Exploring the experience of mental health staff in wellbeing training focussing on their mental toughness and burnout

By

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Declaration

From October 2016 to present

Appendix 4: Student Declaration Form

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Type of Award PhD

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ABSTRACT

Background

Burnout in mental health staff is a major problem. Mental toughness, the capacity of an individual to deal effectively with stressors, pressures and challenges, has been associated with lower symptoms of burnout.

Aim

To explore the experience of mental health staff of participating in wellbeing training focussed on their mental toughness and burnout.

Methodology and methods

A pragmatic paradigm using a convergent parallel mixed methods design was selected. A literature review informed the idea for wellbeing training for mental health staff. A Nominal Group Technique (NGT) with ten mental health staff from two mental health rehabilitation units identified strategies and techniques that could help with burnout and mental toughness.

The training consisted of a variety of mental toughness coaching strategies. This training was implemented with eleven mental health staff from three mental health rehabilitation units across the North West of England.

Quantitative measures (MTQ48 and MBI-HSS) were used before and after the training and at a three month follow up. Qualitative semi-structured interviews were carried out after the training and three months after.

Results

The literature review supported the use of mental toughness coaching strategies. Themes from the NGT discussion included, culture/organisation, staff wellbeing and education.

Staff perceived the training as having an impact on themselves including their confidence and on life outside of work. They also perceived the training as having applications with service-users. The group average score for overall mental

toughness score and personal accomplishment was higher after the training, whereas emotional exhaustion and depersonalisation scores were lower.

Originality/Value

No other published studies have explored the idea of teaching mental toughness coaching strategies as a way of focussing on the mental toughness and burnout in mental health staff. This is important as it may reveal new ways of focussing on the wellbeing of mental health staff.

ACKNOWLEDEGMENTS

I would like to express my sincere gratitude to everyone who has helped and supported me throughout my academic journey leading me to complete this PhD. I would particularly like to thank my Director of Studies: Dr Jessie Janssen and my supervisors: Dr Hazel Roddam and Dr Louise Connell who consistently supported and encouraged me. I would like to thank Ian Wilson for being an advisor and providing me with expert mental health knowledge. I would also like to thank Esmira Ropaj for her assistance with the practicalities of the training.

I would like to thank the mental health staff who gave up their time and agreed to participate in this study, without whom this study would not have been possible. In addition to this I would like to thank the managers of the services that were open to this research.

Last but certainly not least, I would like to say thank you to my incredibly supportive husband Sam, my parents, family and friends whose encouragement and support have been invaluable and greatly appreciated.

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ABBREVIATIONS

MTQ48	Mental toughness questionnaire 48
MBI-HSS	Maslach burnout inventory-human services survey
EE	Emotional exhaustion
DP	Depersonalisation
PA	Personal accomplishment
CBT	Cognitive behavioural therapy
MDT	Multidisciplinary team
PSI	Psycho-social intervention

GLOSSARY OF TERMS

Burnout

Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors in the workplace. Burnout has multiple dimensions of emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach *et al*., 1996).

Emotional exhaustion

Emotional exhaustion refers to feeling depleted and fatigued.

Depersonalisation

Depersonalisation includes negative attitudes towards work and clients.

Personal accomplishment

A reduced sense of personal accomplishment, refers to a negative self-evaluation of work and how well an individual feels they are fulfilling their job role.

Mental toughness

Mental Toughness describes the capacity of an individual to deal effectively with stressors, pressures and challenges, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough *et al*., 2002).

Visualisation

This refers to the underlying principle that we can imagine success or we can imagine failure in our minds and we can learn from that (Strycharczyk and Clough, 2015).

Attentional control

This refers to the underlying principle that, focus, sustained attention and concentration, enables us to work better and for longer. (Strycharczyk and Clough, 2015).

CHAPTER 1

INTRODUCTION

1.1 Introduction

This thesis presents the findings of a study exploring the implementation of a training package for mental health staff wellbeing focussing on their mental toughness and burnout. No other published studies have explored the idea of teaching mental toughness coaching strategies as a way of improving both mental toughness and reducing burnout rates in mental health staff. This is important as it may reveal new ways of improving the wellbeing of mental health staff. It is important that mental health staff wellbeing is taken seriously and that new interventions are developed to help staff to keep themselves well. Interventions that improve an individual's perceived mental toughness and burnout could be hugely beneficial for staff wellbeing as well as having an impact on the care and interactions provided to service-users.

The purpose of this chapter is to provide the rationale for this study as well as explain the organisation and structure of this thesis.

1.2 Rationale for the study

This research was prompted by concerns regarding the poor mental wellbeing and high levels of burnout currently found in mental health staff. The impact that this can have on staff wellbeing and their interactions with service-users is a problem. NICE guidelines (2015) recommend that workplaces should 'create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing'(NICE guidelines, 2015, p8). Clear recommendations are being made to provide opportunities for staff to enhance their own mental wellbeing.

These are set out as the following:

- demands (workload, work patterns and work environment).
- control (how much say the employee has in the way they do their work).
- support (from the organisation, line manager and colleagues).
- relationships (promoting positive working to avoid conflict and dealing with unacceptable behaviour).
- role (if employees understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles).
- change (how change is managed and communicated in the organisation). (NICE guidelines, 2015, p.8)

However, in mental health services, support provided to staff usually focuses on service-user wellbeing and how to work effectively with service-users, rather than specifically providing interventions or support to target the mental health workers own wellbeing (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). The British Psychological Society (BPS) and New Savoy staff wellbeing surveys in 2014 and 2015 displayed that professionals working in the mental health care sector were working under stress. Burnout, low morale and depression were highlighted as a problem in this staff group. The BPS suggests that services with good staff wellbeing make a bigger difference to the individuals they are helping and are more sustainable services. They recommend that mental health staff wellbeing should be a priority that organisations and services focus on, in order to deliver effective services.

The World Health Organisation note that staff morale and burnout are important factors to consider when creating mental health services. It is discussed that staff burnout in these services may be specifically related to working in mental health care. This is the case in particular for staff who have the most face to face contact with service-users, have little say in the organisation and are 'low' in the hierarchy of clinical staff, such as support workers. In addition, mental health work can be challenging and stressful. It is recommended that providing support

for the staff so that they are able to see the rewards of their work, such as improvements in service-users and the effectiveness of their service can help with morale and burnout. It is important to consider staff wellbeing and to make an active effort to support staff and prevent burnout (World Health Organisation, 2014).

Public Health England in 2016 carried out an evidence review and included evidence from systematic reviews and evidence syntheses. They reported that burnout leads to lower productivity levels, decreased job satisfaction and commitment to the job and less effectiveness at work. In addition, burnout can lead to other health issues such as stress, depression, musculoskeletal pain and type 2 diabetes. With the Labour Force Survey (2018) finding that in 2017/18 stress, depression or anxiety accounted for 44% of all work-related ill health cases and 57% of all working days lost due to ill health. By occupation, professional occupations that are common across public service industries (such as healthcare workers; teaching professionals and public service professionals) show higher levels of stress as compared to all jobs. Health professionals, in particular nurses, reported high levels of work related stress (2760 cases per 100,000 workers) compared to other occupations (1,320 cases per 100,000 for all industries). Interventions to target this population group is essential. On review of the evidence of the interventions to reduce burnout in high risk individuals, Public Health England report that stronger evidence on interventions to reduce burnout is required. This includes interventions to prevent rather than cure burnout. This is because there is more evidence of interventions to use for those at high risk of burnout and who have clinically established burnout compared to those individuals in the pre-burnout phase. Therefore, to gain a greater perspective on interventions for burnout it is not necessary to recruit only individuals who are experiencing burnout. This research intends to include staff with varied experiences of burnout and mental toughness, in order to explore the use of the intervention with different individuals.

It is suggested that providing mental health staff with a better understanding of mental illness and training them in a broader range of interventions helps them to be more positive in their attitudes towards the service-users they are working with and experience less feelings of stress (Ewers *et al*., 2002; Doyle *et al*., 2007). However, training that teaches skills such as this, seem to have failed to put the staff at the heart of the training and instead has offered only a new way of working with individuals and has not focussed on the staff own wellbeing. This concept shall be explored in the literature review to help in finding a new way of focussing on the wellbeing of mental health staff.

It is acknowledged that burnout and mental toughness links closely to resilience theories and has links to positive psychology, however the link between burnout and mental toughness has not been fully explored in mental health staff. This research aims to put the staff at the core of the training, to find ways of focussing on their wellbeing. Staff will be involved in coming up with ideas for the training. It will aim to be personable to them as they will learn to apply techniques to themselves and their colleagues. It will differ to other existing interventions, as it will provide coaching strategies to improve staff wellbeing, whereas most training has focussed only on teaching staff new ways of working. By exploring techniques and strategies that focus on staff wellbeing it is anticipated that important insights can be gained into improving the wellbeing of mental health staff.

1.3 Researchers relevant experience

The experience I have had in research and as a professional is important to acknowledge in this thesis as it has shaped who I am as an individual, my beliefs and values, as well as my motivation for this study. Prior to starting this PhD, I had some experience of undertaking research as part of programmes of academic study. This experience had been mainly using quantitative methods. I am a HCPC (Health and Care Professions Council) registered occupational

therapist. Before commencing on this study I was a therapy lead across two mental health rehabilitation services for a registered charity organisation. The team I managed included occupational therapists, art psychotherapists, project workers and support workers. I also worked directly with service-users on a daily basis. As a mental health professional I was concerned by the wellbeing of staff working within mental health and I was intrigued by ways of potentially improving staff wellbeing.

I was familiar with the concept of burnout prior to commencing this PhD, however until embarking on my literature review I had very little prior knowledge of the concept of mental toughness. However, through this journey I have become very interested and enthusiastic about mental toughness and how this concept could be used with mental health staff in wellbeing training.

1.4 Thesis aims and objectives

The aim and objectives of this study were as follows:

Aim: To explore the experience of mental health staff of participating in wellbeing training focussed on their mental toughness and burnout.

Objectives:

1. To highlight any gaps in the current knowledge base surrounding training and interventions for mental health staff wellbeing.
2. To develop an understanding of what techniques and strategies mental health staff think could improve their wellbeing.
3. To develop and implement staff wellbeing training informed by literature and mental health staff ideas.
4. To explore mental health staff's views on their participation in the training and to use measurement tools to measure the mental toughness and burnout of these staff.

1.5 Structure of the thesis

This section gives an overview of the thesis and the structure of the content of each chapter. It also highlights the order of the main stages of this thesis to clearly display the order and process of this research (figure 1.1).

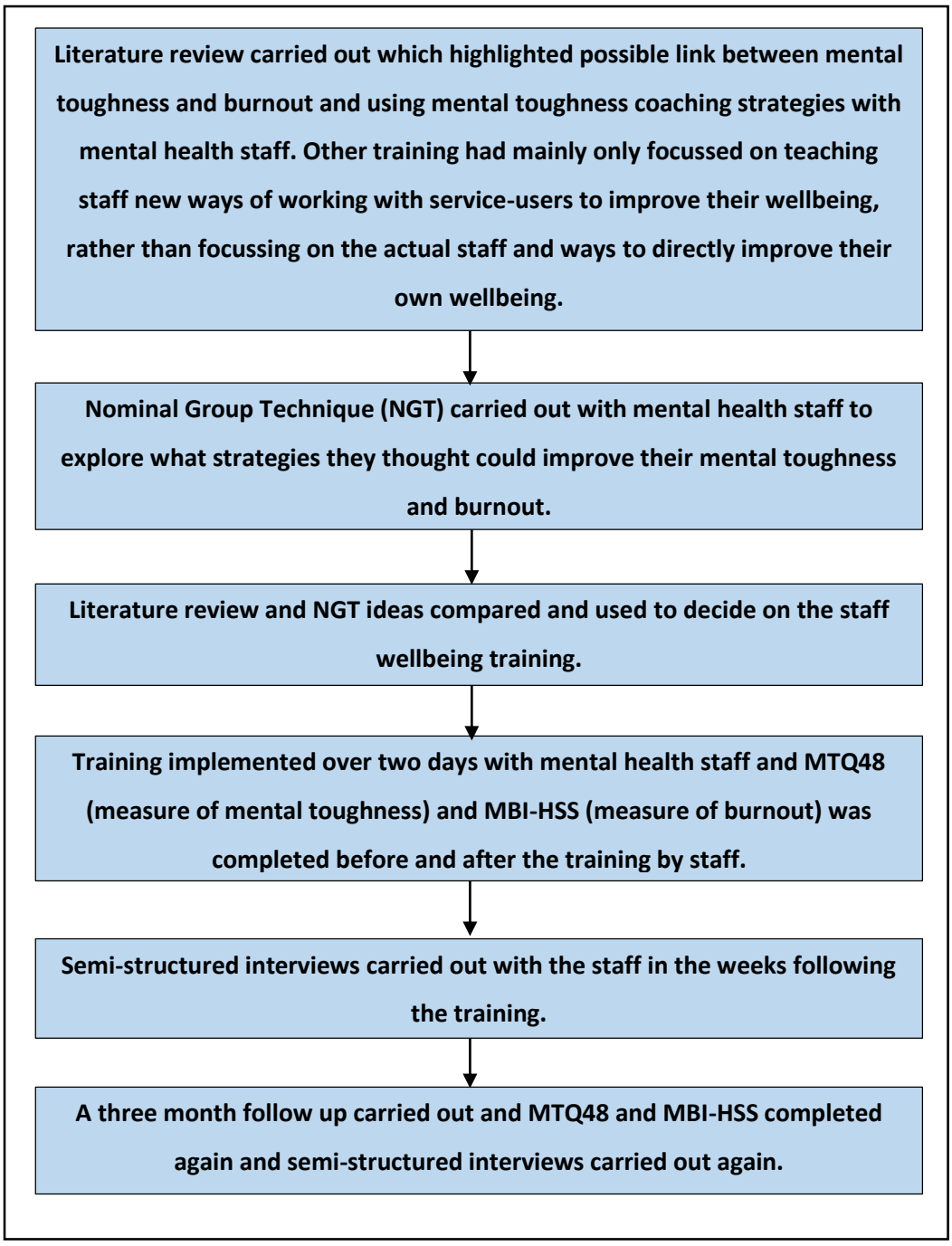


Figure 1.1: The order and process of the main stages of this thesis.

Chapter 2 provides the background to this research topic and the literature review. It provides information on the search strategy used to discover relevant literature that helped shape this study. It details and critically appraises the literature around the existing training and interventions to reduce burnout in mental health staff. It also details the mental toughness literature, focussing in particular on the potential of improving mental toughness as a way of reducing burnout. Conclusions are then drawn from the literature to identify gaps in the current knowledge base surrounding the topic of mental health staff wellbeing.

Chapter 3 provides the methodology for this thesis. It includes the underlying assumptions that guided the research process as well as detailing what was done and why.

Chapter 4 provides in-depth details of the methods of the nominal group technique (NGT).

Chapter 5 presents the results of the NGT and a discussion of the NGT.

Chapter 6 takes the information gathered from the literature review and from the NGT findings and presents the training package that was decided on and implemented with the mental health staff. It describes how the training was decided on and when and how the training was refined. It also provides an outline of the content used for training day 1 and 2 and a brief rationale for the timings, duration and location of the training.

Chapter 7 provides in-depth details of the methods of the wellbeing training intervention.

Chapter 8 presents the results of the wellbeing training intervention. It provides findings regarding the training delivery, content and setting. It presents the results from the quantitative outcome measures (MT48 and MBI-HSS) and the qualitative semi-structured interviews, before and after the training, as well as at a three month follow up. It also provides a discussion of the results of the wellbeing training.

Chapter 9 discusses the implications for practice, research and policy. It consolidates the results and conclusions from the study and presents insights into how these may contribute to wider knowledge. The limitations of the study are also discussed. This chapter also discusses the application of frameworks and models to the findings. It also highlights reflexivity and my role as the researcher. Recommendations and directions for future research are provided and final conclusions are then drawn, as well as how this PhD provides an original contribution to knowledge.

Chapter 10 is the final chapter and brings together the thesis and highlights the main conclusions that have been made.

CHAPTER 2

LITERATURE REVIEW

2.1 Background

Mental health is becoming a more widely accepted and talked about topic (Posner *et al*., 2017). However, even today mental health can still be viewed as a 'taboo' subject or one that people find difficult to discuss openly, due to the stigma attached to this condition (Morse *et al*., 2012). The World Health Organisation defines mental health as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (World Health Organisation, 2014). Mental health services have seen an increase in demand for their services (Lasalvia *et al*., 2009). However, high-volume work demands and targets in these services make it a pressurised environment to work in (Dowthwaite, 2016).

Many different types of mental health services exist. There are pathways for different stages of the individual's condition, such as early intervention through to rehabilitation. Mental health services cater for all different people and tend to include adult services, child and adolescent, forensic, learning disability, older adult and substance misuse services. These services in England deal with a wide range of mental health issues, including but not limited to, depression, anxiety, psychosis, obsessive compulsive disorder, eating disorders, post-traumatic stress disorder and dementia (National Health Service, 2016). There are many different roles within mental health services. Most of these services consist of a variety of different professionals as part of a multidisciplinary team. Roles in mental health services may include psychiatrists, mental health nurses, support workers, occupational therapists, clinical psychologists, social workers, art psychotherapists, cognitive behaviour therapists and psychological wellbeing

practitioners. Different services will have different needs and so will consist of varying roles depending on what is required (National Health Service, 2016). For example, in mental health rehabilitation, the focus is often on recovery and independence. Therefore, professionals such as occupational therapists, art psychotherapists and music therapists, may be hired more in these services, compared to in other services where medication from nurses is more of a priority.

Mental health staff face organisational pressures such as low staffing levels, long shifts and more demands, with low levels of support (Lasalvia *et al*., 2009). In addition to this, the mental health staff face challenges working in these settings, partly due to the complex nature of the conditions they are working with, including at times challenging behaviour from service-users, which can be stressful for the staff (Jenkins and Elliott, 2004). A combination of these factors can be linked to mental health staff experiencing burnout (Lasalvia *et al*., 2009).

