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Stress and Coping in IAPT Staff: A Mixed Methods Study

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Abstract

Background: Research indicates National Health Service (NHS) mental health workers have particularly high levels of stress. Improving Access to Psychological Therapies (IAPT) is an NHS mental health service with new ways of working. **Aims:** This exploratory study sought to investigate whether IAPT staff experience high levels of stress and, moreover, identify sources of stress and ways of coping.

Method: A mixed methods design was utilised. Forty four IAPT workers completed a quantitative survey in which prevalence of stress (GHQ-12) and dispositional coping styles (COPE) were measured. Qualitative interviews were conducted with 6 staff and analysed using thematic analysis.

Results: Almost 30% of IAPT staff reached criteria for minor psychiatric morbidity. Identified stressors included high volume and target orientated work, constant change, resource issues, team dynamics, demands of high stakes in-service training, managing and holding distress and risk, and home-work conflict. Greater engagement in acceptance and active coping styles related to lower stress, whereas focusing on and venting emotions related to higher stress.

Conclusions: Stress is an issue for IAPT staff, with newly reported stressors including emphasis on targets and high stakes in-service training. Interventions aimed at promoting acceptance and active coping may be beneficial.

Keywords: Stress, Coping, IAPT, Mental health workers, Mixed methods

Introduction

Stress in National Health Service (NHS) staff is a major problem estimated to cost the NHS £300-400 million a year (NHS Employers, 2012). In a recent NHS Staff Survey, 38% of respondents reported experiencing work-related stress (Care Quality Commission, 2012). Stress and associated sickness affects the individual, their colleagues and, moreover, quantity and quality of patient care (Michie & Williams, 2003). Within NHS staff, mental health workers have been particularly highlighted as vulnerable to stress, with rates of minor psychiatric disturbance ranging from 31-47% of staff (Evans et al., 2006; Fagin et al., 1996; Hannigan, Edwards & Bernard, 2004).

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The development of Improving Access to Psychological Therapies (IAPT) has led to a new group of NHS mental health staff. Since its inception in 2006, IAPT has trained over 3,600 therapists to treat people with common mental health problems such as depression and anxiety; a figure expected to rise to 6,000 therapists by 2015 (IAPT, 2012a). With new ways of working, for example self-referral systems and an emphasis on training and measuring outcomes (DOH, 2008), it is important to assess the impact of IAPT work on staff wellbeing. To date, no published study has investigated stress within this workforce.

Previous research on stress in mental health workers has identified a range of stressors, such as administration, workload, resourcing, change, professional self-doubt, home-work conflict, client-related issues and interprofessional conflict; with the majority of studies focused on psychiatric nurses (Currid, 2008; Edwards & Burnard, 2003; Jenkins & Elliott, 2004; Prosser et al., 1997). IAPT roles are varied and include both trainee and qualified Psychological Wellbeing Practitioners (PWP) and High Intensity Workers who work at different levels of the Stepped Care Model. In addition to Service Managers, many IAPT teams now also include other clinical staff such as Counsellors (DOH, 2012; IAPT, 2013). Understanding stress in this diverse workforce requires consideration of both the extent stress is experienced and sources of stress, but also the influence of coping.

Coping refers to the process of managing aspects of the person-environment relationship appraised as stressful (Lazarus & Folkman, 1984). Despite its assumed importance, many studies investigating stress in NHS mental health workers have not assessed coping (e.g. Prosser et al., 1997; Sorgaard, Ryan & Dawson, 2010). Cushway and Tyler (1994) found that active coping styles related to reduced stress in British Clinical Psychologists, whilst avoidance coping styles related to increased stress. Such findings indicate the importance of assessing dispositional coping styles related to stress in IAPT workers.

