Proving unsustainable, professional identity deteriorated and professionals prioritised personal wellbeing until maintaining balance became difficult again in 2018. Personal identity did not emerge as a theme in itself, potentially because questions focused on workplace experience with responses potentially skewed in the professional direction.

Aligning personal values with systemic demands proved challenging. Therapeutic restrictions and perceptions of failing clients compromised identity and wellbeing deteriorated. Years feeling undervalued, misunderstood and replaceable through down-banding, micromanagement, target focused bullying and underdevelopment resulted in hopelessness. Managerial styles reflected in this study contrasts with workforce recommendations (Boorman, 2009).

Micromanagement and target-related bullying was attributed to IAPT's design where decommissioning and competition created job insecurity. Survival instincts compromised wellbeing and identity as manipulating recovery figures became incorporated into practice. Binnie (2015) suggests that tendering processes encourage managers to reinterpret guidelines and manipulate statistics creating a false economy detrimental to treatment. Reducing standards to meet competitive requirements shows infidelity to the original IAPT model (Health and Social Care Information Centre, 2015).

Professionals felt pressurised to provide substandard care alongside increases in complexity outside training remits culminating in a despairing workforce with low self-esteem. Without development opportunities and with predominant CBT focus, professionals felt deskilled. Wellbeing declined as inter-professional rivalry arose. Dissent between psychological professionals hinders the development of a unified psychological voice required to promote advice about safe caseloads, targets and development.

Client distress was exacerbated by environmental issues resistant to therapeutic treatment. Frustration mounted in underprivileged areas with pressure to deliver therapeutic outcomes within the same parameters as affluent areas. Greater socioeconomic deprivation is associated with poorer therapeutic outcomes (Delgadillo et al., 2016) suggesting KPIs should reflect local populations.

Limited service cohesion contributed to poor wellbeing as funding cuts to some services led to increasing demands upon others. Attempts to mitigate demand pressure by reducing eligibility criteria left vulnerable patients being inappropriate for services and professionals feeling responsible for system flaws. Governmental blame, as the NHS became a prominent focus of media attention during the UK election (Ipsos MORI, 2015) reduced wellbeing further.

Systemic change occurred continuously and rapidly, and without consultation, professionals became exhausted and disempowered. Collaboration with staff to promote safe service changes was part of the NHS Constitution pledge (DH, 2009), but is not incorporated into culture.

Without appropriate clinical supervision, reflective space and preparation time, professionals were exhausted and improvement is required to enable self-care and workforce support. Limited support, influenced by isolated working, aggravated challenges to contain patient distress. Agile working impacted wellbeing through resource limitations and consequent competition contributing to inefficient working practice and fragmented teams.

Limited resource and absence created circular problems. As absence increased in line with targets, professionals were pressured to meet demands with lower numbers, increasing possibilities of working unpaid overtime and further absence. With the subsequent increase in burnout, professionals lost empathy and compassion for absentees and worked despite ill-health in order to support colleagues and through fear of disciplinary action.

Professionals requested systemic improvements and blame reduction. Without strong workplace foundations (better workplace environment, professional relationships, career structure and role, supervision, resources) wellbeing initiatives were perceived to fail. Respondents advised that greater balance between professional and personal identity through workplace benefits and protected time, would improve wellbeing.

Limitations

Respondents were predominantly white females consistent with the professional group demographic profile (80% female). Services in Scotland, Northern Ireland and Wales are not directly comparable to IAPT, limiting generalisability to England.

Demographic data was not collected consistently with a change in age categories and variation in work setting and professional background collection. Participants were separated into IAPT and non-IAPT professionals based on work setting between 2014 and 2016 and professional background in 2017.

Snowball sampling limitations should be acknowledged. Whilst an economical and effective method for assessing change over time and producing in-depth results quickly (Atkinson & Flint, 2001), it has been related to selection bias as participants outside of known

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networks can be excluded (Van Meter, 1990). This was mitigated, partly, by using a large sample (Atkinson & Flint, 2001).

Clinical & Practical Implications and Future Directions

Professionals should be enabled to find balance between personal and professional identities. A culture discouraging unpaid overtime, systemic changes and ensuring supervision would aid in facilitating change. Considering alternatives to isolated and agile working have the potential to improve reflective practice and support in the workplace.

The promotion of the roles and value of psychological professionals, guidance regarding work tasks, improvements to work environment and culture, job security and the benefits of consultation and systemic changes are important. This could reduce experiences of micromanagement and bullying, improving feelings of value, support and wellbeing. Incorporating psychological professionals as consultants within change processes could reduce the widening gap between systemic priorities and professional identity enabling professional values to be reflected by employers.

The data manipulation, poor professional wellbeing and questionable client care suggests that IAPT's design in regards to commissioning, service interface, connections with other services and outcome measures would benefit from a review. With socioeconomic factors associated with therapeutic outcomes (Delgadillo et al. 2016), targets and therapeutic limitations set for individual IAPT services should take into account contextual population challenges.

Respondents reported limited resources and feeling disempowered to change social and economic systems. Vulnerability associated with such demands has led them to become unwell or leave their roles. The sadness is of the personalisation of failure rather than challenging the reality of what is being asked for and what is needed to deliver an effective service.