2.1.1 What is wellbeing and burnout?

Wellbeing can be conceptualised as a spectrum, with flourishing, happiness and high wellbeing at one end, and elevated depression, anxiety and low wellbeing at the other (Johnson and Wood, 2016). Examples of some of the measures for wellbeing include the Hospital Depression and Anxiety Scale (Zigmond and Snaith, 1983), the General Health Questionnaire (Goldberg and Hillier, 1979), stress measures such as the Perceived Stress Scale (Cohen *et al*., 1983) and the Positive and Negative Affect Schedule (Watson *et al*., 1988). Research in wellbeing has been growing (e.g., Diener *et al*., 1999; Kahneman *et al*., 1999; Keyes *et al*., 2002; Stratham and Chase, 2010). Knowing the historical background to the study of wellbeing helps to understand the definition of wellbeing. Two main approaches emerged including the hedonic tradition, which accentuated constructs such as happiness, positive affect, low negative affect, and satisfaction with life (e.g., Bradburn, 1969; Diener, 1984; Kahneman *et al*., 1999; Lyubomirsky and Lepper, 1999); and the eudaimonic tradition, which

highlighted positive psychological functioning and human development (e.g., Waterman, 1993). However, despite the differences in approach, it is now considered that wellbeing is a multi-dimensional construct (e.g., Ryff and Keyes, 1995; Keyes and Waterman, 2003). A dimension that can impact on wellbeing is thought to be burnout (Maslach and Jackson, 1981; Burke and Richardsen, 1993).

The definition of burnout has been described in different ways (Maslach and Jackson, 1981; Chemiss, 1980; Burke and Richardsen, 1993). However, the most favoured and accepted definition is one that has multiple dimensions of emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach *et al*., 1996). Emotional exhaustion refers to feeling depleted and fatigued. Depersonalisation includes negative attitudes towards work and clients. A reduced sense of personal accomplishment refers to a negative self-evaluation of work and how well an individual feels they are fulfilling their job role (Maslach *et al*., 1996). Burnout has been seen as a specific reaction to job related stress and has even been described as a work related mental health impairment (Awa *et al*., 2010). Burnout is an issue in many different areas of work, in particular for those working in highly demanding and pressurised environments and has been reported a problem in jobs including the police force (Burke and Mikkelsen, 2005; Burke and Mikkelsen, 2006; Vila, 2006), armed forces (Adler *et al*., 2017; Walters, 2014) and other emergency services such as the fire service (Halbesleben *et al*., 2006) and paramedics (Murphy *et al*., 1994). Burnout in mental health staff is acknowledged as a major problem, with as much as 67% of mental health workers experiencing high levels of burnout (Morse *et al*., 2012). Mental health staff are particularly vulnerable to burnout due to factors such as low staffing levels, client pressures and lack of support (Barling, 2001). With burnout rates in staff being linked to an increase in stress levels then the development of new interventions to address this critical area is needed (Morse *et al*., 2012). Burnout has shown to have a negative impact on the wellbeing of staff (Carson *et al*., 1997) and the quality of interactions between staff and service-users (Duquette *et al*., 1994). Therefore, ways of improving levels of burnout in mental health staff is vitally important.

2.1.2 What is Mental toughness?

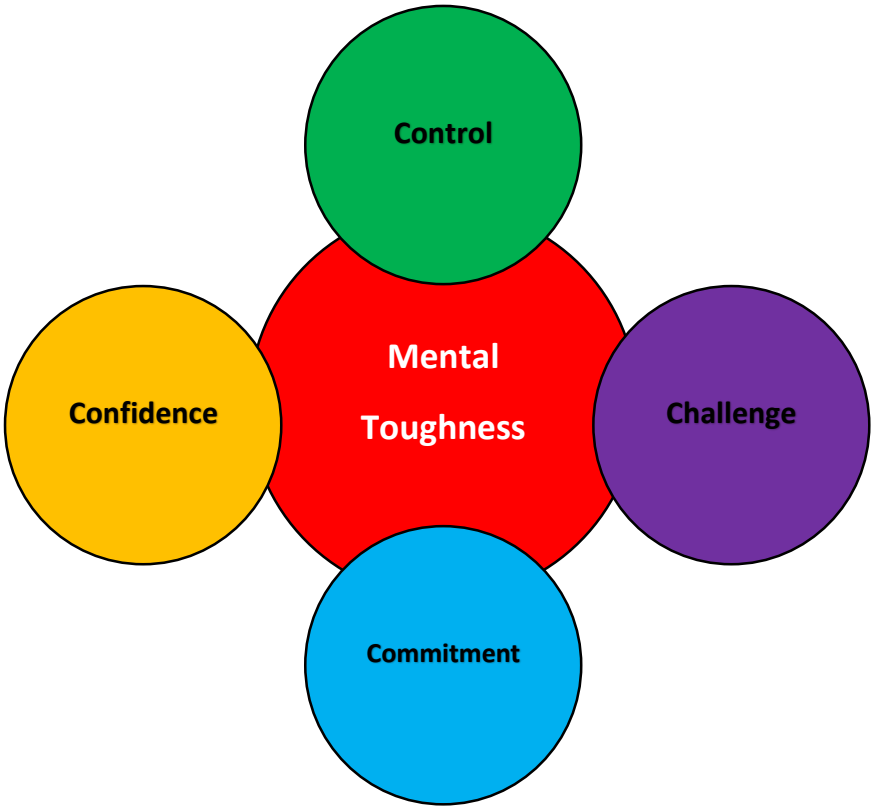
The chosen definition for mental toughness in this thesis is that mental toughness describes the capacity of an individual to deal effectively with stressors, pressures and challenges, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough *et al*., 2002). However, it is acknowledged that the literature contains widely differing mental toughness definitions, including that mental toughness may be an ability to cope with or handle pressure, stress, and adversity (Goldberg, 1998; Williams, 1988). It has also been defined as an ability to overcome or rebound from failures (Dennis, 1981). It has also been seen as the possession of superior mental skills (Jones, *et al*., 2002; Bull *et al*., 1996; Loehr, 1982, 1995).

It is suggested that those who can use energy positively during times of crises and pressure and during challenging and demanding situations are able to have positive attitudes and this reflects high mental toughness (Loehr, 1982). Loehr (1982) published a model of mental toughness that included seven characteristics: self-confidence, negative energy, attention control, visual and imagery control, motivation, positive energy, and attitude control. However, little rationale for the selection of the seven mental toughness factors was given for this model.

Strycharczyk and Clough (2015) believe that mental toughness can be taught and enhanced to individuals from a wide variety of backgrounds. They created the 4C's model of mental toughness (figure 2.1), which suggests that overall mental toughness is a product of four key factors. This includes seeing challenge as an opportunity, having high levels of self-belief and confidence, being committed to and being able to stick to tasks and believing that you control your own destiny. Mental toughness can be developed through the learning of mental toughness training and techniques (Strycharczyk and Clough, 2015). Mental toughness coaching strategies may include mindfulness training, positive thinking, visualisation, relaxation and attentional control (Strycharczyk and Clough, 2015). Crust and Clough (2011) suggests that mental toughness can be enhanced in

individuals by providing a challenging yet supportive environment, providing an effective social support mechanism and encouraging individual reflection.

The debate surrounding the concept of mental toughness and how to best define this is ongoing and one that is evolving. Currently there still remains debate without a definitive or universal understanding of this concept(Connaughton, *et al*., 2008). However, although it is acknowledged that other definitions of mental toughness exist and the debate surrounding this concept is ongoing, the 4C's model of mental toughness was used in this thesis as it has been used in other health related research (Gerber *et al*., 2013,2015; Haghighi and Gerber, 2018). Therefore, this model was the most applicable and relatable when applying it to the research topic in this thesis.



Mental Toughness =

Resilience *(coping with life's difficulties)* **+** ***Positivity*** *(seeing and seizing opportunity)*

Figure 2.1: The 4C's of mental toughness.

(adapted from https://aqrinternational.co.uk/mtq48-mental-toughness-questionnaire)

A concept very similar to that of mental toughness is resilience. Resilience can be described as having the ability to recover quickly from difficulties. This describes an ability to recover from an adverse situation either largely or completely. Resilience and mental toughness are related. Most if not all mentally tough individuals are resilient but not all resilient individuals are mentally tough. The difference lies in the positive component. Although it will help that an individual is optimistic or positive, this is not a necessary condition for resilience (Strycharczyk and Clough, 2015).

It is important that mental health staff wellbeing is taken seriously and that new interventions are developed to help staff to keep themselves well. Interventions that improve an individual's perceived burnout and mental toughness could be hugely beneficial for staff wellbeing, as well as having an impact on the care and interactions provided to service-users.

2.2 The Literature search

This chapter explores the literature regarding both burnout in mental health staff and the literature regarding mental toughness coaching. Essentially, it aimed to explore what was known about existing interventions to improve burnout and mental toughness. It also outlines how the previous literature could be used when developing wellbeing training. A conclusion is made at the end of the review with recommendations for the development of a training package.

2.3 Search Strategy

The search focussed on available research published in English in both UK and international journals. Several databased were used to carry out an online search for literature, with no date criteria specified. Relevant literature was identified through searches of databases which included AMED, CINAHL, Scopus, PsychINFO and Medline. In addition, the reference lists of retrieved articles were also examined. Boolean terms for the literature included:

(burnout prevention OR burnout intervention OR burnout training OR mental toughness) AND (mental health staff OR mental health professionals OR mental health workers).

2.3.1 Inclusion and exclusion criteria

The inclusion criteria for the literature search were as follows:

-Population/setting: adults working in mental health workplace settings. All mental health services/workplaces were included.

-Intervention: Any intervention that was used to reduce symptoms and impact of burnout and reduce burnout risk were included.

-Outcomes: all studies that reported outcomes relating to reduced symptoms of burnout, including emotional exhaustion, depersonalisation and reduced personal accomplishment were included. Other relevant outcomes such as sickness absence, stress related outcomes and job satisfaction scores were also included where reported. Studies reporting outcomes relating to improvements in mental toughness were also included.

-Study designs: included all peer reviewed papers, except grey literature and opinion pieces.

The exclusion criteria for the literature search were as follows:

-Studies that did not specify the intervention effects.

-Studies on general health promotion interventions, unless specifically relating to burnout.

-Studies focussing primarily on the term resilience rather than mental toughness.

-Studies that did not specify the environment in which it was taking place e.g. mental health rehabilitation service.

The search retrieved 81 titles specifically relating to interventions to reduce burnout in mental health staff. An additional 67 papers were found on mental toughness. The majority of the mental toughness papers measured changes in mental toughness in sport, business and education. The research that has investigated mental toughness in health, focussed its attention to areas such as

addictions, obesity, fitness and patient behaviour. No current study had explored mental toughness in mental health staff. The selection of the papers was then made on the basis of reviewing abstracts and to determine the value of research. The literature that has been included in the review, was chosen as most relevant and appropriate to meet the objective of highlighting any gaps in the current knowledge base surrounding training and interventions for mental health staff wellbeing. Of the articles retrieved, ten of these regarding wellbeing interventions for mental health staff were selected as appropriate based on the inclusion and exclusion criteria and included in this literature review (appendix 1). Of the selected intervention studies, five were randomised control trials, three pre and post-test and follow up design and two qualitative design. The papers included nine from the UK and one from the USA.

2.4 The Literature review results

This next section will outline the results from the literature review. This includes the findings regarding burnout in mental health staff and the interventions that have been currently used with mental health staff to reduce burnout. It will then outline the findings from the mental toughness literature. This will then be followed on by a section that will summarise and discuss the findings from all the literature and how this fits with this thesis.

2.4.1 Mental health staff and burnout

Mental health staff can experience high levels of burnout. It is estimated from several studies that between 21-67% of mental health staff may be experiencing this (Webster and Hackett, 1999; Rohland, 2000; Siebert, 2005; Oddie and Ousley 2007). The consequences of staff burnout rates in mental health services can be severe. In a study by Webster and Hackett (1999) in Northern California, community mental health workers were found to have high burnout rates. Of these 151 participants, 54% displayed high emotional exhaustion, such as feeling

depleted and fatigued and 38% high depersonalisation, such as having negative attitudes towards work and clients. However, although Webster and Hackett (1999) concluded that these aspects of burnout rate were high, they failed to discuss in detail that personal accomplishment were still rated as high despite high levels of depersonalisation and emotional exhaustion. In a similar study, of community mental health directors in Iowa, two-thirds of staff scored high on emotional exhaustion and low personal accomplishment. Half of these staff also scored high levels of depersonalisation (Rohland, 2000). However, a limitation of this study is the low sample size and no power calculation compared to Webster and Hackett (1999) which had a much larger sample size. Both of these studies were also carried out in the United States of America and therefore generalising to mental health staff in the United Kingdom may be difficult due to the difference in healthcare system, which may provide a difference in burnout and stress. In a UK based study, Johnson *et al*. (2010) carried out a mixed method study to examine morale of NHS inpatient mental health staff. They had multiple objectives including to describe staff morale and investigate if morale is associated with staff turnover and sickness. Largest levels of burnout were found for emotional exhaustion including feeling depleted and fatigued. Rehabilitation units in this study had an overall rate of 29% for emotional exhaustion burnout. Staff on acute wards scored 49% for emotional exhaustion. This UK study was larger in scale than other similar NHS studies carried out before it and improves on sample size and power. However, it is noted that although a variety of potentially important links were found, the causal status of these is often unclear (Johnson *et al*., 2010).

Staff burnout rates have been linked with negative attitudes and feelings from staff towards the service-users that they work with (Holmqvist and Jeanneau, 2006). Research was carried out with 510 psychiatric workers, across 28 different mental health units. They explored staff burnout rates and the effect on their feelings towards service-users. They found that there were high levels of emotional exhaustion and depersonalisation, which were linked with negative attitudes towards service-users, which came in the form of being distant and

rejecting the service-user (Holmqvist and Jeanneau, 2006). In 333 mental health staff, from 31 different teams working with service-users with mental illness, team level emotional exhaustion such as fatigue was significantly related to average service-user satisfaction scores for those teams (Garman *et al*., 2002). Therefore, displaying a link between staff burnout and poor service-user satisfaction.

In a review of the literature Morse *et al*. (2012) state that overall burnout rates for staff working in mental health, is associated with several negative outcomes for staff, organisation and service-users. However, they criticise that many of these studies are cross-sectional and correlational. Therefore, consequences of burnout in staff may not accurately capture the direction of relationships. They give the example that staff who score high on emotional exhaustion and added work pressure, may do so because of other existing problems, such as physical health problems that are causing them to feel fatigued (Morse *et al*., 2012). The literature on burnout in staff can also be criticised as many studies assess job satisfaction not burnout rates directly and make assumptions that low job satisfaction is directly linked to burnout rates (Schulz *et al*., 1995). Previous literature clearly identifies that burnout amongst mental health staff is a current and ongoing problem and ways to reduce or prevent this are needed (Morse *et al*., 2012; Garman *et al*., 2002; Holmqvist and Jeanneau, 2006). This chapter goes on to explore the existing training and interventions that have been studied as possible ways of improving burnout in mental health staff.

2.5 Existing training and interventions to reduce burnout in mental health staff

Despite burnout in mental health staff having clear negative outcomes towards both the staff member themselves and possibly the service-users, very little attention has been focussed on the best ways to prevent or reduce burnout rates in this population. This problem has been evident for several decades and the

need for interventions to deal with this issue was noted early on by Pines and Maslach (1978). However, despite this issue been known very few programs and interventions have currently been implemented and evaluated. In a review by Leiter and Harvie (1996), only one intervention study directly related to burnout rates in mental health staff had been conducted. In a review by Morse *et al*. (2012), eight studies were identified as exploring ways of reducing burnout in mental health staff. Of these studies, two of these were carried out in the United States of America and the other six carried out in the UK and European countries including Italy, Sweden and the Netherlands. In a more recent review to identify which educational interventions reduce burnout and promote wellbeing in mental health nurses and care workers, clinical supervision and psychological intervention training was found to be effective (Stewart and Terry, 2014). In the review carried out by Stewart and Terry (2014) five studies were included for final analysis, none of which were carried out past 2011.

This thesis literature review outlines that training programmes to help reduce burnout in mental health staff have tended to focus on three main areas. This includes psychosocial interventions (PSI), clinical supervision and social support. Therefore, this chapter will go on to explore the research behind these interventions and discuss how this past research has helped shape the training used in this thesis.

2.5.1 Psychosocial Interventions

In this literature review four papers were identified with regards to using psychosocial interventions (PSI) as a way of improving levels of burnout in mental health staff (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). These will now be outlined and discussed. The theory behind this model of training is that it aims to teach staff a new way of working with service-users (Ewers *et al.,* 2002). The skills taught often help staff become more empathetic towards service-users. It does this by increasing their understanding of mental health and learning strategies to work through

problems effectively, that service-users may be experiencing (Ewers *et al*., 2002). PSI often includes cognitive behavioural therapy or family intervention (Doyle *et al*., 2007). Typical components of PSI include psycho education, goal-setting, problem-solving and relapse prevention (Doyle *et al.*, 2007).