Understanding IAPT workers' experience of stress and coping could provide valuable insights into employee wellbeing and factors relevant to stress management intervention. In light of the exploratory nature of the current research, a mixed-methods approach was utilised. Mixed-method approaches can be particularly beneficial in health service research, enabling researchers to triangulate findings to gain a better overall account of complex phenomena (Östlund, Kidd, Wengström & Rowa-Deward, 2011). This exploratory study had the following aims:

- To investigate the prevalence of stress in IAPT workers.
- To qualitatively investigate perceived sources of stress in IAPT workers.
- To investigate whether dispositional coping styles relate to stress experienced by IAPT workers.

Method

Design

A mixed methods design was used comprising a quantitative survey and qualitative interviews.

Recruitment of participants

A convenience sample of IAPT workers was recruited by the lead author via email between April and June 2012. One hundred and nineteen staff employed by a single IAPT service were invited to participate in a postal survey and/or qualitative face to face interviews. Forty four staff completed and returned the survey; yielding a response rate of 37%.

The first 6 respondents to the interview email were interviewed and comprised: high intensity workers (3), psychological wellbeing practitioners (2) and a counsellor (1). The majority of interviewed participants (66.7%) were female.

Measures

The questionnaire pack incorporated questions on background information, stress and coping styles:

Background information. Details of participants' gender, age, job title, working hours, ethnicity and length of service in IAPT were obtained.

Stress. The General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1988) was used as a measure of psychological stress. This 12 item measure was selected because it enables identification of probable cases of minor psychiatric disturbance and has been previously validated with NHS staff (Hardy, Shapiro, Haynes & Rick, 1999). It has also been widely used in studies of mental health worker stress (e.g. Evans et al. 2006; Prosser et al., 1996). Positive and negative items are included and rated on a 4 point scale. The GHQ-12 can be scored using the GHQ method (0-0-1-1) and the Likert method (0-1-2-3). In accordance with previous research, the GHQ method was employed to identify cases of significant minor psychiatric disturbance, with a score of 4 or more indicating caseness (Hardy, Shapiro, Haynes & Rick, 1999). The Likert method was also employed to allow for additional analyses using GHQ-12 total score (Evans et al., 2006). Internal reliability of the GHQ-12 (both scoring methods) was high (Cronbach's $\alpha = 0.91$).

Coping styles. The 60-item COPE (Carver, Scheier, & Weintraub, 1989) was used to measure 15 dispositional coping styles. The associated subscales and their Cronbach's α include positive reinterpretation (0.60), mental disengagement (0.36), focus on and venting of emotions (0.84), use of instrumental social support (0.76), active coping (0.75), denial (0.29), religious coping (0.97), humour (0.92), behavioural disengagement (0.63), restraint (0.71), use of emotional social support (0.85), substance use (0.91), acceptance (0.84), suppression of competing activities (0.54) and planning (0.80). The 4 response options range from "I usually don't do this at all" to "I usually do this a lot". The low internal reliability of a number of the subscales should be noted. This may be due to the small sample size however similar findings for mental disengagement have been reported previously (Carver, Scheier, & Weintraub, 1989).

Statistical Analysis

Quantitative data were analysed using SPSS (version 17). Descriptive statistics were obtained for all variables, and relationships between GHQ-12 total scores and coping styles were analysed using Kendall's tau correlations.

Qualitative Interviews

Face to face interviews were conducted exploring IAPT workers' experiences of stress using a semi-structured interview schedule. Participants were asked three questions about general perceptions of the job, and three questions specifically about stress. Example questions included "How do you feel about your job?" and "What do you feel causes you stress?". On average, interviews lasted 43 minutes. All interviews were recorded and transcribed verbatim. The first author, with a degree in Psychology and training in qualitative methods, conducted an inductive thematic analysis on sources of stress based on steps outlined by Braun and Clarke (2006). As a quality check, the second author inspected excerpts of coding and the emergent themes. Discussion then took place between the two authors to agree the final themes. These were shared with participants and respondent validation obtained.

Ethical considerations

Ethical approval was granted by Coventry University and the local NHS Research and Development Office.