Finally, training and career progression should be considered in relation to IAPT clinical presentations. Clear career structures and reviewing types of therapeutic interventions offered could reduce discontent between the disciplines. Equally, a consideration of wider therapeutic approaches could reduce CBT dominance improving therapeutic outcomes and treatment choice (Binnie, 2015).

The Charter for Psychological Staff Wellbeing and Resilience (BPS & NSP, 2016), the Collaborative Learning Network (CLaN) (BPS, 2018) promote the importance of psychological professionals' wellbeing.

CONCLUSION

In conclusion, between 2014 and 2018, IAPT psychological professional wellbeing was poor resulting from continuing identity, systemic and economic pressures. Wellbeing improved through enhanced clinical supervision and support and the prioritisation of personal identity. Going forward, plans should include the recommendations outlined above including the development of training opportunities and a review of IAPT's systematic design. ■

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Appendix 1

Table 1a. Participant Demographics: Gender

Gender	Percentage of Participants (Number)				
	2014	2015	2016	2017	2018
Female	73.29 (118)	78.76 (293)	79.1 (420)	79.38 (154)	83.16 (237)
Male	22.98 (37)	20.43 (76)	19.4 (103)	19.59 (38)	14.39 (41)
Transgender	0.62 (1)	0.27 (1)	0.38 (2)	0.52 (1)	-
Not Documented	3.11 (5)	0.54 (2)	1.13 (6)	0.52 (1)	2.46 (7)
Other	-	-	-	-	-

Table 1b. Participant Demographics: Ethnicity

Ethnicity	Percentage of Participants (Number)				
	2014	2015	2016	2017	2018
Asian or Asian British	1.24 (2)	4.30 (16)	3.77 (20)	7.22 (14)	4.56 (13)
Black or Black British	2.48 (4)	1.88 (7)	3.01 (16)	4.64 (9)	1.40 (4)
Mixed	3.11 (5)	2.42 (9)	2.64 (14)	4.12 (8)	3.51 (10)
White	90.68 (146)	83.60 (311)	86.82 (461)	77.84 (151)	85.61 (244)
Other Ethnic Group	-	2.69 (10)	0.75 (4)	2.58 (5)	1.05 (3)
Not Documented	2.48 (4)	5.11 (19)	3.01 (16)	3.61 (7)	3.86 (11)

Table 1c. Participant Demographics: Age

Age	Percentage of Participants (Number)						
	2014		2015		2016	2017	2018
		Age		Age			
		16-20	0.27 (1)	18-24	2.82 (15)	2.06 (4)	2.11 (6)
20-30	14.91 (24)	21-30	10.75 (40)	25-34	27.68 (147)	36.6 (71)	31.58 (90)
31-40	22.98 (37)	31-40	23.92 (89)	35-44	24.11 (128)	19.59 (38)	18.95 (54)
41-50	22.98 (37)	41-50	25.54 (95)	45-54	27.5 (146)	24.74 (48)	27.37 (78)
51-60	29.81 (48)	51-65	37.63 (140)	55-64	15.07 (80)	12.27 (24)	12.98 (37)
61+	5.59 (9)	66+	0.81 (3)	65-74	0.94 (5)	2.58 (5)	2.81 (8)
				75+	0.19 (1)	-	4.21 (12)
Not Documented	3.73 (6)		1.08 (4)		1.69 (9)	2.06 (4)	-

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Table 1d. Participant Demographics: Region

Region	Percentage of Participants (Number)				
	2014	2015	2016	2017	2018
North England	32.29 (52)	52.41 (195)	44.44 (236)	-	62.11 (177)
South England	67.08 (108)	43.73 (165)	50.85 (270)	-	35.79 (102)
Wales	0.62 (1)*	1.08 (4)*	0.56 (3)*	-	1.40 (4)
Northern Ireland	-	-	-	-	0.35 (1)
Scotland	-	2.15 (8)*	1.13 (6)*	-	0.35 (1)
Not Documented	-	-	3.01 (16)	-	-

**It is acknowledged that IAPT services are not located in Scotland and Wales, however these participants identified as working within IAPT services.*

Table 1e. Participant Demographics: Professional Background

Professional Background	Percentage of Participants (Number)				
	2014	2015	2016	2017	2018
Admin	0.62 (1)	-	-	-	0.70 (2)
AHP	1.86 (3)	-	-	-	-
Counsellor	14.91 (24)	-	12.43 (66)	13.4 (26)	13.33 (38)
IAPT	13.66 (22)	-	23.35 (124)	60.31 (117)	48.07 (137)
Mental Health	4.97 (8)	-	-	-	0.70 (2)
Nurse	3.11 (5)	-	1.51 (8)	-	1.05 (3)
Psychotherapist	9.94 (16)	-	3.39 (18)	-	4.56 (13)
Psychological Therapist	32.3 (52)	-	39.92 (212)	23.71 (46)	16.84 (48)
Psychology: Unqualified	1.86 (3)	-	-	-	-
Practitioner Psychologist	11.8 (19)	-	10.55 (56)	-	13.33 (38)
Social Worker	1.86 (3)	-	-	-	0.35 (1)
Trainee	-	-	3.95 (21)	2.58 (5)	0.70 (2)
Not Documented	1.86 (3)	-	-	-	-
Other	1.24 (2)	-	4.9 (26)	-	0.35 (1)

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