PSI have been shown to be effective to decrease aspects of burnout in mental health staff (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). Three of these studies used multiple interventions such as how to develop engagement skills, how to use a variety of different mental health assessment tools, interventions for anxiety, depression, auditory hallucinations and delusions, as well as an introduction to family interventions (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). The training was both educational and practical in nature to allow staff to actively engage and practice the skills they were taught. The training also aimed to change staff attitudes by moving them away from a purely medical model by teaching them a more flexible, therapeutic approach to mental health problems. All of the studies found that after the training, staff knowledge about mental health had increased, attitudes towards service-users had improved and burnout rates had improved. However, only one of these studies found that burnout had improved in all measured burnout subscales of emotional exhaustion, depersonalisation and personal accomplishment (Ewers *et al*., 2002). This training was implemented with ten mental health staff over twenty days and each day covered a separate topic. In comparison, other studies using PSI to improve burnout have only found improvements in one of the dimensions of burnout (Corrigan *et al*., 1997; Doyle *et al*., 2007; Redhead *et al*., 2011). All of the studies used the Maslach Burnout Inventory (Maslach and Jackson, 1981) to measure changes in self-reported burnout. One of the studies carried out interactive staff training. This consisted of staff identifying service-user rehabilitation needs, as well as deciding on behavioural rehabilitation strategies to assist with these needs. The implementation of the plan that was decided in this meeting was discussed in

detail along with the risks and benefits. This was carried out with thirty-five mental health staff, each month for ninety minutes (Corrigan *et al*., 1997). Improvements were only found in the emotional exhaustion element of burnout. In comparison, another study found improvements only in the personal accomplishment element of burnout (Doyle *et al*., 2007). Another found only improvements in the depersonalisation element of burnout (Redhead *et al*., 2011). Differences in the changes in self-reported burnout scores may be due to several reasons, such as differences in the content of the course. For example, some of the studies consisted of a wide selection of interventions including introduction to stress vulnerability model, engagement, coping strategy enhancement, case formulation and working with anxiety (Redhead *et al*., 2011). Another consisted similarly of multiple interventions, however contained different content such as developing engagement skills, introduction to global and specific assessment tools such as tools for assessing psychosis (Ewers *et al*., 2002). One of the studies also had different content depending on whether the staff were qualified or unqualified staff (Redhead *et al*., 2011).

The training in the PSI studies were carried out over different timescales. The longest course consisted of twenty full days of training over a six month period (Ewers *et al*., 2002) and the shortest consisted of ninety minute sessions over eight months (Corrigan *et al*., 1997). The other two studies consisted of sixteen, three hour sessions (Doyle *et al*., 2007) and sixteen day training over a period of eight months (Redhead *et al*., 2011). The largest sample involved in the training was 35 direct care staff (Corrigan *et al*., 1997) and the smallest sample consisted of 10 participants in the experimental group (Ewers *et al*., 2002). In this study only specialised nurses took part, whether findings have implications for all mental health staff is not clear. Also, the sample came from staff that self-selected into the training. Therefore, there is the potential that participants may be individuals who were naturally more keen and able to learn and retain new information and more adaptable to change.

Three of the studies did benefit from having a control group. This involved the participants being assessed on all the same measures as the experimental group. However, they received no intervention or were placed on a waiting list (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). The majority of the PSI studies were carried out in the North West of England (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). Only one of the studies did not specify the location of the study. However, the researchers and authors were all based in Chicago mental health departments in the United States of America (Corrigan *et al*., 1997). These PSI studies provide some evidence of the effectiveness of PSI training in improving burnout among nurses and care workers, in particular in secure settings. PSI training enhance professionals' knowledge of service-user's factors, such as the behavioural aspects of severe mental illness, which can promote understanding and empathy towards service users. Although there is some evidence of a link between working in mental health and burnout, the methods of reducing burnout are complex and require further exploration.

The PSI literature has highlighted the emphasis that has previously been placed on teaching mental health staff new ways of working with service-users, as opposed to focussing on ways of helping the staff improve their own wellbeing. When staff are involved in PSI training, they are told what topics they will learn and how this may help with the service-users. The staff do not choose which topics are covered or provide opinions on what they would like to learn in order to help. It is extremely important that training aimed to improve staff wellbeing is informed by staff opinions and consultation (Coates and Howe, 2015). In a study by Coates and Howe (2015), 55 individuals who worked in mental health were surveyed. This was to explore what the valued and desired wellbeing initiatives for this staff group might be. In order to keep themselves well, staff identified four key areas that could be used in this initiative. This included emotional, physical, social/work life balance and educational needs. A key focus on emotional support identified supervision, peer support, stress reduction and

training about working in emotionally demanding environments, as important areas for staff wellbeing. Other areas included time for meditation, relaxation and team building. This Australian study identifies that it is paramount that new training and initiatives to improve staff wellbeing, including burnout, is informed by mental health staff views and ideas. Therefore, it is important to consider a combination of past research and staff ideas when designing and implementing new training programmes to improve burnout.

2.5.2 Using the PSI literature for developing wellbeing training

The PSI literature identified some key findings that were useful to consider when developing the wellbeing training for mental health staff. These include the following:

-It may be useful for mental health staff to move away from a purely medical model and teach them a therapeutic approach to mental health problems (Ewers *et al*., 2002).

-PSI may increase staff knowledge about mental health and this in turn may reduce dimensions of burnout (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). Therefore, educating mental health staff about mental wellbeing could be useful.

-In the PSI literature three of the four studies found improvements in one of the three dimensions of burnout. For one study emotional exhaustion reduced (Corrigan *et al*., 1997), another depersonalisation reduced (Doyle *et al*., 2007) and another only personal accomplishment improved (Redhead *et al*., 2001). Therefore, wellbeing training should focus on ways of improving on all three dimensions of burnout.

-The content of the PSI training was aimed at working with service-users, e.g. case formulation, working with service-user anxiety (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). Training could focus on

techniques specifically for the staff to use for themselves, e.g. managing their own anxiety as oppose to only service-user anxiety.

-New training and initiatives to improve staff wellbeing should be informed by mental health staff views and ideas (Coates and Howe, 2015).

2.5.3 Clinical Supervision

In this literature review four papers were identified with regards to using clinical supervision as a way of improving levels of burnout in mental health staff (Hyrkas, 2005; Edwards *et al*., 2006; Walsh, 2009; Walsh and Freshwater, 2009). This is relevant to this thesis as these studies have used clinical supervision as an intervention to help with levels of burnout in mental health staff (Walsh, 2009; Walsh and Freshwater, 2009). This thesis has also explored a way of focusing on the burnout of mental health staff and therefore this is why these studies have been included in this literature review. These will now be outlined and discussed. Clinical supervision can be described as a formal process of learning and professional support (Edwards *et al*., 2006). It is often implemented to staff in groups and if it is offered to staff it usually occurs every six weeks. Studies have investigated clinical supervision as a strategy for improving burnout in mental health staff (Hyrkas, 2005; Edwards *et al*., 2006). However, these studies have focussed on evaluating how clinical supervision that is already in place in mental health services, have impacted on burnout, as oppose to implementing clinical supervision as a new intervention into services. In a study in Finland, clinical supervision was linked to lower levels of perceived burnout in mental health nurses. After staff received a minimum of six months of clinical supervision, staff rated burnout levels as lower and job satisfaction as higher (Hyrkas, 2005). Similarly, Edwards *et al*. (2006) found that clinical supervision with community mental health nurses reduced perceived burnout on the Maslach Burnout Inventory. This study was conducted across eleven National Health Services across Wales and found that individuals who had received six or more sessions of clinical supervision reported lower perceived burnout. However, the long-term

benefits of clinical supervision were not investigated and not compared to the effect of other factors or interventions that could improve or change burnout (Edwards *et al*., 2006).

Two studies that did use clinical supervision as a new intervention with staff, found that it enhanced psychological wellbeing (Walsh, 2009; Walsh and Freshwater, 2009). It is thought that clinical supervision helps to develop emotional intelligence, which in turn helps nurses to manage emotional stress (Walsh, 2009). Walsh (2009) carried out clinical supervision as a means of developing awareness of emotional labour in prison nursing. The first phase of the study involved semi structured interviews with nine qualified registered nurses from three adult prisons: two male establishments and one female. In phase two of the study, two of these nurses entered into a supervisory relationship with the researcher, with the researcher as clinical supervisor. Monthly clinical supervision sessions were held with both nurses over six months. The study found that there were benefits to the staff wellbeing by developing emotional intelligence and reflective learning (Walsh, 2009). In another study, also in the prison environment, clinical supervision was implemented over a much longer time frame, with three phases of clinical supervision being carried out over seven years (Walsh and Freshwater, 2009). The first phase was the implementation of relevant work based training. The next phase involved the implementation of clinical supervision. The final phase involved attending learning groups where they received supervision on how to develop clinical supervision in their own services (Walsh and Freshwater, 2009). Benefits of reflective practice due to clinical supervision, to manage emotions and enhance wellbeing were found. Neither of the studies specifically assessed burnout in the staff, rather they looked at wellbeing in relation to other factors such as emotions and stress. Walsh and Freshwater (2009) had a small sample of only nine participants in the first phase and two in the final stage. There was also no control group and the study was based only in London prisons. In comparison,

Walsh and Freshwater (2009) had a larger sample of seventy participants and the study was based across England and Wales.

2.5.4 Using the clinical supervision literature for developing the wellbeing training

The clinical supervision literature identified some key findings that were useful to consider when developing the wellbeing training for mental health staff. These included the following:

-This thesis has explored a way of focusing on the burnout of mental health staff. The clinical supervision literature suggests this type of intervention could be used to help with levels of burnout in mental health staff and therefore this is relevant to consider in this thesis (Walsh, 2009; Walsh and Freshwater, 2009).

-Clinical supervision may play a significant part in providing staff with a mechanism through which to address and ensure their mental well-being (Hyrkas, 2005; Edwards *et al*., 2006; Walsh, 2009; Walsh and Freshwater, 2009).

-Reflective learning was an important element of the clinical supervision sessions that were found to be beneficial to the staff (Walsh, 2009; Walsh and Freshwater, 2009). Therefore, allowing time for reflection during wellbeing training could be useful.

-Staff required six or more sessions (six hours or more) of clinical supervision to be effective (Hyrkas, 2005; Edwards *et al*., 2006). Therefore, wellbeing training may benefit from being more than six hours in total.

-A recognised problem of using clinical supervision is that individuals don't always get the opportunity and time out of normal working duties to attend these sessions and they are not always regularly available (White and Roche, 2006). Therefore, an intervention or training that teaches staff to look after their own wellbeing in a shorter more condensed training package, could be beneficial for both the staff and services.

2.5.5 Social Support

Social support can be provided in varied ways and is often defined as support from colleagues, supervisors, managers and also outside of work support from family and friends (Jenkins and Elliot, 2004). It may include assistance or help with a specific work related task or emotional support to a situation, such as listening sympathetically (Jenkins and Elliot, 2004). According to Jenkins and Elliot (2004) social support may be an important factor that impacts on burnout and therefore an intervention or training that includes some element of support for mental health staff could be beneficial.

Support for staff in the form of individual or group support has shown to be effective in improving burnout in mental health staff (Jenkins and Elliot, 2004). A survey was used to assess burnout in 93 qualified and unqualified mental health staff, as well as the impact of social support on burnout. It was found that social support impacted on burnout in a variety of ways, social support had the largest effect on the emotional exhaustion dimension of burnout (Jenkins and Elliot, 2004). From this research it was also recommended that to be effective, social support should be structured, to minimise negative communication between staff and encourage staff to have discussions that are helpful and constructive (Jenkins and Elliot, 2004). Fenlason and Beehr (1994) suggest that social support can come in varied forms. They suggest that it can be emotional, including the act of someone listening and caring sympathetically to another individual. It may also be instrumental, which may involve active and practical support, such as help and support with specific tasks at work. Social support may also reduce burnout in mental health staff if regular feedback is given to them with regards to the short and long term expectations of their jobs. Social support interventions or training that includes this element should focus on staff that have been in the job role for longer, to increase feelings of personal accomplishment (Kilfedder *et al*., 2001). Interventions that allow time to reflect

and gain support on non-work as well as work related issues, may be useful in reducing staff burnout (Kilfedder *et al*., 2001).

Carson *et al*. (1999) initially investigated social support as an intervention to reduce burnout, however they concluded that this was unsuccessful. Support from colleagues can improve an individual's self-esteem. Self-esteem is said to be one of the most important moderating variables in determining the effects of stress on individuals (Carson *et al*., 1997). In a further study it was explored whether self-esteem workshops could improve burnout in mental health staff (Carson *et al*., 2001). The intervention was carried out with a total of 141 staff, including occupational therapists, mental health nurses, social workers and unqualified staff, over three days and consisted of ten modules. The modules covered areas in the workshop such as self-image, self-belief, roles, identity, achievements, goal setting and self-esteem. Assessments included the use of the Maslach Burnout Inventory to measure change in burnout. This was carried out before and after the self-esteem workshops were complete. The findings showed positive changes in burnout due to the implementation of the self-esteem workshops. Levels of rated emotional exhaustion and depersonalisation reduced and rated levels of personal accomplishment improved. The study consisted of a control group that did not receive the self-esteem workshops, instead were placed on a waiting list for the workshop. Burnout scores for those on the waiting lists were slightly worse at post assessment. Although perceived burnout improved from the workshops, the main improvements were found in rated levels of self-esteem. Although self-esteem levels may be linked to perceived burnout, Carson and Dennison (2008) suggest that more ways of reducing burnout are needed and should be researched.

2.5.6 Using the social support literature for developing the wellbeing training

The social support literature identified some key findings that were useful to consider when developing the wellbeing training for mental health staff. These included the following:

-Social support is varied and may include listening to colleagues, communicating constructively and increasing the self-esteem of colleagues (Jenkins and Elliot, 2004; Fenlason and Beehr, 1994; Carson *et al*., 2001).

-Social support interventions have tended to focus on the element of improving self-esteem to reduce burnout. Social support interventions that have not included the element of self-esteem have not been effective (Carson *et al*., 1999). Therefore, training that incorporates ways of improving the self-esteem of staff could be beneficial for staff wellbeing.

-As only two studies in the literature review explored self-esteem interventions for mental health staff, exploring these techniques in more detail could be beneficial (Carson *et al*., 1997; Carson *et al*., 2001).

2.6 Mental toughness and its potential link in reducing burnout

This chapter so far has outlined the literature regarding interventions that have been used to reduce burnout in mental health staff. This has included psychosocial interventions, clinical supervision and social support. In addition to these highlighted interventions, the literature search also identified the literature on mental toughness. This next section outlines the findings with regards to mental toughness, as well as the literature that suggests the potential link between mental toughness and burnout. The following section will then go on to present the findings of the literature search with regards to mental toughness coaching interventions that have been used previously, although not with mental health staff.

The concept of mental toughness is becoming more widely used, however definitions of this may sometimes vary. Mental toughness describes the capacity of an individual to deal effectively with stressors, pressures and challenges, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough *et al*., 2002). As already noted mental toughness is often known as a trait that individuals either do or don't have, however it is believed that mental toughness can be taught to individuals from a wide variety of backgrounds. The 4C's model suggests that overall mental toughness is a product of four key factors. This includes seeing ***challenge*** as an opportunity, having high levels of self-belief and ***confidence***, being ***committed*** to and being able to stick to tasks and believing that you ***control*** your own destiny (Strycharczyk and Clough, 2015). Individuals who have high mental toughness, often have different characteristics to those who are not mentally tough. Those who are mentally tough often have a strong sense of self-belief and coping ability, as well as being able to pay attention to the right things at the right time (Gordon, 2012). Mental toughness has been researched and measured and found to be successful in many areas including sport, business, education and health (Strycharczyk and Clough, 2015). There is a strong interest in mental toughness as it may improve performance. Therefore, it is becoming highly desirable to develop this area.

The research that has investigated mental toughness in health, currently focuses its attention to areas such as addictions, obesity, fitness and patient behaviour. No current study has explored mental toughness in mental health staff. Whether learning mental toughness strategies could change mental health staff self-rated mental toughness and/or burnout has not been explored. This section will go on to discuss briefly the mental toughness literature from other disciplines, followed by a look at the limited literature exploring mental toughness and mental health. This will then be followed by a discussion on why using mental toughness coaching strategies with mental health staff may be a good idea in terms of improving burnout rates and mental toughness.

The majority of research focuses on mental toughness in sport performance (Crust, 2008). Although earlier mental toughness research in areas such as sport, may not seem completely relevant to mental toughness in mental health staff, many of the underlying principles and ideas of mental toughness seem to fit with this population. In the early perspectives of mental toughness, Loehr (1982) suggested that those who can use energy positively during times of crises and pressure and during challenging and demanding situations, are able to have positive attitudes, which reflects mental toughness. Therefore, similarly to areas such as sport where being able to deal with pressure and challenge productively and positively is an advantage, being able to deal well in these situations when working in the mental health sector may also be beneficial. However, using the term positive energy is very broad and this definition of mental toughness is seen by some as outdated (Crust, 2008.). Another perspective includes that mental toughness may be partially due to genetics (Golby and Sheard, 2004). However, the more favoured definitions now consider mental toughness as a personality trait. In earlier literature, personality has often been divided into several traits, with Catell *et al*. (1957) suggesting that personality consists of 16 different traits, one of this being tough-mindedness. This personality trait was defined by Catell *et al*. (1957) as being the opposite of being emotionally sensitive and was described as being independent, self-reliant and realistic. These ideas were first put forward before research into mental toughness developed. However, this general concept of what mental toughness might be is supported by new perspectives and research. Clough *et al*. (2002) defines mental toughness to be a 'personality trait which determines in large part how people deal effectively with challenge, stressors and pressure…irrespective of circumstances.' This definition and perspective has been chosen as the definition when discussing mental toughness throughout this thesis.

Both quantitative and qualitative research has been carried out to develop a clearer understanding of mental toughness and how this concept may be developed. In a notable qualitative study by Jones *et al*. (2002), they used interviews and focus groups with elite athletes, to gather detailed information on

the qualities they considered a mentally tough individual to have. They also gathered information from coaches and sport psychologists to gain their perspective. With this research, 12 key attributes of mental toughness were developed by the researchers with the participants they interviewed and these were ranked in order of importance.

These included in order of importance:

(1) Having an unshakable self-belief in your ability to achieve your competition goals.

(2) Bouncing back from performance set-backs as a result of increased determination to succeed.

(3) Having an unshakable self-belief that you possess unique qualities and abilities that make you better than your opponents.

(4) Having an insatiable desire and internalized motives to succeed.

(5) Remaining fully focused on the task at hand in the face of competition-specific distractions.

(6) Regaining psychological control following unexpected uncontrollable events.

(7) Pushing back at the boundaries of physical and emotional pain, while still maintaining technique and effort under distress in training and competition.

(8) Accepting that competition anxiety is inevitable and knowing that you can cope with it.

(9) Not being adversely affected by others' good and bad performances.

(10) Thriving on the pressure of competition.

(11) Remaining fully-focused in the face of personal life distractions.

(12) Switching a focus on and off as required.