Results

Quantitative Analysis

Survey respondents. Participants included Qualified High Intensity Workers (N=20), Qualified (N=11) and Trainee (N=3) Psychological Wellbeing Practitioners, Counsellors (N=6), Assistant Psychologists (N=2) and Management (N=2). The majority of participants were female (84%), White British (95%) and reported working in IAPT for 2-3 years. The average age was 40.

Prevalence of stress. Using the GHQ method, mean GHQ score was 2.45 (SD = 3.37). Thirteen participants scored 4 or above; therefore 29.5% of respondents met criteria for significant minor psychiatric disturbance.

Coping styles. Means and standard deviations for dispositional coping styles are reported in Table 1, alongside Kendall's tau correlations with GHQ-12 total scores. A significant moderate negative correlation was found between GHQ-12 total score and acceptance coping and a significant small negative correlation was found with active coping. Conversely, a significant moderate positive correlation was found between GHQ-12 total score and focus on and venting emotion. This indicates that lower stress is associated with greater acceptance and active coping styles and less focusing on and venting emotions.

Table 1: *Descriptive statistics for dispositional coping styles and correlations with GHQ-12 total scores (N=44)*

| Coping style | Mean (SD) | τ (GHQ-12) |
|-------------------------------------|------------------|-----------------------------------|
| Positive reinterpretation | 12.02 (2.46) | -0.17 |
| Mental disengagement | 8.18 (2.35) | 0.14 |
| Focus on and venting emotions | 9.73 (3.00) | 0.34** |
| Instrumental social support | 11.37 (2.57) | -0.05 |
| Active coping | 11.86 (2.23) | -0.24* |
| Denial | 4.59 (1.02) | -0.06 |
| Religious coping | 5.39 (2.94) | 0.18 |
| Humour | 8.05 (2.92) | -0.06 |
| Behavioural disengagement | 5.70 (1.82) | 0.17 |
| Restraint | 8.45 (2.28) | -0.14 |
| Emotional social support | 11.68 (3.00) | -0.07 |
| Substance use | 5.32 (2.04) | -0.04 |
| Acceptance | 11.23 (3.12) | -0.33** |
| Suppression of competing activities | 8.68 (2.23) | -0.11 |
| Planning | 12.43 (2.42) | -0.14 |

* $p < 0.05$, ** $p < 0.01$. Significance values are two-tailed.

Qualitative Analysis

The focused thematic analysis identified seven themes relating to sources of stress in IAPT workers: high volume and target orientated work, constant change, resource issues, managing and holding distress and risk, team dynamics, demands of high stakes in-service training and home-work conflict.

High volume and target orientated work. Most participants spoke of high volume work within IAPT as stressful. Participants discussed difficulties fitting tasks into the working day, as well as frustration with increasing administrative demands and prioritisation of targets such as recovery rates. When reflecting on the increase in administration one participant stated:

Yes a big shift and it gets more and more, but I mean we are still expected to do a certain number of clients, clinical work as well, so there is quite a bit of dissonance between the two really.

Another participant discussed the emphasis on targets:

...the practical demands of work and targets that we're given that we have to hit, are really unhelpful for our stress levels, um and probably make us worse therapists to be honest because you're constantly thinking about the targets that you've got to hit, and not so much about the clients that are sat in front of you.

Constant change. The majority of participants spoke of constant changes within the service, primarily in relation to processes but also in relation to teams. Change was described as generating considerable stress. One participant reflected:

...I think you know the biggest stress, and this is true of everywhere but particularly the NHS, is pace of change. The problem is that we're constantly changing.

Another participant spoke specifically of change within processes:

I think sometimes it's trial and error with systems... there's just this constant change. And I think that's one of the things that stresses me out. I'm ok with change, but one of my colleagues who retired actually said she couldn't take another change.