(Jones *et al*., 2002)

Although the above mental toughness attributes as identified by Jones *et al*. (2002) in some cases clearly represent athletes and those in the area of sport, many of the attributes could be considered as being able to relate to a wider variety of individuals (Strycharczyk and Clough, 2015). Jones *et al*. (2002) also suggest that mental toughness may be a trait that could be developed through psychological interventions. They also found that an individual's mental toughness was not only due to the sport, however was also based on interactions in their personal life. Clough *et al*. (2016) described the results of a pilot exercise in a UK school, aimed at enhancing the components of mental toughness. Students completed a measure of mental toughness and took part in six lessons which lasted one hour each and focussed on mental toughness. Each started by describing data from the mental toughness questionnaire and explaining the focus of the upcoming session. Lessons covered goal setting, imagery, self-talk, reframing, and relaxation skills. Following the final lesson, students again completed a measure of mental toughness. There was a clear upward trend in all aspects of mental toughness. Although further work is needed to establish the underpinning and generalisability of the observed improvements in mental toughness, these findings add to the growing evidence of the potential for improving mental toughness. The importance of this literature is that there are suggestions that mental toughness consists of key attributes that may be able to be developed through training.

Although earlier mental toughness research in areas such as sport, may not seem completely relevant to mental toughness in mental health staff, many of the underlying principles and ideas of mental toughness seem to fit with this population and these shall be explored in this next section. Mental toughness has not specifically been investigated in mental health staff, however mental toughness has been researched and found to mitigate the relationship between high stress and depressive symptoms (Gerber, Brand *et al*., 2013; Gerber, Kalak *et al*., 2013). High mental toughness has also been found to be associated with

lower symptoms of burnout and decreased levels of life stress (Gerber *et al*., 2015). In a longitudinal study, 54 Swiss vocational students completed self-report questionnaires twice, ten months apart. Perceived stress, mental toughness, and burnout were measured. Those with higher mental toughness remained below the cut-off for mild burnout, whereas an increase in burnout symptoms was observable among students with low mental toughness (Gerber *et al*., 2015). This study supports the notion that the mental toughness of an individual could be directly linked to the perceived levels of burnout in that individual. Therefore, it supports the idea that developing an individual's mental toughness could improve self-reported burnout. Limitations of this research are acknowledged, including that the sample contained a small sample size of 54 students. The participants were also only vocational students and therefore whether the findings generalise to other populations such as mental health staff are unclear. In addition, the 18 item short form of the MTQ48 was used to assess mental toughness. Therefore, the study was unable to examine the impact of specific dimensions of mental toughness, that the MTQ48 which contains 48 questions might have done, which might have provided additional insights into explaining burnout.

2.7 Mental toughness coaching strategies

Mental toughness can be developed by using coaching strategies that may be able to improve areas such as performance, resilience and wellbeing (Strycharczyk and Clough, 2015). The development of mental toughness may be achievable through the coaching or training of techniques, sometimes referred to as mental skills training or psychological skills training. These techniques include, positive thinking, visualisation, relaxation and anxiety control, attentional control and goal-setting. This next section will briefly discuss some of these techniques, along with the possible use of these in training focussing on the mental toughness and burnout of mental health staff.

2.7.1 Positive Thinking

The development of positive thinking is used in many areas such as cognitive behaviour therapy, positive psychology and sport coaching (Fredrickson, 2001; Seligman and Csikszentmihaly, 2000). According to Strycharczyk and Clough (2015) the techniques for training in positive thinking include helping an individual to think positively, being able to discard negative thoughts and reframe negative thoughts into positive thoughts. The benefits of positive thinking include that individuals who think positively often perceive stress as less of a problem and less threatening, allowing them to cope more effectively and maintain better wellbeing (Naseem and Khalid, 2010). According to Carver and Scheier (1998), those who adopt positive thinking are able to cope effectively with stressful situations, by appraising the situation as controllable. Positive thinkers can also use problem-solving skills and remain optimistic in the face of difficult situations or pressure. A meta-analysis showed that work performance, perception of self and others, coping, wellbeing and health, all displayed benefits from positive thinking (Lyubomirsky and King, 2005).

Mindfulness is also a technique that Strycharczyk and Clough (2015) discuss as part of the potential techniques to use for positive thinking. However, they do recognise that mindfulness could be used as part of attentional control, anxiety control and visualisation. Mindfulness can be defined as paying attention in a non-judgemental manner to the present moment (Kabat-Zinn, 2003). Mindfulness practice supports the development of challenge, confidence, commitment and control, the 4C's of mental toughness (Strycharczyk and Clough, 2015). Mindfulness may allow individuals to improve focus and hence impact on the control element of mental toughness. It may also be able to manage difficult thoughts, feelings and emotions (Strycharczyk and Clough, 2015). Shapiro *et al*. (2005) recommend mindfulness training to improve perceived stress, quality of life and self-compassion. They found improvements in these areas after health care professionals received this training. Therefore,

mindfulness as a technique may be beneficial for both burnout and mental toughness in individuals. Mindfulness could be important to consider when developing a training package for mental health staff for their wellbeing.

Mindfulness has a growing evidence base demonstrating its efficacy for mental health service-users (Hofmann *et al*., 2010; Khoury *et al*., 2013). However, it has also been studied to evaluate its usefulness for mental health staff. Mindfulness has been used in studies as part of retreat programmes for mental health staff to reduce burnout (Salyers *et al*., 2011; Razzaque and Wood, 2016). One of these studies used only mindfulness techniques over a two-day retreat for 22 psychiatrists, 2 middle grade doctors and 2 trainees (Razzaque and Wood, 2016). The activities included mindfulness exercises such as meditation and mindful walking. Results demonstrated a significant positive impact on perceived burnout following the mindfulness retreat. The decrease in burnout was also found at the one week follow up. However, which dimensions of burnout improved were not specified. In comparison, Salyers *et al*. (2011) carried out a one-day retreat with 84 mental health staff and the training included mindfulness and meditation, along with other areas such as education on the principles of burnout prevention. The training encouraged participants to learn relapse prevention for burnout, by developing a toolkit which consisted of identifying burnout signs and triggers, as well as techniques to prevent burnout. With this information, participants were encouraged to create a burnout prevention plan. Of the 74 participants that completed the follow up, burnout was found to reduce in the components of emotional exhaustion and depersonalisation. Participants also displayed higher levels of optimism for service-users at the follow up compared to baseline. Both studies used the Maslach Burnout Inventory to measure changes in burnout. The follow up of the mindfulness training was at one week (Razzaque and Wood, 2016) and six weeks (Salyers *et al*., 2011) and can be criticised for having a short follow up, which makes it difficult to evaluate the long-term effectiveness of the training. Razzaque and Wood (2016) study had a

small sample size and both studies were limited by the study design lacking a control group. However, the sample size was justified by the researchers as the training was part of a pilot study. The sample self-selected to take part in the retreat which meant that participants are likely to have had some knowledge of mindfulness and therefore are not representative of mental health professionals as a whole. In addition, it cannot be reliably determined that the improvements in scores were solely caused by the retreat itself. It is likely that having time away from work may also have had some benefit.

2.7.2 Visualisation

Closely linked to positive thinking is the technique of visualisation. Visualisation involves being able to actively create a positive scenario or outcome of a situation as a mental image (Isaac and Marks, 1994; Wood, 1993; Pham and Taylor, 1999; Crust and Azadi, 2010) Visualisation involves focussing on positive feelings during the scenario that they imagine (Wood, 1993; Pham and Taylor, 1999; Evans *et al*., 2004). The scenario should be as near to the real life situation as possible and similarly to positive thinking, negative thoughts should be reframed with positive thoughts (Strycharczyk and Clough, 2015). When exploring the use of visualisation techniques with undergraduate students, raising and maintaining positive mood was found to be possible. This was through the students visualising themselves as the best possible selves (Sheldon and Lyubomirsky, 2006). It also appears important that these techniques need to be used and practiced regularly for them to be effective (Sheldon and Lyubomirsky, 2006). Therefore, it may be important to encourage regular practice of such techniques in a training programme for mental health staff. In addition to this, the consideration of refresher or follow up sessions, in order in maintain the effectiveness of the techniques may be beneficial.

2.7.3 Relaxation and anxiety control

Relaxation techniques to control anxiety may be beneficial to an individual's mental toughness. The 4C's model of mental toughness links to anxiety, as feelings of worry, fear, or anxiety can often have a negative impact on confidence levels, life control, emotional control and how challenge is perceived (Strycharczyk and Clough, 2015). According to Strycharczyk and Clough (2015) anxiety control involves developing skills to cope with situations that are uncontrollable. They suggest that controlling anxiety may be possible through developing relaxation techniques, controlled breathing and controlled distraction. The use of relaxation has been found to be a useful psychological skill to improve mental toughness in athletes from a variety of sports at club/university level. Relaxation was one of the eight techniques that had the largest impact on mental toughness and performance (Crust and Azadi, 2010). It is suggested that peak performances are more likely to be achieved through the use of such techniques (Williams and Krane, 2001). Currently no research has displayed the impact of anxiety control through relaxation on mental toughness in mental health staff. However, relaxation techniques have been found to be beneficial in improving burnout in mental health staff (van Dierendonck *et al*., 1998).

2.7.4 Attentional control and goal setting

While relaxation may be a useful technique to control anxiety, in order to do this effectively, focus and control is required. Focus is an important factor when considering mental toughness. Mentally tough individuals tend to have a good level of attentional control. Attentional control refers to the underlying principle that focus, sustained attention and concentration, enables us to work better and for longer (Strycharczyk and Clough, 2015). Attentional control can be explained through the 4C's model of mental toughness. Individuals that can focus under

pressure and challenge, can control their focus, achieve success and improve confidence, as well as be committed to where their attention should be, in order to achieve their goal, are more likely to be mentally tough (Strycharczyk and Clough, 2015). Although practising to concentrate may not always be effective at improving attention, the more an individual practises a task, the easier it becomes. Therefore, there are less attentional demands and less control is required. A useful technique for improving concentration and attention is goal setting. Focussing attention on an outcome or end result of a task is more beneficial than focussing attention on to specific components of a task, as a greater demand on attentional resources is required to do this, often leading to error (Marchant *et al*., 2007). Goal setting may also be useful in improving performance by not only encouraging an individual to focus but also to put effort into a task, be persistent and learn new strategies (Locke *et al*., 2002). In additional to goal setting, other useful techniques and skills for improving focus include practise, routines, reducing distractions, reducing stress and taking breaks. However, more specific tools that can be used to learn to have better attention are number grids, the stroop test and a variety of games, including computer games (Strycharczyk and Clough, 2015).

It is worth noting that based on the literature already discussed, goal setting may also be useful in improving burnout in mental health staff, as interventions such as clinical supervision, which often involve group goal setting can be beneficial in reducing burnout in this setting (Edwards *et al*., 2006).

2.7.5 Using the mental toughness literature for developing the wellbeing training

Factors such as levels of mental toughness and stress may affect performance and there appears a link between developing mental toughness and performance (Clough *et al*., 2012). When individuals are performing well, individuals tend to have better wellbeing. Similarly, when an individual has better wellbeing they tend to perform better. It is noted that an individual's

state of mind can account for at least 50% of the variation in performance levels. However, individuals tend to only focus around 5% of their time actively trying to improve or optimize their performance through mental training (Clough *et al*., 2012). Therefore, the literature suggests that improving wellbeing by using mental toughness coaching training, may be useful in improving both the wellbeing of an individual as well as their performance. Mental toughness coaching strategies including positive thinking, visualisation, relaxation and anxiety control, attentional control and goal setting can be used to develop mental toughness (Strycharczyk and Clough, 2015). In addition, having higher mental toughness could be linked with lower levels of burnout (Gerber *et al*., 2015). Therefore, wellbeing training that includes using mental toughness coaching strategies with mental health staff, could be beneficial to focus on developing their mental toughness and reducing burnout.

2.8 Summary and discussion of the literature review

This chapter has successfully met objective 1 of this thesis which was:

1. To highlight any gaps in the current knowledge base surrounding training and interventions for mental health staff wellbeing.

It has done this by presenting the existing literature around training and interventions to improve burnout in mental health staff, as well as the mental toughness literature and how this may be used with mental health staff. By doing this it has highlighted gaps in the current knowledge that will now be discussed.

The literature review explored the current knowledge base for burnout in mental health professionals and the literature regarding mental toughness coaching. Essentially, it seeked to explore what was known about existing interventions to improve burnout and mental toughness in mental health staff.

The evidence from previously published theoretical and empirical papers identified certain factors that appear important to consider when developing a

training programme for the wellbeing of mental health staff. Previous interventions with mental health staff have included, psychosocial interventions (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011) clinical supervision (Hyrkas, 2005; Edwards *et al*., 2006) and social support (Jenkins and Elliot, 2004).

The more successful interventions tended to involve multiple interventions and varied techniques (Morse *et al*., 2012). However, the literature highlighted the lack of existing training for mental health staff that focusses on their own wellbeing and how to improve this. It identified that past research has strongly focused on teaching staff new ways of working with service-users as a way of improving their wellbeing rather than training that is centred around the actual staff and putting how they feel at the core of the training.

The literature review also identified that interventions and training to reduce mental health staff burnout can be effective from as little as a one day retreat (Salyers *et al*., 2011). It also emphasised the importance of these interventions been based on staff opinions and consultation (Coates *et al*., 2015). Evidence shows that initiatives adapted to the needs and preferences of individual clinical services and staff are more effective (Coffey *et al*., 2004; McCray *et al*., 2008).

The mental toughness research suggested that mental toughness can be developed and that this is possible through the learning of psychological skills training/mental toughness coaching strategies (Strycharczyk and Clough, 2015). Techniques include visualisation, positive thinking, attentional control, goal-setting, anxiety control and relaxation (Strycharczyk and Clough, 2015). Mental toughness has primarily been researched in other areas such as sport and education and currently using these techniques with mental health staff has not been explored.

Most interestingly the review identified that mental toughness has also been found to be associated with lower symptoms of burnout (Gerber *et al*., 2015). Mental toughness had also been researched and found to act as a stress buffer in

adolescents and students (Gerber, Brand *et al*., 2013; Gerber, Kalak *et al*., 2013). Therefore, suggesting that mental toughness could be directly linked to perceived levels of burnout. With the literature suggesting that mental toughness can be developed through mental toughness coaching strategies and that mental toughness could be associated with lower levels of perceived burnout in an individual, this offered interesting information for developing a training package for mental health staff.

In summary, the literature review provided a clearer understanding about the training and interventions that existed to improve the wellbeing of mental health staff, particularly to reduce burnout. It offered interesting insight into the concept of mental toughness and why developing this could be beneficial. It identified the potential link between burnout and mental toughness in individuals and highlighted a gap in the current knowledge base, specifically with regards to mental health staff training needs and the potential link between mental toughness and burnout in this population. This thesis has intended to help bridge this gap of knowledge and has explored using mental toughness coaching strategies with mental health staff as a way of focussing on their wellbeing, in terms of their mental toughness and burnout.

CHAPTER 3

METHODOLOGY

3.1 Introduction

In this chapter the methodology of the research is outlined. This includes setting out the underlying assumptions that guided the research process as well as detailing what was done and why. This research is embedded in a pragmatic paradigm and has used mixed methods and these are described in chapter 4 and 7 in detail. This chapter however aims to explain why these were used and how this fits with my beliefs. Social sciences research is underpinned by philosophical assumptions about the world and these worldviews are explained in this chapter, along with an explanation to the chosen pragmatic paradigm.

The research paradigm or worldview is an important set of beliefs about how problems should be understood and addressed (Crotty, 1998). The term paradigm is a difficult concept to agree a definition on, instead it is suggested that it is perhaps better to think in terms of worldview (Creswell and Plano Clark, 2007). These research worldviews are usually characterised through their ontology, epistemology and methodology (Crotty, 1998). The terms often used in research and the relationship between them can be seen in figure 3.1.

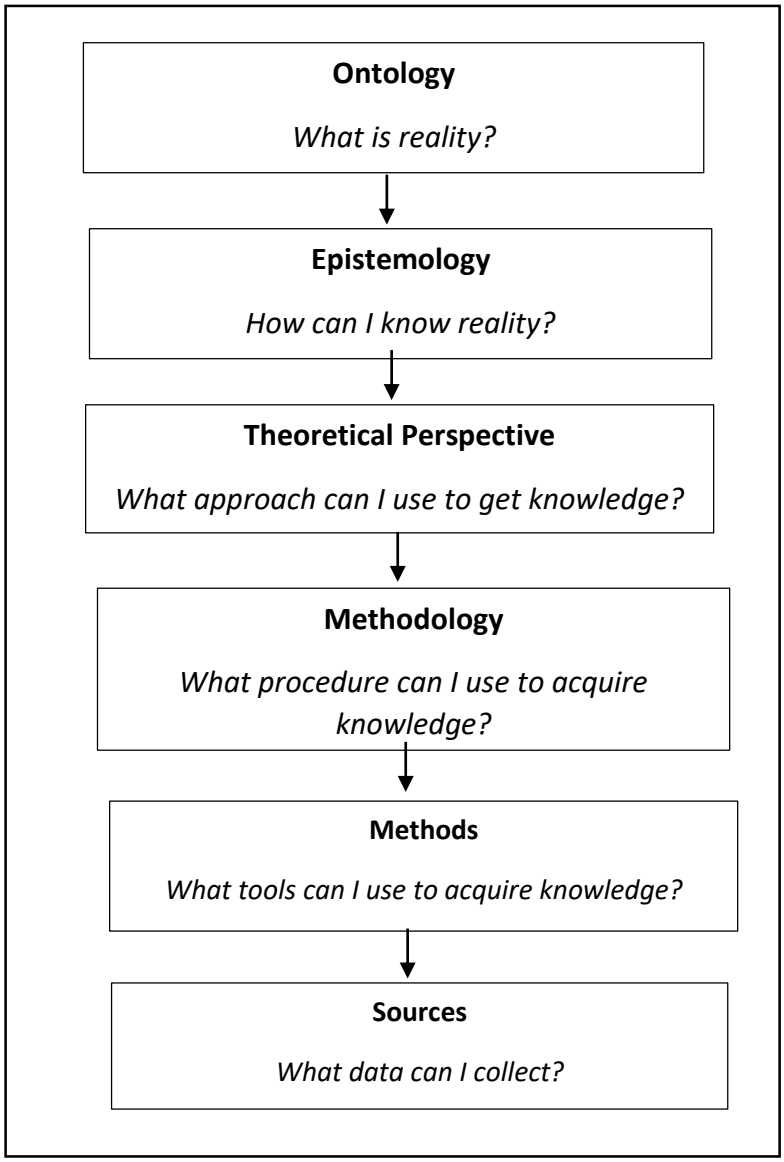


Figure 3.1: Ontology, epistemology, theoretical perspective, methodology, methods and sources-what these mean and the relationship between them (adapted from Crotty, 1998).

3.2 Positivists and Interpretivist Worldviews

The two major worldviews which have influenced much of the social research is positivism and interpretivism. Distinctions are often made and compared with

these two research philosophies (Bryman and Bell, 2007). The ontology of positivists is that there is one single, objective reality (Bryman, 1988). This positivist philosophy tends to be based on deductive theorising with empirical verification (Babbie, 2005). The epistemology of positivists is that reality can be known by observing and measuring and therefore are more likely to use quantitative methods to measure this reality (table 3.1). With quantitative methods, large amounts of data are often required and social phenomena is viewed objectively (Hughes and Sharrock, 1997). The overarching aim of quantitative research is to classify features, count them, and construct statistical models in an attempt to explain what is observed (Babbie, 2010).

In contrast to the positivists is the interpretivist paradigm. The interpretivist paradigm offers an opposing ontology to positivists, in that interpretivism suggest that there is no single reality, instead reality is based on an individual's perspective and this can be influenced by many factors, such as social and cultural norms and values (Houghton *et al*., 2012). A mixture of these factors can influence an individual's interpretation and account of an experience or situation. The interpretivist philosophy tends to be based on inductive reasoning and is based on this individual experience. The epistemology of interpretivists is that reality can be known by more than just measuring and empirical verification. While a conclusion of a deductive argument is often certain, interpretivists instead adopts a method of reasoning which is seen as supplying some evidence for the truth of the conclusion, rather than broader generalisations. Therefore, by observing factors of the social world, patterns that could explain wider principles might be found (Babbie, 2005).

3.3 The pragmatic worldview

A pragmatic worldview is driven by actions, situations and consequences (Creswell, 2014). Using this approach, the aim is to outline all available methods and use any method which works best, in order to find solutions and ultimately

find out what works (Patton, 1990). Pragmatists believe that reality is constantly renegotiated, debated, interpreted, and therefore the best method to use is the one that solves the problem (Creswell, 2014). Pragmatism is a deconstructive paradigm that advocates the use of mixed methods in research and sidesteps the contentious issues of truth and reality (Feilzer, 2010). It focuses instead on 'what works' as the truth regarding the research questions under investigation (Tashakkori and Teddlie, 2003). Therefore, researchers with a pragmatic worldview will often use a mixture of approaches including both qualitative and quantitative methods (Creswell, 2014).

Table 3.1: Positivism, interpretivism and pragmatism worldviews (adapted from Crotty, 1998).

Worldview	**Ontology**	**Epistemology**	**Methodology**	**Method**
Positivism	There is a single reality or truth	Reality can be measured using reliable and valid tools	e.g. -Experimental research -Survey research	Usually quantitative could include: Questionnaire Surveys
Interpretivism	Multiple realities	Reality needs to be interpreted to understand the underlying meaning of events and activities	e.g.- Ethnography -Phenomenological research -Grounded Theory	Usually qualitative could include: Qualitative interview Observation Case study
Pragmatism	Reality is constantly renegotiated and debated and interpreted	Practically collecting, analysing and integrating together whatever forms of data necessary to answer the research questions	e.g. -Design based research -Participatory action Research	A combination of any of the above usually mixed methods with quantitative and qualitative methods.

3.4 Pragmatic worldview and mixed methods as applied to this research

The components of ontology, epistemology, methodology and methods are philosophically determined and therefore vary depending on the worldview of the researcher. Each of these play a role in the design and implementation of research as they decide what and how we can know the social world (Creswell and Plano Clark, 2007). In this section each of these components are described in regards to the research process of this thesis.

I entered into this research as a person who had experienced and seen the need for mental health staff to improve their wellbeing. I had beliefs that in order for mental health staff to truly work effectively and overall look after the service-users to the best of their ability, that their own wellbeing needed to be looked after. It was this experience and these beliefs that was the underlying motivation for the choice of research topic that developed into this thesis. As a researcher I hold my own philosophical beliefs about the world and the nature of research. These philosophical beliefs are formed by my own life experience, my opinions on the world and my previous research. In essence my beliefs about research are already 'in built' based on my own experiences (Creswell, 2014).

As a researcher I identify myself with the pragmatic worldview and believe that this may be due to my professional background. As an occupational therapist that has worked in a variety of mental health settings, this often leads itself to a view that the world is often not completely clear cut and that being open to using methods and approaches that work best, at a particular time, for a particular purpose, or person, is often the best approach to take.

When considering the ontology of this thesis, I was at first torn between my view on reality. On one side I was from a quantitative research background. However, I believed through my professional background that there are often multiple realities which are individual and this is important to explore.

Epistemology asks how reality can be known and in social sciences this is often related to the objective versus subjective nature of reality (Crotty, 1998). However, as a researcher I recognise the value in using different but complimentary strategies to answer research questions. I identify through this thesis with the pragmatic worldview which puts aside ontological and epistemological debate about what and how we can understand social phenomena and the world. Instead I support Tashakkori and Teddlie (2003) pragmatism definition that 'debunks concepts such as truth and reality and focusses instead on what works as the truth regarding the research question under investigation'.

The research aim, which was to explore the experience of mental health staff of participating in a mental toughness training package, focussed on findings ways to help with their wellbeing, was placed at the centre of this research. This aim was the main focus and the ontological and epistemological debate about the position of reality and knowledge was not seen as central to this research. This was in line with pragmatism and not being focussed so strongly on truth and reality (Tashakkori and Teddlie, 2003). There is dispute that positivists and interpretivists paradigms are not always clear cut and that there should be openness to the idea that these paradigms are often not perfectly distinct and can be blurred (Teddlie and Tashakkori, 2009). This is in line with my beliefs and therefore this is reflected in my choice of a pragmatism for this research. Pragmatism allows for mixed methods and for whatever epistemological and methodological approach to be implemented in order to best answer the research aim or question (Hanson *et al*., 2005).

Methodology refers to the philosophy underlying the research and its design. Methods refers to the specific techniques and tools used for data collection. The next section will outline the justification for methodological pragmatism for this research and why other methodologies were considered but not used for this particular research.

3.5 Methodology considerations

I did consider the different worldviews to which my research would fit best, as well as different methodologies that could be used. This included realist evaluation, ethnography, phenomenology, grounded theory, case study approach and action research. I considered realist evaluation (Pawson and Tilley, 2004). However, the focus here is on evaluating the intervention and I realised that I wanted to explore the experience of mental health staff in wellbeing training focussing on their mental toughness and burnout rather than evaluating the intervention. Realist evaluation does not just look at if an intervention works, it explores what works for whom, under what circumstances and how. Theories are placed before the interviewee for them to comment on with a view to providing refinement. The subject matter of the interview is the researcher's theory and interviewees are there to confirm, falsify and basically, refine the theory (Pawson and Tilley, 2004). I considered if my research could ask the staff if they agree with the theory that improving their mental toughness reduced their burnout and evaluate what mechanisms helped this to occur. However, the focus here is on evaluating the intervention and this was not the main aim of my research.

Ethnography as a methodology is a study of and often observations of groups and communities, to study social interactions and behaviours (Mackenzie, 1994). This methodology did not fit with my research as it would not have explored the thesis aim. It did not fit with my beliefs of using any methods which best explores the aim. The core aim of ethnography is to provide a rich, holistic and a deep understanding of interactions and peoples perspective and behaviour in the environment and world they live in (Larsen, 2007). The methods used are usually qualitative in nature and include observations and interviews. However, I did not feel that these methods alone would help explore my aim.

The methodology of phenomenology has the aim of describing a lived experience rather than to explain or quantify it in any way (Giorgi, 2012). Questionnaires such as the MTQ48 and MBI-HSS used in this research, would be seen as too

structured and not allowing for participants to share openly and freely, which is key in phenomenology. Due to being a pragmatist I used these methods in my research as I believed they helped to explore the thesis aim in more detail. Phenomenology is concerned with the study of the experience from the perspective of the participants and has a strong emphasis on subjectivity. The methods may include open interviews (Moustakas, 1994). For all of these reasons, this methodology was not appropriate for this thesis.

Grounded theory is a methodology that attempts to develop adequate theoretical conceptualisations of findings (Strauss and Corbin, 1990). Grounded theory methodology has been viewed by some as a positivist methodology (Charmaz, 2006; Age, 2011), whereas others have considered it to be an interpretive methodology (Goulding, 1998). When considering ground theory as a possible methodology for this thesis, this was from a positivist stance. Grounded theory would not have been appropriate as I was not trying to develop a theory from the data. Instead I already had some ideas and theories relating to my research aim based on previous literature and was focussed on exploring this gap of knowledge, rather than developing new theories. Whereas with grounded theory, a researcher starts with no pre-existing theory, expectation or hypotheses of the findings, instead it is centred around a theory that emerges directly from the data, that is the theory is grounded in the data (Strauss and Corbin, 1990). In grounded theory, the researcher uses multiple stages of collecting, refining, and categorizing the data. Therefore, these stages and the process of grounded theory did not fit with this thesis.

A case study methodology approach was also considered for this research. In particular research that would contain multiple case studies rather than just a single case study. Case studies were considered as a way of exploring the research problem of staff wellbeing in a way that was in-depth and could provide a better understanding of real life scenario (Yin, 2014). However, when this was considered I felt that the research became quite narrow and was not all encompassing of the aim. In comparison by being more pragmatic, I realised I

would be able to choose mixed methods, that would be best to explore the research aim. In addition, I felt that even with multiple case studies, fewer mental health staff would be involved in this research. I believed it was appropriate for mental health staff from a variety of roles and professions, across different services, to be invited to the research, as this would best help me to explore the aim. Abu-Zidan *et al*. (2012) suggest that a case series should have more than four participants while four participants or less should be reported individually as case reports.

When I had confirmed that my beliefs fit within pragmatism, I considered other methodologies that may be used such as participatory action research. Participatory action research is an empirical and reflective process, by which traditional research participants are engaged in a participative fashion, to work towards positive and practical outcomes (Stringer, 1999). However, this research did not positon itself in a way that would allow for the research cycle involved in action research. Susman (1983) distinguishes five phases to be conducted within each research cycle. Initially, a problem is identified and data is collected for a more detailed diagnosis. This is followed by a collective postulation of several possible solutions, from which a single plan of action emerges and is implemented. Data on the results of the intervention are collected and analyzed, and the findings are interpreted in light of how successful the action has been. At this point, the problem can be reassessed and if needed the process begins another cycle. I felt that action research may have been appropriate if the research involved designing an intervention and changing this in a cyclical manner based on participant's feedback. However, I kept my research aim at the core and believed that this methodology would have changed my research aim and therefore was not selected as the methodology. The next section outlines what motivates the methodological and research design choices of this thesis.

3.6 Motivation behind the research design

A strategy that utilizes multiple data types offers the best opportunity to answer the research aim being explored in this thesis. There are some criticisms from methodological purists that by combining different methods and data types is philosophically incoherent (Johnson and Onwuegbuzie, 2004). However, this research was based on the view that social research does not operate in isolation from the world it seeks to understand, instead the research process and its outcomes are shaped by the problems it seeks to answer (Tashakkori and Teddlie 2003). This is what motivates the methodological and research design choices of this research.

Effective mixed methods research involves making purposeful and logical decisions about what types of data and analysis techniques will be most appropriate for answering the research question or aim (Creswell, 2009). As stated in Chapter 1, the general aim of the thesis was:

To explore the experience of mental health staff in wellbeing training focussed on their mental toughness and burnout.

In order to do this the four main objectives were:

1. To highlight any gaps in the current knowledge base surrounding training and interventions for mental health staff wellbeing.
2. To develop an understanding of what techniques and strategies mental health staff think could improve their wellbeing.
3. To develop and implement staff wellbeing training informed by literature and mental health staff ideas.
4. To explore mental health staff's views on their participation in the training and to use measurement tools to measure the mental toughness and burnout of these staff.

3.7 The convergent parallel mixed methods design

Mixed methods allows for strengths from both a quantitative and qualitative approach to be gained and at the same time helps minimise the weaknesses of either approach on its own (Johnson and Onwuegbuzie, 2004). In order to explore the experience of mental health staff of participating in wellbeing training focussed on their mental toughness and burnout, this study applied the principles of convergent parallel mixed methods design.

This study involves the simultaneous and independent collection and analysis of two strands of data. This is made up of the quantitative data derived from the outcome measures (MTQ48 and MBI-HSS) and the qualitative semi-structured interviews. In the analysis stage the results are compared and contrasted in order to look for patterns or contradictions (Creswell and Plano Clark, 2011). Interpretations can then be made based on these findings by comparing or combining results from both methods (figure 3.2). The rationale behind using a convergent parallel mixed method design, is that it provides a design that helps to generate a better understanding of a research topic, by using different but complimentary data on the same topic (Creswell and Plano Clark, 2011).

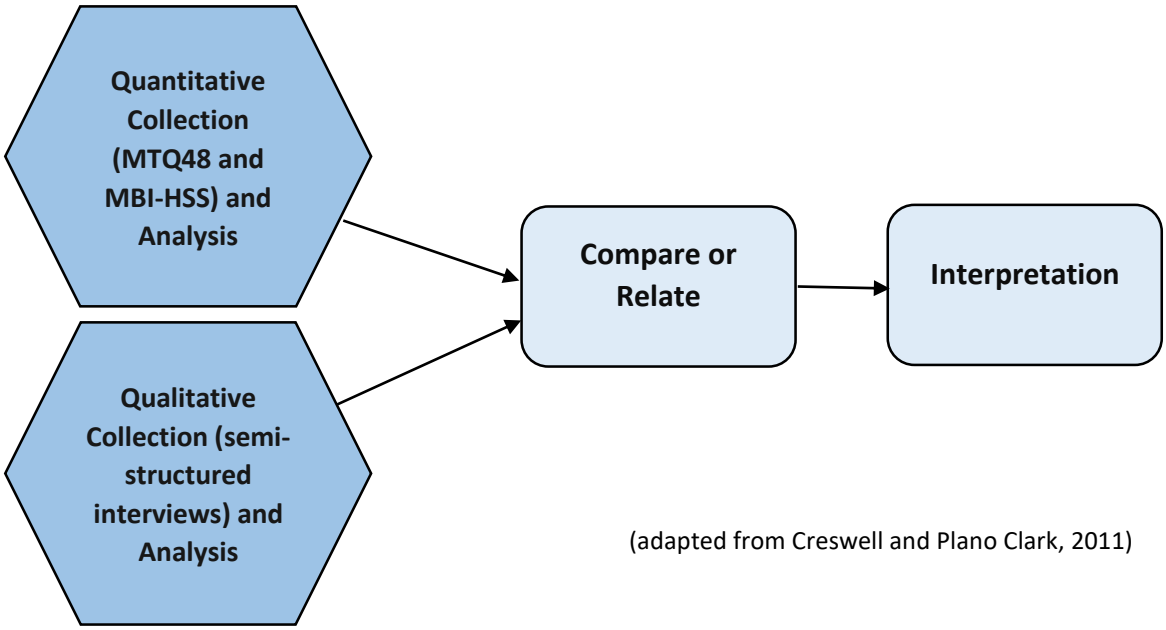


Figure 3.2: Convergent Parallel Mixed Method Design.

Effective mixed methods research involves selecting the most purposeful and appropriate types of data and analysis techniques that will best answer the research question (Creswell, 2009). For this research, quantitative methods (the MTQ48 and MBI-HSS outcome measures) and qualitative methods (semi-structured interviews) were used for data collection (see Chapter 7 for more information). Through the analysis it was decided on the weighting given to these methods to see how best to explore the aim.

The analysis of the quantitative data involved using descriptive statistics to see if any patterns were found from the outcome measures. The qualitative analysis involved using thematic analysis to help explore the interviews. The rationale behind this chosen qualitative analysis was that thematic analysis is a method for identifying, analysing, and reporting patterns (themes) from data which can provide trustworthy and insightful results (Braun and Clarke, 2006). This helped to explore the experience of mental health staff of participating in the wellbeing training. Attride-Stirling (2001) analytic steps for thematic analysis (see chapter 7, section 7.5) was followed as a guide, alongside the software NVivo to find themes and analyse the transcipts from the interviews. Codes can be pre-set or emerge from the data (Taylor and Bogdan, 1998). These initial codes stem from prior knowkdge the researcher has of the research area and questions. Emergent codes are those that simply emerge from reading and analysing the transcripts and are not pre-set (Taylor and Bogdan, 1998). In this thesis codes emerged from the data and a list of pre-set codes were not used. These codes were stored in a code book to display the list of codes that emerged and what they mean (appendix 21 and 22).

However, I acknowledge by being reflexive to this process that although codes were not pre-set, that my own initial thoughts, ideas and knowledge on the topic area could influence the coding process, as these preconceived ideas may have influenced how I interpreted the data. In order to try and minimise this, a

research supervisor also coded the initial transcipts in order to compare codes and see if similiar codes emerged from two different researchers. Transcripts were coded using this guide and codes were revisted multiple times in order to refine these codes. Time was spent exploring how core codes and themes might overlap by using the code book, in order to create codes and themes that were transparent in the research. Attride and Sterling (2001) provide a descriptive yet flexible approach to thematic analysis, which has been used as a guide to analyse the themes resulting from the interviews. This is in line with my beliefs of using the best approach to measure and analyse data to explore the research aim.