Resource issues. Some participants also spoke of insufficient resources in staffing and clinic space leading to lengthy waits for clients. Waiting lists were discussed as distressing and stressful for staff. One participant discussed the impact of staffing issues:

...When you're constantly under resourced, and then you have to take the flack from the people who, you know, don't want to wait. Um you know you assess somebody, and then they want help and you can't give it them for 3 or 4 months. It's not on.

Another participant discussed stress generated from waiting lists:

Well I think, it's the pressure. It's the idea that there is a waiting list and the waiting list is important because the waiting list is made by human beings er waiting there, in potential distress. Sometimes it feels a bit disempowering from a clinician perspective knowing that you have people waiting and, every day for them counts and you can't do anything... So delivering therapy with an eye on the waiting list can be quite stressful...

Managing and holding distress and risk. Most participants spoke of stress emanating from aspects of clinical work, particularly in terms of managing and holding distressing and risk-related information. There was a sense that participants often felt isolated in this. One participant stated:

We do, you know, have to sit and listen to some really awful things and there's not a lot of time to debrief about those sorts of things because also the clinicians that you're working with, their time is very precious... so a lot of it just gets carried really. And I find that quite stressful.

Another participant discussed the issue of risk:

...I've known people that are climbing walls because they're absolutely terrified that someone's going to kill themselves. And they end up writing hundreds and hundreds of

words for kind of risk assessments and everything else when our service isn't specifically for risky people. But because we have self-referral, it's that idea that all of a sudden we're taking it on. And I think that's the other thing, that there is no shared responsibility...

Team dynamics. Many participants spoke of politics and difficulties within teams as contributing to stress. This was primarily in relation to co-workers but also extended to management and the wider NHS context. One participant reflected:

Um some of the internal politics within the NHS is er, it's unnecessary, and I think that's stressful.

Another participant discussed contradictions within teams:

And I think team is a, can be a great source of stress as well as help. Um where there are tensions around, how people do things, that some people do relatively little and some people do a hell of a lot... Um some kind of members of staff can be really really supportive, if you're having a bad day, struggling, they can be there. But equally they can be the ones that make life really difficult for you.

Demands of high stakes in-service training. Training required for qualification as a Psychological Wellbeing Practitioner or High Intensity therapist was also identified as a stressor by participants who had completed or were currently completing the course. This was due to demands of the course and the fact that employment contracts are contingent upon passing. One participant reflected:

...There were loads of targets that we had to meet clinically as well as academically so it was really really hard work. I did find it really really difficult. I pretty much found, for the twelve months, that I was just head down, didn't really talk to people. Got into work, did my work, left.

Another participant spoke of the pressures of having to pass the course:

Because although I knew that the job was related to me passing the course, I knew that, but when I failed an essay it brought it all back to home, like oh my god if I fail it again I'm kicked off the course and then I lose my job.

Home-work conflict. Many participants spoke of an interaction between demands at work and within their personal lives. The combination and conflict of these demands was discussed as contributing to stress. One participant reflected on being unable to meet family demands due to the impact of work:

There are other demands on me that I can't meet and that's probably the hardest part. I do think, probably not for everyone again, but for quite a few people I do think this kind of work does have quite a large effect on your relationship.

Another participant reflected on the difficulties of combining work with family life:

Because if you've got family commitments, and that's the thing that I struggle with, more than anything else, it's not the job so much, it's combining both.

Discussion

Prevalence of Stress

This exploratory study is the first reported investigation of stress in NHS IAPT workers. Survey results indicate a relatively high prevalence of stress, with almost 30% of staff meeting criteria for significant minor psychiatric disturbance. Compared with other studies using the General Health questionnaire, the current findings are similar to prevalence rates obtained for mental health nurses (Fagin et al., 1996) but lower than mental health social workers and clinical psychologists (Evans et al., 2006; Hannigan et al., 2004). Clearly such comparisons are limited by the different sample sizes and methods employed. Nevertheless, it would seem that stress is a significant issue amongst IAPT staff.