3.8 Outcome Measures for measuring Burnout and Mental toughness

This next part of the chapter will briefly discuss the literature on burnout and mental toughness outcome measures as a way of providing a rationale for the choice of ouctome measures used in this thesis. It is important to explore this literature in order to help select the most appropriate outcome measures for this research.

3.8.1 Burnout Outcome Measures

It is vital that burnout outcome measures are reliable and valid instruments, in terms of both data collection and also for the individual involved. Several burnout measures exist and this next section will review some of these with the purpose of providing a rationale for the outcomes measures used in this thesis.

Arguably the most frequently used outcome measure for assessing burnout is the *Maslach burnout Inventory Human Service survey (MBI-HSS)* (Maslach and Jackson, 1981). Around 90% of burnout studies use this as the main outcome measure of burnout (Shirom *et al*., 2006). This outcome measure is mostly used with professionals who work with individuals in some capacity, this includes all health care professionals. The assessment originally measured emotional

exhaustion, depersonalisation, personal accomplishment and involvement (Maslach and Jackson, 1981). However, the involvement dimension is no longer included (Maslach *et al*., 1996). Research supports the reliability and validity of the MBI-HSS (Maslach *et al*., 1996, Schaufeli *et al*., 2001). Maslach *et al*. (1996) reported internal consistency estimate of reliability of 0.90 for emotional exhaustion, 0.79 for depersonalisation and 0.71 for personal accomplishment. Therefore, the three dimensions on this outcome measure, which propose to measure burnout, produce similar scores (Maslach *et al*., 1996).

The second most widely used outcome measure to assess burnout is the *Burnout Measure (BM)* (Pines *et al*., 1981). The BM is used in around 5% of the burnout studies. Compared to the MBI-HSS which has three dimensions of burnout, the BM only has only one dimension of burnout, known as exhaustion. Similarly, to the MBI-HSS, the BM is an internally consistent measure to assess burnout. The MBI-HSS subscales of emotional exhaustion and depersonalisation are able to discriminate between individuals with burnout and those who are not experiencing this and make a useful tool for assessing differences in burnout compared to the BM (Schaufeli *et al*., 2001). The MBI-HSS sensitivity is also superior to that of the BM, in that it correctly identifies clinical burnout (Schaufeli *et al*., 2001).

An alternative outcome measure for burnout is the *Oldenburg Burnout Inventory (OLBI)* (Demerouti *et al*., 1998). This measure divides burnout into exhaustion and disengagement and includes the physical, affective and cognitive elements of these two dimensions. The OLBI evaluates two dimensions of burnout using 16 positively and negatively formulated items. Also, the OLBI can be used to measure burnout in most employees and is not restricted to human services (Reis *et al*., 2015). There are several other outcome measures that exist to measure burnout. Other alternatives relevant to this research project, include measures specifically aimed at assessing burnout in health professionals. The *Staff Burnout Scale For Health Professionals*, is a one dimensional measure with 20 items to measure burnout (Jones, 1980). This measure assesses adverse

cognitive, affective, behavioural and psychophysiological reactions which are considered to form part of burnout experiences in health professionals. This measure has been validated with this staff group; however, samples of the studies are small. *The Questionnaire for Burnout in Nursing* (Moreno-Jimenez *et al*., 2000) is a scale used specifically with nurses. This scale claims to focus on the evaluation of the most relevant variables of burnout in nurses. Another more recent outcome measure is *the scale of medical professional wear syndrome pertaining to the medical professional wear questionnaire* (Moreno-Jimenez *et al*., 2006). This instrument allows specific assessment of the dimensions of medical burnout. The scale suggests factors of medical professional burnout include exhaustion, detachment and loss of expectation. These scales have acceptable internal consistency on this questionnaire (Moreno-Jimenez *et al*., 2006). However, these health related burnout scales would be unsuitable for use in this thesis, due to their specific nature of measuring burnout in only nurses or medical professionals, rather than health professionals from a multidisciplinary team.

Several other burnout outcome scales exist, however are not used as frequently as others such as the MBI-HSS. In particular, in the health care sector where the MBI-HSS tends to be used the majority of time to assess staff burnout. Other scales worth noting include the *Perceptual Job Burnout Inventory* (Ford *et al*., 1983), the *Emener-Luck Burnout Scale* (Emener and Luck, 1980) and *Holland Burnout assessment survey* (Holland and Michael, 1993). However, such scales were designed to be used outside of health services and are used in other areas and professions such as education and teaching.

From carrying out a brief review of the literature, the MBI-HSS (Maslach and Jackson, 1981) has been chosen to measure burnout in this research. The MBI-HSS offers an outcome measure to assess burnout in health professionals. Due to its reliability and validity, this outcome measure has been the most popular assessment tool used in burnout studies (Shirom *et al*., 2006). The three dimensions of burnout within the MBI-HSS, including emotional exhaustion,

depersonalisation and personal accomplishment is a widely accepted and used model of burnout (Maslach *et al*., 1996, Schaufeli *et al*., 2001). For these reasons the MBI-HSS is an appropriate outcome measure to assess burnout in this research with mental health staff.

3.8.2 Mental toughness Outcome Measures

Early research of mental toughness focussed on qualitative data in order to form conceptualization of the model of mental toughness (Sheard, 2010). The *Mental toughness questionnaire 48 (MTQ48)* (Clough *et al*., 2002) was created as an instrument to measure self-reported mental toughness in individuals. It uses the key components of mental toughness including control, commitment, challenge and confidence, also known as the 4C's model (Clough *et al*., 2002). The questionnaire contains the subscales; challenge, commitment, control (including sub-scales emotional control and life control) and confidence (including sub-scales confidence in abilities and interpersonal confidence). Individuals respond to questions on a 5 point likert scale from 1 (strongly disagree) to 5 (strongly agree). The MTQ48 was found to have an overall test-retest coefficient of 0.90, therefore suggesting excellent reliability of this scale. All subscales of the MTQ48 reached the minimum acceptable level (0.70) as recommended by Kline (1999) when investigating the reliability of the psychological constructs. This supports the homogeneity of each subscale and the MTQ48 as a whole. The MTQ48 was also found to be valid, the concurrent validity for the MTQ48 and its scales ranges from 0.25 to 0.42, which is generally accepted as a high or acceptable score, therefore indicating that it measures what it claims to measure (Strycharczyk and Clough, 2015). The measure is also normative; the tests results are compared to results for a relevant norm group which represents the general and larger population. This means that the measure can also be used for evaluation by measuring progress and the impact of interventions. It can also be used for research, such as assessing which interventions are most useful and with different people (Strycharczyk and Clough, 2015).

The *psychological performance inventory (PPI)* was created by Loehr (1986). This earlier measurement contained 48 items and assessed mental toughness dimensions of self-confidence, negative energy, attention control, visual and imagery control, motivation, positive energy and attitude control. However, Middleton *et al*. (2004) noted that PPI was not a reliable and valid tool. Therefore, a newer version of the PPI was created and in comparison to the earlier version only contained 14 items and 4 dimensions. These dimensions included determination, self-belief, positive cognition and visualization (Golby *et al*., 2007). Both versions of the PPI have been used in mental toughness research in a variety of sports (Golby and Sheard, 2004; Sheard *et al*., 2009). However, the validity of this measure is unclear (Madrigal *et al*., 2013). Mack *et al*. (2008) used Loehr (1994) definition of mental toughness to develop a mental toughness measure known as the *Mental, emotional and Bodily Toughness Inventory (MeBTough)*. This measure has 43 items and has been shown to be consistent with good variability (Mack and Ragan, 2008). The measure is criticised by those wanting to use this measure for assessing mental toughness in athletes as it was developed using undergraduate students (Madrigal *et al*., 2013).

Another measure developed specifically for assessment of mental toughness in sport is the *sports mental toughness questionnaire (SMTQ)* (Sheard *et al*., 2009). The questionnaire contains 14 items and consists of three subscales of confidence, constancy and control. The SMTQ has satisfactory psychometric properties, with adequate reliability and divergent validity (Sheard *et al*., 2009). The mental toughness scale was designed to measure mental toughness with college athletes, due to the existing measures focussing on elite athletes. The 11 item version of this measure was shown to have good reliability and validity and was suggested as being less time-consuming than other assessments tools for measuring mental toughness (Madrigal *et al.*, 2013).

However, the validity of some of these assessments, especially the MTQ48, has divided some sports psychologists. Gucciardi *et al*., (2012) called for a

comprehensive inspection of the MTQ48 before it is taken as the perfect assessment. This was because Gucciardi *et al*., (2012) disputed the low factorial validity of the questionnaire which led a further study to specifically examine this construct (Perry *et al*., 2013). Perry *et al*., (2013) results support the factorial validity of the MTQ48 and indicate that the MTQ48 is a robust psychometric measure of mental toughness. A further research article underlined limitations to the inspection by Gucciardi *et al*., (2012) including that it lacked a comprehensive literature review and used inappropriate samples (Clough *et al.*, 2012).

From a brief review of the existing outcome measures to assess mental toughness, the MTQ48 has been selected as the most appropriate outcome measure to assess mental toughness in this thesis. This is because the MTQ48, unlike many of the other mental toughness measures, has major applications in a variety of sectors outside of sport (Strycharczyk and Clough, 2015). This includes education, health, social work, care and occupational settings, therefore making it more applicable to mental health staff than the other mental toughness measures. The MTQ48 also has other benefits such as being easy to administer, either online or via pencil and paper. It is easily accessible with a reading age of 9+ in the UK English version. The test is quick and easy to administer, taking approximately ten minutes to complete. The reports that are generated from the MTQ48 are also user-friendly and available in several formats. The measure also benefits from its proven reliability and validity of the outcome measure (Strycharczyk and Clough, 2015). Therefore, for these reasons the MTQ48 is most suited for the research in question with mental health staff.

3.9 Frameworks and models

This section briefly outlines the frameworks and models that have been considered for this thesis. A description of these and the rationale behind using the chosen model is provided here. In Chapter 9 (section 9.6) how this model fit with the results will be further discussed. In addition, other possible appropriate models or frameworks the results fit within will also be discussed.

3.9.1 The 4C's model of Mental toughness

After the literature had highlighted that using mental toughness coaching strategies could be a way of improving wellbeing in mental health staff it was decided that the 4C's model of mental toughness could be used in this thesis (Strycharczyk and Clough,2015). As previously described in Chapter 1, the 4C's breaks down overall mental toughness into four main components, this includes challenge, confidence, commitment and control. ***Challenge*** refers to seeing challenge as an opportunity. ***Confidence*** refers to having high levels of self-belief. ***Commitment*** refers to being able to stick to tasks. ***Control*** refers to believing that you control your own destiny (Strycharczyk and Clough,2015).

In the theoretical development of the construct of mental toughness, several different perspectives have been offered. Clough *et al*. (2002) used hardiness as a theoretical framework to develop the definition and the 4C's model of mental toughness. Specifically, the components of hardiness (i.e., control, commitment, challenge) are combined with confidence. Jones and Moorehouse (2007), reported 30 attributes of mental toughness and proposed a framework on how these attributes can be used. Specifically, the framework consists of four separate dimensions (i.e., attitude/mindset, training, competition, and post-competition) and offers insights into which of the attributes are necessary in the different settings. Gucciardi *et al*. (2008) adopted Personal Construct Psychology (PCP) as a framework to create a grounded theory of mental toughness. A key principle of PCP is that individuals strive to make sense of themselves and their environment by devising theories about their world. The 4C's model has been chosen as the model of mental toughness to apply in this thesis due to the emphasis on the positive component of confidence. My beliefs about mental toughness and wellbeing fit with this model. In addition, this model has been applied to a variety of settings including the health sector. Whereas with other models the focus of application has been strongly weighted towards to the world of sport or business.

3.10 Potential Sources of Bias

Due to being reflexive during the research process, I recognise potential sources of bias using the design and methods employed in this thesis. Social desirability is acknowledged as a common source of bias when the participant knows the researcher and interviewer (Grimm, 2010). Participants may respond in a particular way that they feel is more favourable to the researcher or interviewer (Grimm, 2010). Three of the participants had previously worked with me within the same service and organisation. Therefore, it is possible that this may have impacted on their discussions in the NGT, how they answered the questionnaires and the interview questions. However, to minimise this risk, most of the participants, a total of seven for the NGT and eight for the wellbeing training had never met me before. Participants were also informed that direct quotes may be used but will be anonymous and not attributable to any participant. This was to try and minimise participants feeling that they should answer in a particular way.

Another common bias is researcher/experimenter bias, whereby a researcher without meaning to may influence the participant, data or results due to their own subjective views and influence (Pannucci and Wilkins, 2010). It is possible due to myself implementing all aspects of the research including facilitating the NGT, giving out the questionnaires, implementing the training and conducting the interviews that I may have unconsciously caused influence to the results. Even though this may be the case and is at times unavoidable, I took many measures to try and minimise the risk of this happening. This included reflecting on myself to reduce the risk of being misled by my own experiences, thoughts and feelings. For example, the research involved an emotive subject of work wellbeing and I had to make sure that I did not project my own feelings with regards to this topic onto the participants or within the implementation of the training. I also had to be fully aware of my own thoughts with regards to this topic. If I did not do this, it may have changed what I asked in the interviews and how I interpreted it. One of the most useful ways I found throughout this process of doing this was by keeping a diary of my own thoughts and feelings.

This allowed me to reflect on how I was feeling and how this may have affected the training, the interview or what I interpreted on that day. For example, my diary identified that by the last interview I felt more relaxed asking the questions. In addition, I felt more comfortable asking for more information about what the participant was saying as the interviews progressed. All of this information was used to identify my own thoughts, feelings and behaviours during the interviews in order to make this transparent.

A bias that can be found in follow up studies is that of recall bias. This is when errors or inaccuracies occur in the participant's recollections of events or experiences after a period of time has passed (Pannucci and Wilkins, 2010). In the follow up study at three months, recollection errors may have occurred when answering questions during the interview with regards to their experience of the training. However, recall bias aimed to be minimised by allowing the participants time during the interview to reflect and think about real life examples of how the training may have impacted on how they think or do things differently now. It also gave them an opportunity to think of actual examples of when this occurred in the past three months (Pannucci and Wilkins, 2010). Also, having the follow up at three months was thought to be an appropriate time for the training still to be quite 'fresh' in the participant's mind. In addition, in regards to timing, it is possible that due to the questionnaires being completed at the very beginning of training day 1 and the end of training day 2, that there was not enough reflection time for the participants to think and consider their answers in more depth. However, this was minimised by not setting a time limit on how long the participants had to complete the questionnaires. Also, the MTQ48 and MBI-HSS does encourage participants to 'not spend too much time on any one item' as the questionnaires are supposed to be completed on initial feelings and not overthought.

3.11 Research Rigour

Promoting research rigour is an essential part of the research design (Shenton, 2004). The rigour or trustworthiness of research is essential for evaluating the research worth (Lincoln and Guba, 1985). A set of four criteria that Lincoln and Guba (1985) devised to establish rigour include; credibility, transferability, dependability and confirmability.

In addressing credibility, I tried to show that a real and true picture of the phenomenon was being presented, i.e. there is confidence in the truth of the findings and they had value and believability. Credibility of the analysis and interpretation of the results was also strengthened, as my supervisors compared codes from the interviews and reviewed the themes that I put forward that had emerged.

For dependability of the research and to display reliability I chose a systematic and replicable approach to data analysis (as described by Attride-Stirling, 2001) to strengthen dependability and confirmability. In addition, to enhance the accuracy of the data, reflexivity was a regular and a useful process I engaged in to critically examine my own role, potential bias and influence on the participants, data collection and analysis. This was done to clearly evidence that the findings are from the data and not my own views and predispositions i.e. the findings are not based on my own bias, interest or motivation. Any contradictory data was also taking into account and analysed to ensure that all data was analysed and interpreted and that my own views did not influence the findings. Lincoln and Guba (1985) dependability criteria suggest that researchers should make great efforts to enable a future researcher to repeat the study i.e. show that the findings are consistent and could be repeated.

To help promote transferability of a study Lincoln and Guba (1985) suggest that researchers should provide enough information of the research context, so that another individual could decide whether or not the environment and context is similar to another setting or situation, i.e. the findings have applicability in other

contexts. To increase transferability, this study contains a clear account of the methods, data collection and analysis throughout the research process.

3.12 Summary

This chapter has outlined and justified the methodological approach used in this thesis in order to appropriately meet the aim of this research study. The different research paradigms I considered as well as their unique ontology, epistemology and methodology have been explored and discussed in relation to how it has been applied in this thesis. My experience as an occupational therapist in mental health settings, combined with previous research experience, formed the basis for my ontological and epistemological viewpoints.

The motivation behind the research design and the choice of mixed methods have been rationalised for this research in this chapter. The chapter then discussed the importance of reflexivity with the research design and methods including the potential sources of bias and the significance of research rigour.

The next chapter that follows will describe the methods used for the NGT and then go onto present the results from the NGT.

CHAPTER 4

METHODS OF PHASE 1

4.1 Introduction

This chapter describes the methods used for the group discussion part of this study using the Nominal Group Technique (NGT). The aim of the NGT was to explore mental health staff views on what strategies and techniques they thought could help improve burnout and mental toughness in mental health staff.

4.2 Ethical Considerations and Approval

The NGT part of this study was submitted for approval to the University of Central Lancashire ethics committee and received approval on 26/09/16- Ref: STEMH 535 (appendix 2). This study involved human participants and involved identifying the ethical considerations for working with mental health staff when carrying out a group discussion with regards to a sensitive and emotional topic of wellbeing, burnout and mental toughness.

Written consent was obtained from all participants who wished to take part (appendix 3). A copy of this was sent initially to the participants along with the letter of invitation (appendix 4) and information sheet (appendix 5). The participants were asked to sign the consent form prior to the NGT taking place. Written consent was collected from all individuals wishing to take part prior to any research taking place. One copy was kept for research records and one copy was given to the participant to keep.

To ensure that consent was informed, participants were provided with information regarding the study. An information sheet was provided during recruitment. This provided participants with information on what was involved in

the study, why the study was taking place, what would happen with the information, how participants would be selected and recruited, how much time it would take and where the study was taking place. It also covered what to do if they did not want to take part, what to do if they didn't want to continue with the study, the potential risks and benefits of taking part, who was doing the research and who the research had been approved by.

Participants were made clear about their right to withdraw. The information sheet contained a section titled 'do I have to take part?' and 'what will happen if I don't want to continue with the study?'. It was clearly explained that participation in this group was completely voluntary and that they were under no obligation to take part. They were informed that they were free to withdraw at any point, without question, even if they had signed the consent form. Participants were informed that if they changed their mind after the group discussion, information that was anonymous and could not be traced back to them may still be used. The consent form asked participants to consent that they understood that their participation was completely voluntary and that they understood their right to withdraw.

Other considerations of the study included making arrangements for participants who might not adequately understand verbal explanations or written information given in English, or who had special communication needs. This was done by making any information on paper available in larger font sizes for those who may have a visual impairment. All questions and information in the NGT was also read aloud by the researcher. Therefore, if individuals had difficulty with the written text, they received the same information verbally.

An assistant was present during the NGT, this individual had previous experience of working in these services, however was no longer a staff member there. They were a current PhD student, studying in the mental health field. This individual did not contribute to the group discussion, they only observed the session, as

well as assist with practicalities of the NGT, including ensuring the digital audio recorder was recording appropriately.

It was possible that due to the nature of the discussion topic, sensitive issues may be discussed and that the opinions of some participants may differ to others of the group. All information that was shared during the group was treated as personal and sensitive and it was vital that all group members respected this and treated this as confidential. I tried to make all participants as comfortable as possible in terms of discussion and all participants were encouraged to talk to the researcher if they were worried or had concerns. In the unlikely event that an individual displayed signs of emotional distress during any point of the project, data collection would be stopped. The participant would also be advised to seek local sources of support e.g. their line manager or GP. This information was clearly stated on the participant information sheet.

Confidentiality is essential both for the integrity of the research and to the trust relationship between researcher and participant. Participants were made aware that all information was anonymous and would be kept confidential throughout. Although there was potential for the participants to be identified through the recording of the group discussion, via their voice been recognised, or if they identified their job role, participants were aware that they did not have to identify themselves. They signed on the informed consent form that they understood that reports from the study would not contain any identifiable personal information and that direct quotes may be used, but would not be attributable to any participant. They also agreed to anonymised data being utilised within reports, publications and or presentations by signing the consent form. Participants also gave signed consent that they understood that all data would be stored securely in line with the UCLan code of conduct for research and UCLan data protection policy. To assure confidentiality of data was implemented, data and codes and all identifying information was kept in separate locked filling cabinets. Access to computer files was available by password only. All activities which involve personal data of any kind, in any way, must comply with the Data Protection Act 1998

(DPA). This checklist outlined the requirements of the DPA and the measures that needed to be taken when processing personal data. It also provided a mechanism for recording the steps I took to ensure the personal data being used was safeguarded. A data protection checklist was completed, submitted and approved as part of the UCLan ethical approval process (appendix 6).

The study required travel to a meeting room at one of the services. A travel/fieldwork risk assessment was completed (appendix 7). This was to ensure that all possible hazards and risks were identified and an appropriate action plan was in place to minimise any possible risks.

4.3 Recruitment

For the NGT an agreement had been made to recruit participants from two mental health rehabilitation services in the North West. The services supported service-users with psychosis as well as other conditions such as depression and anxiety. The organisation of these services was a registered charity which has around 101 services across the UK, with around 27 of these focused on mental health. These two services recruited from provided residential rehabilitation for service-users. One of these services had a maximum of 12 service-users, male or female, aged over 18. The other service had a maximum of 10 service-users, male only, aged over 18. The staff teams consisted of multi-disciplinary teams of mental health nurses, occupational therapists, support workers, art psychotherapists and project workers.

Participants were sampled via convenience sampling to include individuals from the services who were available and willing to participate in the study. The inclusion criterion was:

-any mental health worker who had been working in mental health services for at least three months. This included managers and any staff member who had any service-user/patient contact within the service.

The exclusion criterion was:

- Staff who had no service-user/patient contact within the service e.g. administration or finance staff.

Participants were first identified from two mental health services in the North West. Each service has approximately 18 members of staff. However, a maximum sample size of 10 was set due to practicalities of the group discussion, such as the size of the room. If there was a high number of staff who wished to take part they would be divided into multiple groups and the NGT would be repeated with the different groups. The manager at these services agreed for staff to be recruited for this research and was supportive of this study. The manager agreed that staff who wanted to attend would be allowed time away from their work and shifts.

In the first instance, the manager of the services agreed for a poster (appendix 8) advertising the study to be displayed in the services several weeks in advance. This was to ensure that staff were aware of the study in advance of it taking place and was aimed to allow staff to be able to organise shift patterns and attendance accordingly. All staff from these services were then sent a letter of invitation, information sheet and consent form in one envelope in their individual staff letterbox, which all staff had provided by the organisation at the service in which they worked. This was seen as the best way to recruit across these services, due to varying shift patterns and to avoid feeling coerced. The staff then could contact the researcher to ask additional questions or to actively opt in and volunteer to take part in the study. If no response was received from participants a follow up letter (appendix 9) was posted in the staff letterbox after two weeks. There was no coercion as participants were not being approached directly and it was made clear that their choice to participate was completely voluntary.

4.4. Data Generation Methods

A NGT was used to capture both individual ideas and a group consensus to the question *"What strategies and techniques do you think could help improve burnout and mental toughness in mental health staff?".*

The group discussion included a clear introduction, why the NGT was being used, as well as that a wellbeing training package for mental health staff is proposed. The researcher gave definitions for burnout (Maslach *et al*., 1996) and for mental toughness (Clough *et al*., 2002). The NGT question was then presented to the group. The process consisted of five stages (figure 4.1). Stage 1: Participants were asked to write ideas in brief phrases and to work silently and independently. Stage 2: Each individual engaged in a round-robin feedback session to concisely record each idea (without debate from the group). The researcher recorded all ideas from the group on a flip chart that the whole group could see. Stage 3: Each recorded answer was discussed for clarity and importance. Ideas that were similar were discussed and grouped together under one heading, which the staff called themes. Stage 4: Individuals voted privately to prioritise the ideas and ranked these themes from their most favoured action to least favoured action. Stage 5: Individuals reported their priority list back to the group. Votes were tallied and calculated to identify the themes that were rated highest by the group as a whole. The ideas that were most highly rated by the group were most favoured group actions or ideas in response to the question posed at the start (Allen *et al*., 2004).

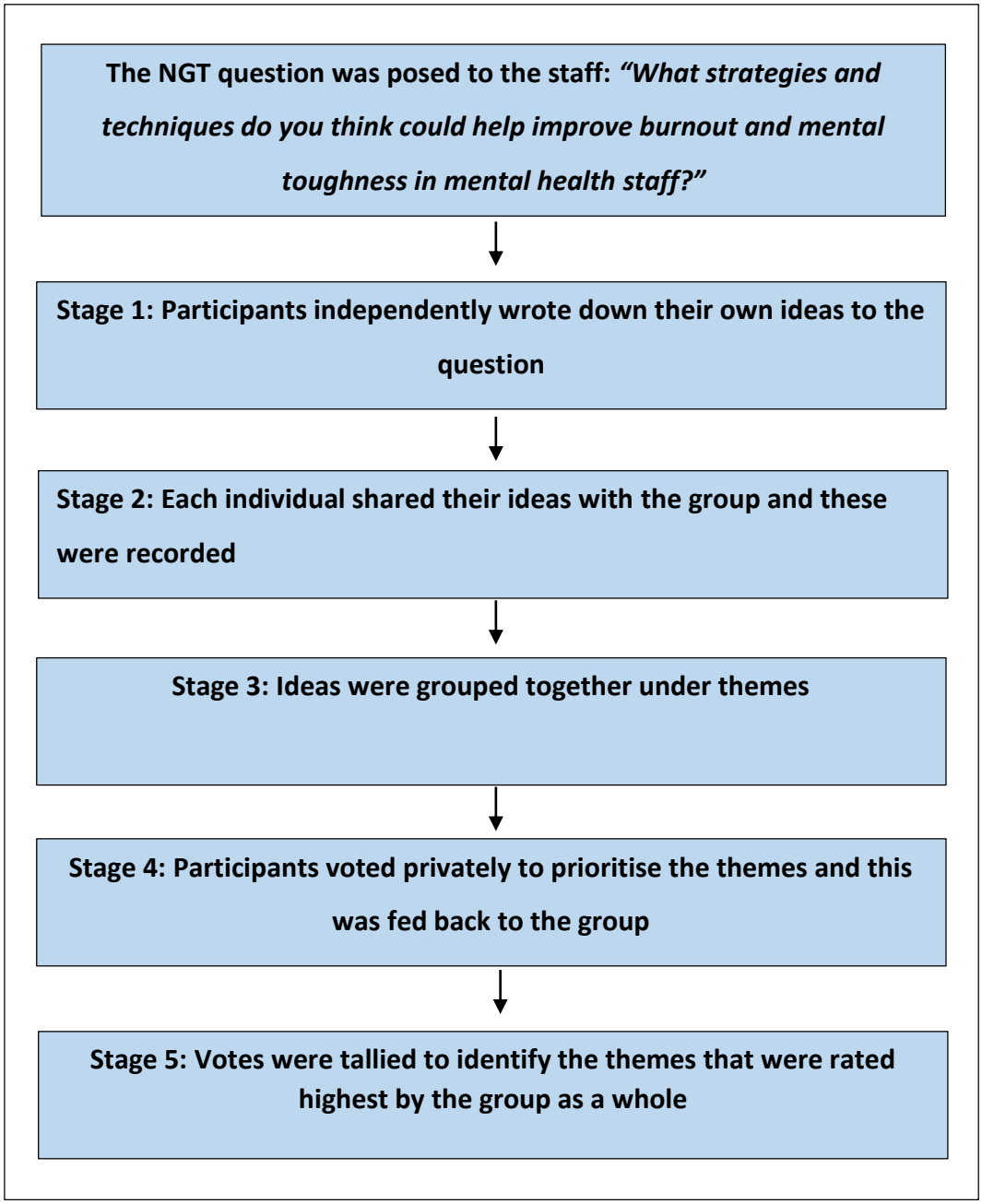


Figure 4.1: Process for data collection for the NGT (Allen *et al*., 2004).

4.5 Data Analysis Plan

The individual ideas that were recorded from the NGT were grouped together by the staff if they were similar e.g. positive feedback more often to colleagues and

learn to engage in positive thinking rather than negative thinking, were similar ideas that the staff chose to group under a heading called 'positive thinking/feedback'. These headings the staff decided to call 'themes' as they agreed between themselves that this was the best way to describe topics, subjects or ideas that were related to each other. As the researcher, I did not influence the staff at any point during the NGT, instead I played the active role of recording their ideas and let the staff lead the development of the themes.
were similar were discussed and grouped together under one heading, which the staff called themes. The ideas that were most highly rated by the group were the most favoured group actions or ideas in response to the question posed at the start. A ranked list of ideas from the group was collated electronically in the form of a Word document. Facilitator session notes and an audio recording was used to explain aspects of the discussion that needed further clarification. The themes and ideas were collated into a table and included direct quotes from the staff that participated (see chapter 5, table 5.1 and figure 5.2).

CHAPTER 5

RESULTS OF PHASE 1

5.1 Introduction

This section contains the results from the Nominal Group Technique (NGT). The ideas on what strategies and techniques the participants thought could help improve burnout and mental toughness in mental health staff are presented, along with the order of priority the group voted these in. An article containing the NGT results has been published in the Journal of mental health training, education and practice (appendix 10).

The following chapter further goes on to present how the NGT helped decide on the staff wellbeing training package.

5.2 Demographics of participants

A total of 10 participants took part in the Nominal Group Technique (NGT), this included a mix of staff from the two services that were initially approached. Participants included staff from varying roles and included one clinical lead, two art psychotherapists, one project worker, one occupational therapist/therapy lead, two support workers, two mental health nurses and one assistant psychologist. Of the 10 participants, 7 were female and 3 were male.
The overall mean age of the participants was 41 years. The overall mean time working in the mental health service which they were recruited from was 4 years 6 months. The mean age of the female participants was 36 years and the mean age of the male participants was 51 years. The mean time working in the mental health service which they were recruited from was 5 years 2 months for the female participants and 3 years 3 months for the male participants.

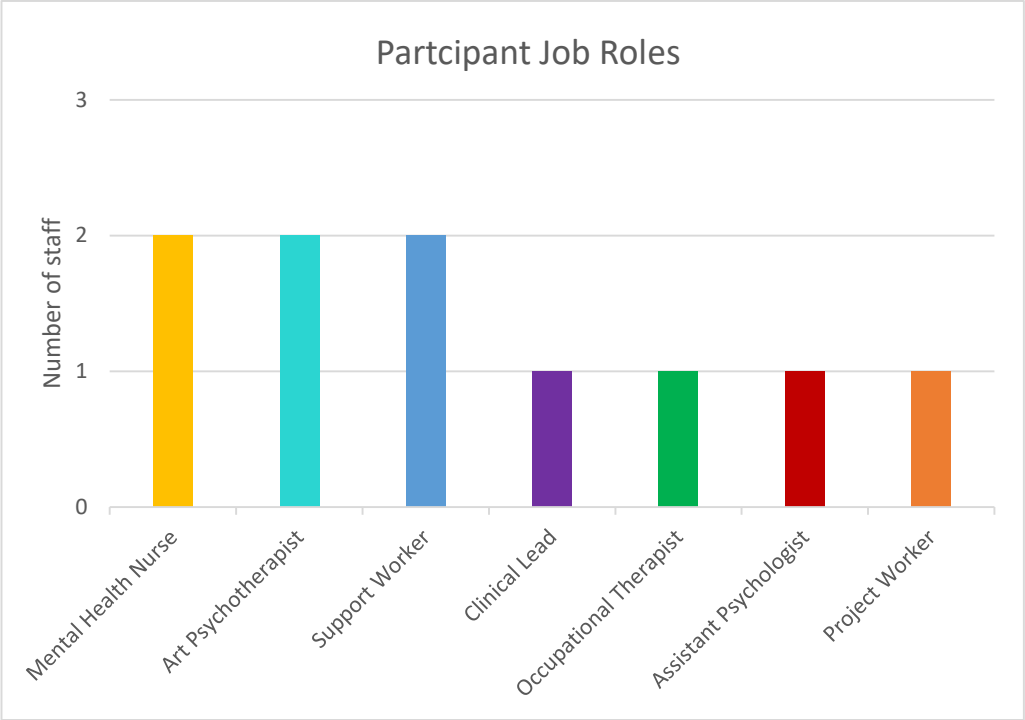


Figure 5.1: Mental health professions that participated in the NGT.

5.3 Definitions of burnout and mental toughness

The participants were asked if they were happy with the definitions of burnout and mental toughness that were given or wished to offer alternative definitions. The staff not only agreed with these definitions, they also displayed motivation and enthusiasm to discuss these topic areas as the definitions appeared to immediately resonate with the staff. (Please note participants were allocated a number each so that any quotes used remained anonymous, therefore 'P' followed by different numbers indicates different participants).

These definitions developed some interesting discussion. One staff member noted that they:

> *"would like to learn strategies to become mentally tough, so they could use these skills when they needed them, such as in times of stress and pressure." (P6)*

Another staff member from another profession also added:

> *"from the definition given I can see that I would like to improve my mental toughness." (P3)*

It was interesting to note that during the discussion of these definitions, staff thought that there may be a link between mental toughness and burnout and one individual commented that:

> "improving one of these areas might improve the other." *(P2)*

5.4 The NGT

The staff had numerous ideas (41 items were recorded) on what strategies and techniques they thought could help improve burnout and mental toughness in mental health staff (table 5.1). Ideas that were similar were discussed and grouped together under one heading. The group chose nine headings for the ideas to be grouped together under; the staff called these headings themes. These consisted of culture/organisation, staff wellbeing, education, teambuilding, positive feedback, support, relaxation, communication and the environment. Table 5.1 shows how each specific idea was placed under each theme, the order of themes voted and the definition for the themes.

The most favoured action identified in the NGT was improvements in the culture and organisation. The least favoured action to take forward was the environment. Although the group came up with nine themes, the importance of each of the 41 individual ideas was acknowledged.

Many important comments were made relating to the NGT question. In particular, throughout the discussion the staff commented on their perception that very little is done to look after or improve staff wellbeing in mental health services.

One staff member commented on why they thought the existing support in place isn't always useful:

> *"Is it a cultural thing? Supervision is in place but sometimes I don't get chance, we don't complain, just dig in and crack on, when really we should go and get supervision. I've felt quite stressed at times if I have not been able to get supervision because my supervisor off sick or something, I don't go and complain, I just crack on, but really is that the right thing to do?" (P10)*

Much of the discussion focussed on why they thought the ideas they had come up with would be beneficial. Some of the quotes from the group discussing the benefits can be seen in figure 5.2.

When the votes were tallied and calculated from the group, most actions received similar scores apart from the theme of environment. Therefore, although culture/organisation was the most favoured action, the other themes of staff wellbeing, education, team building, positive feedback, support, relaxation and communication were rated fairly equally by the staff as important actions to take forward.

Table 5.1 individual ideas from the group, the themes, order voted and definitions.