Stressors

Participants spoke of high volume clinical and administrative work and prioritisation of service targets. Change, particularly in relation to processes was discussed as a constant, stressful occurrence. A lack of essential resources was linked with long waiting lists and participants spoke of stress from managing and holding client distress and risk, with limited opportunities to offload on colleagues and others. Colleagues themselves and dynamics within teams were also mentioned as stressful, as were the demands of rigorous IAPT training. Finally, the confliction between work and home was also highlighted.

Whilst no previous research exists to directly compare findings with, identified stressors are broadly similar to those observed in other NHS mental health workers (Cushway, 1996; Edwards & Burnard, 2003; Hannigan et al., 2004). It should be noted, however, that stress related to high stakes in-service training and target orientated work has not previously been reported. It is conceivable that these stressors are particularly pertinent to IAPT staff, given the requirement for most staff to complete and pass a postgraduate qualification once in post (IAPT, 2012b) and meet numerous performance indicators, such as access to therapy within 28 days of referral and recovery rates in excess of 50% (IAPT, 2008; 2011). The current findings highlight the stressful consequences of rigorous training requirements for IAPT staff. They also raise concerns about the target driven culture, lending weight to the argument that NHS targets are detrimental to the wellbeing of staff (O'Reilly, 2010).

Coping

IAPT workers' most frequently reported coping styles were planning, positive re-interpretation, active coping, emotional social support, instrumental social support and acceptance. Acceptance and active coping were found to relate to significantly lower levels of stress, whilst focusing on and venting emotions related to higher stress as measured by the GHQ-12. The current exploratory findings are supported in part by previous research on clinical psychologists which found active coping related to lower stress (Cushway & Tyler, 1994). Furthermore, a study of accident and emergency consultants found similar correlations between components of the longer

GHQ-28 and active coping, acceptance and emotional venting (McPherson, Hale, Richardson, Obholzer, 2003). The authors suggest that whilst active coping methods can change sources of stress, focusing on and venting emotions could impede such efforts and, consequently, adjustment to stressors.

Limitations

It is important to highlight a number of limitations to the current study. Firstly, all data is self-report and, as such, subjective. Additionally, the correlational design does not allow for causal inferences to be made. The exploratory nature of the current study means participant samples were small and recruited from a single service at one point in time; thus limiting generalisability. Additionally, the low response rate to the survey allows for the possibility of bias. Future research would benefit from utilising a multi-site, longitudinal design.

Implications

Notwithstanding the above limitations, this exploratory study suggests that stress in IAPT workers is a problem. Whilst caution must be exercised until results are replicated on a larger scale, findings indicate a need for intervention.

Whilst organisational-level intervention to address issues such as excessive workload and targets may be preferable, such intervention is perhaps unrealistic. Instead, findings suggest an approach whereby IAPT workers are supported in managing these stressors with acceptance and active coping strategies, as opposed to emotional venting. Clinical and peer supervision may be an important forum for this. Additionally, with its emphasis on promoting acceptance, an intervention which could be implemented within the workplace is Mindfulness (Williams, Teasdale, Segal & Kabat-Zinn, 2007). Mindfulness-based stress reduction groups have previously been shown to be effective in reducing stress in healthcare workers (Shapiro, Astin, Bishop & Cordova, 2005). Future research could investigate the efficacy of Mindfulness interventions for IAPT staff.

Concluding Comment

The current findings suggest stress in IAPT staff is cause for concern. Since “best care can only be provided to others by carers who are themselves well” (Moore & Cooper, 1996, p.82) further research is urgently required to investigate stress and stress management in this new, expanding workforce.

Implications for Practice

- Similar to other mental health workers, IAPT staff report high levels of stress. In this exploratory study 29.5% were stressed at clinical levels.
- Reported stressors are comparable to other mental health staff but also include service targets and high stakes training.
- Mindfulness based interventions could be beneficial for IAPT staff stress management.

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