Individual Strategy	Theme	Order Voted	Definition of Theme
Involving the team in decision making. Staff incentives for good work. Organisation to understand staff wellbeing needs better. Create a positive culture throughout the organisation. Start/end the day with something positive e.g. 5 minutes to reflect on what did well.	Culture/ Organisation	1	Related to anything that involved higher management, the organisation and the way in which they worked.
Recognise burnout. Learn anxiety control. Mental toughness coaching strategies. Visualisation. Learn a good work-life balance. Learn coping strategies to use daily. Mental health wellbeing days for staff. Opportunities to refresh the coping skills. Learn confidence and self-esteem skills. Burnout and mental toughness assessments.	Staff Wellbeing	2	Involved anything relating to keeping well, including burnout, mental toughness, stress and anxiety. It included any specific strategy that could help with wellbeing.
Training for staff for their role. Training for staff to help them develop new skills. Opportunities to learn from other professionals. Education about what is burnout and what is mental toughness. See progression from training in day to day activities by goal setting.	Education	3	Included ideas that would increase knowledge and understanding. It included training, development and anything with an educational aspect.
Away days, time away from work to bond with staff team. Staff groups e.g. breakfast club. Socialising outside of work e.g. nights out, afternoon tea. Support each other, even if task outside of job role e.g. random acts of kindness.	Teambuilding	4	Included anything that involved the staff socialising, improving staff relationships and time together in and outside of work.
Positive feedback more often to colleagues. Engage in peer appraisal and positive recognition. Learn to engage in positive thinking rather than negative thinking.	Positive Thinking/ Feedback	5	Involved improving positive attitudes, thoughts and behaviours.
Personal supervision- opportunity to discuss personal issues. Clinical supervision- discuss difficulties with the team. Work therapist/counsellor for staff. Peer supervision for burnout- discuss wellbeing with their peers. Set manageable and clear goals throughout the team, and support each other to achieve these.	Support	6	Included any support for staff either internally or externally. Included any supervision, any support groups and any therapy/counselling.
Use relaxation techniques at work e.g. breathing techniques. Exercise e.g. yoga, tai-chi, walking groups available to staff. Time and space at work to relax e.g. mindfulness sessions. Massage.	Relaxation	7	Included anything that would help the staff to relax, keep calm and reduce stress and anxiety. It included using relaxation at work and having time and space to relax and unwind at work.
Clearly understand roles by open and clear communication. Handovers and de-briefing.	Communication	8	Included anything that involved staff improving how they respond and communicate to each other
Environment set up so that everyone can do their job effectively e.g. enough computers, chairs, stationary. Provide a quiet space for staff to go to during work. Fresh fruit and water always available to staff to improve nutrition, hydration and energy levels.	Environment	9	Involved any practicalities that would help improve the working environment, such as rooms, furniture and equipment.

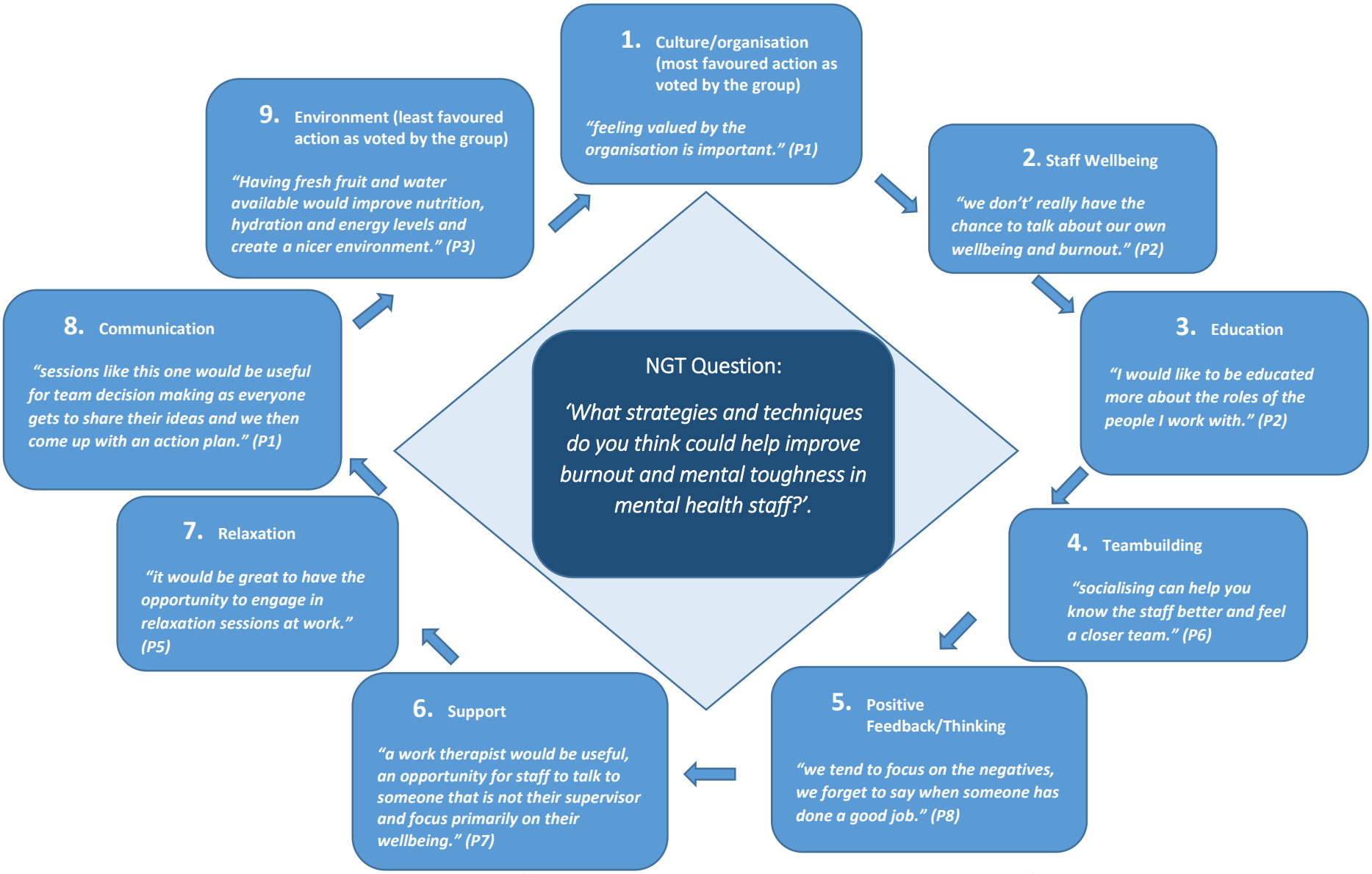


Figure 5.2 The themes as chosen by the staff, the order the group ranked these, along with quotes from the group.

5.5 Discussion of the NGT

This chapter has successfully met objective 2 of this thesis which was:

2. To develop an understanding of what techniques and strategies mental health staff think could improve their wellbeing.

It has done this by presenting the results of the NGT which looked at 'what strategies and techniques do mental health staff think could improve their mental toughness and burnout?'. A discussion of the NGT is now presented.

The NGT showed that staff working in a mental health setting are motivated and enthusiastic to discuss issues around improving their mental health. The top three important themes were: 1) culture/organisation 2) staff wellbeing 3) education. These findings were in line with previously published theoretical and empirical papers. The results have also added value and new knowledge, by generating additional insights to the participants' perspectives and priorities, as well as giving valuable practical pointers for implementation.

The top priority action to take forward from the NGT was improvements in the ***culture and organisation***. This included ideas such as involving the team in decision-making. Previous research identified that it is paramount that new training and initiatives, to improve staff wellbeing and burnout should be informed by mental health staff views and ideas (Coates and Howe, 2015). Therefore, carrying out the NGT was an important process of the development of this training. It is also essential that the staff will be able to see clearly that the training has been created based on their feedback and feel listened too (Coates and Howe, 2015). The staff wanted the organisation to understand staff wellbeing needs and have a better awareness of this issue e.g. training for higher management and supervisors on staff wellbeing. Previous authors suggested that it is beneficial for management to participate in wellbeing training. Scarnera *et al*. (2009) found that teaching managers leadership skills and involving them in wellbeing training such as positive thinking workshops is beneficial, as perceived support from managers can affect burnout levels. Therefore, the NGT findings

reinforce earlier published work that all staff (including managers and supervisors) should be involved in wellbeing training.

The second priority action related to ***staff wellbeing*** techniques. This included helping staff to recognise and prevent burnout by teaching specific techniques e.g. anxiety control, stress reduction. In previous training 84 participants were encouraged to learn relapse prevention for burnout, which showed improved burnout rates (Salyers *et al*.,2011). Therefore, the NGT findings concur with other studies that staff wellbeing training should allow staff to learn about burnout and ways of preventing this. Under this theme, staff reported that they would like training on specific techniques that may make them more mentally tough. Mental toughness coaching strategies may be able to improve areas such as performance, resilience and wellbeing (Strycharczyk and Clough, 2015). The development of mental toughness may be achievable through the coaching or training of specific techniques. These techniques include visualisation, positive thinking, attentional control, goal-setting, anxiety control and relaxation (Strycharczyk and Clough, 2015).

The NGT participants emphasised that developing a good work-life balance by learning skills to help with time-management and goal setting would help improve mental toughness and burnout. This supports previous findings that has displayed that goal setting may be useful, as interventions such as clinical supervision, which involves group goal setting can be beneficial in reducing burnout in these settings (Edwards *et al*., 2006). The mental toughness literature also supports that goal setting and learning to prioritise tasks is beneficial for improving mental toughness. Strycharczyk and Clough (2015) suggests that goal setting helps prioritise and motivate individuals in tasks.

Amongst the staff wellbeing techniques, was confidence and self-esteem training. Positive changes in burnout have been found due to the implementation of self-esteem workshops (Carson *et al*., 2001). Techniques such as visualisation which can help with confidence and self-esteem are also noted to improve mental toughness (Sheldon and Lyubomirsky, 2006). Therefore, self-

esteem and confidence training is found to be effective in previous studies and viewed as important in the NGT.

The NGT group also suggested under the heading of staff wellbeing that there should be mental health wellbeing days for staff and regular opportunities to refresh the coping skills they have learned. Practising wellbeing strategies is important for their effectiveness, with Sheldon and Lyubomirsky (2006) concluding that it may be important to encourage regular practice of such techniques in a training programme for mental health staff. In addition to this, the consideration of refresher or follow up sessions, in order in maintain the effectiveness of the techniques was considered beneficial (Sheldon and Lyubomirsky, 2006).

Staff in the NGT also thought that it would be worthwhile for burnout and mental toughness to be assessed by the workplace, so goals could be made on how to improve. The *Mental Toughness Questionnaire 48 (MTQ48)* (Clough *et al*., 2002) has been found to be useful in assessing which interventions are most useful in improving mental toughness and with different people (Strycharczyk and Clough, 2015). It also allows individuals to see their strengths and limitations and set goals to work on these (Strycharczyk and Clough, 2015). The *Maslach Burnout Inventory-Human Services Survey (MBI-HSS)* (Maslach *et al*., 1996) also allows staff to see how they score in each of the three dimensions of burnout.

The third priority action was ***education***. During the NGT staff agreed that training and education are essential in improving burnout and mental toughness. The ideas they suggested included increasing knowledge to make them more confident and able to fulfil their responsibilities effectively. Some of the wellbeing training was placed under the heading of staff wellbeing rather than education, as selected by the staff. When mental health staff learn new ways of working with service-users, this can improve burnout, as they feel they have more skills to work effectively with those individuals (Ewers *et al*., 2002). Others

that have explored the use of training to reduce mental health staff burnout have often focussed on teaching staff psychosocial interventions (PSI) as a way of doing so (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). The skills taught often help staff become more empathetic towards service-users, by increasing their understanding of mental health and learning strategies to work through problems effectively, that service-users may be experiencing (Ewers *et al*., 2002). The findings are consistent in suggesting that education focussing on new ways of working is valuable.

Apart from the top three priority themes, the other six themes suggested by the staff were still rated as important and were incorporated into the training where possible. Theme four- ***teambuilding-*** included ideas such as away days and time away from work to bond with the staff team. Group teambuilding has been found to be effective in reducing burnout, as well as improving morale and job satisfaction (Robinson-Kurpius and Keim, 1994). Theme five- ***positive feedback/thinking-*** suggested that learning to engage in positive thinking rather than negative thinking would be helpful. Training to manage negative emotions, thoughts and increase positive thinking may reduce burnout (Scarnera *et al*., 2009). Theme six was ***support***. There are positive outcomes in terms of reduced burnout levels in mental health staff with the use of clinical supervision, which provides support to staff (Edwards *et al*., 2006). However, a recognised problem of using clinical supervision to improve burnout in mental health staff, is that individuals don't always get the opportunity and time out of normal working duties to attend these sessions and they are not always regularly available (White and Roche, 2006). Although ***relaxation*** as a technique to improve burnout and mental toughness was prioritised as seventh, the staff were motivated when discussions were had about the benefits of relaxation techniques in the workplace. Goodman and Schorling (2012) support that a mindfulness course can reduce burnout in healthcare providers. As well as training on formal mindfulness practices, the course focussed on how mindfulness could be applied in the workplace, an area that the NGT emphasised

as important. Positive and constructive ***communication*** was seen as important during the NGT discussion in improving burnout and mental toughness, even though rated eighth in the themes. Communication is important for staff wellbeing, negative communication should be minimised and staff should be encouraged to have discussions that are helpful and constructive (Jenkins and Elliot, 2004). Although voted as the least favoured action to take forward by the group, the staff still selected ***environment*** as a theme. Staff require time and space to immerse themselves in the wellbeing techniques they are taught and being away from work in a different environment is beneficial (Razzaque and Wood, 2016).

As discussed the findings are in line with previously published theoretical and empirical papers. However, this study was unique in involving mental health staff in discussing their ways of improving their mental health. It was also unique as it found nine strategies to do this and these were used to help decide what to include in the wellbeing training for mental health staff.

Staff who engaged in the NGT discussion displayed a clear interest in the topic area of improving staff wellbeing. They offered many ideas and engaged in open discussion on the strategies and techniques that they thought could help improve self-reported burnout and mental toughness in mental health staff. They also valued being engaged in the decision making process of what to include in the proposed training package. The NGT showed that mental health staff want to improve the organisational culture towards mental health and their wellbeing and want to be educated about this topic. Staff wellbeing training may be a beneficial way of doing this.

5.6 Summary

This section has presented the results from the NGT. In order to summarise the NGT and highlight some of the key take homes messages an outline is provided below.

5.6.1 Take home messages-from the NGT

- Staff who engaged in the NGT discussion displayed a clear ***interest in the topic area*** of improving staff wellbeing.
- Staff offered many ideas (***41 individual ideas***) and engaged in open discussion on the strategies and techniques that they thought could help improve self-reported burnout and mental toughness in mental health staff.
- The staff ***valued*** being engaged in the ***decision making process*** of what to include in the wellbeing training for mental health staff.
- The NGT showed that mental health staff want to ***improve the organisational culture towards mental health*** and their wellbeing and want to be educated about this topic. Staff wellbeing training may be a beneficial way of doing this.

CHAPTER 6

The Training Package

6.1 Introduction

This chapter combines the information gathered from the literature review and the NGT findings and presents the training package that was decided on and implemented with the mental health staff. It describes how the training was decided on and when and how the training was refined (table 6.3). It also provides an outline of the content used for training day 1 and 2 (table 6.1 and 6.2) and a brief rationale for the timings, duration and location of the training.

6.2 Using the literature and NGT to decide on the training to be used

The literature review helped to decide on the training to be used. The literature review identified that mental toughness coaching strategies could be used to develop mental toughness in individuals (Clough *et al*., 2016; Strycharczyk and Clough, 2015). In addition, individuals with higher mental toughness also reported lower levels of burnout (Gerber *et al*., 2015). However, no research was conducted regarding mental toughness development using these strategies and mental health staff. Therefore, from this it was suggested that mental toughness coaching strategies could be used in the training. In addition, previous training had mainly only focussed on teaching staff new ways of working with service-users (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011) to improve their wellbeing rather than focussing on the actual staff and ways to directly improve their own wellbeing. It was also reiterated that new training and initiatives to improve the wellbeing of staff in an organisation should involve the staff ideas and input (Coates and Howe, 2015). Therefore, a key interest of this research was to explore and include staff ideas on what they thought could improve their mental toughness and reduce burnout. The ideas that came out of the NGT were in line with some of the coaching strategies such

as positive thinking, relaxation and goal setting, already used to develop mental toughness in other areas such as sport and business (Strycharczyk and Clough, 2015). Therefore, it was decided that using mental toughness coaching strategies could be useful in the training and that the training could involve teaching the staff mental toughness coaching strategies as used and recommended by Strycharczyk and Clough (2015).

The adult version of the mental toughness development toolkit was purchased through the company AQR, in order to select strategies and techniques to be taught to the mental health staff. The mental toughness development toolkit is an array of experiential exercises which can be run in classrooms, offices and training rooms with individuals and/or small and large groups. Each exercise is supported with a cue card which provides full instructions for use, equipment required and guidance for managing reflection and learning. The toolkit has been designed to work with the mental toughness model and its psychometric assessment the MTQ48. The mental toughness development toolkit is designed to develop positive thinking, goal setting, visualisation, anxiety control, attentional control and self-awareness. The toolkit contained 35 different activities that could have been chosen to be used and these all came under the main categories of positive thinking, visualisation, anxiety control, attentional control and goal setting. Of these 35 activities, 15 of these were chosen to be used as part of the training package. The rationale for the amount of content was mainly due to timings of the training which are explained in more detail in section 6.4. The selection of activities was based on the discussions and ideas that were had by the staff at the NGT. These were prioritised in the training package based on the NGT results. For instance, positive thinking and relaxation were prioritised by the staff in the NGT. Therefore, more time was given to these strategies and the content included more of these techniques (table 6.1 and table 6.2).

The selection of activities was also thought to be appropriate for all members of staff regardless of position or qualifications. The chosen activities were then put together as part of the staff wellbeing training package, along with other specific

elements that were deemed important based on the NGT discussions. These extra elements in addition to the mental toughness coaching strategies, included definitions of mental toughness and burnout and a brief outline of the literature and NGT and how this led to the decision of what would be included in the training. It also included a brief discussion on the importance of practicing techniques and time for practice and reflection. This involved the staff being asked to reflect on one the techniques and to practice the chosen technique again. The training was presented as a PowerPoint presentation. In addition to the content outlined, to meet the 'environment' theme from the NGT, staff were given a fruit infuser water bottle for them to take back to work with them to help stay hydrated.

6.3 The Training Package Content

As described the training package consisted of teaching the staff a variety of mental toughness coaching strategies that had already been developed to improve mental toughness in other areas such as sport and education (Strycharczyk and Clough, 2015). The adult version of the mental toughness development toolkit was purchased through the company AQR via their website, in order to select strategies and techniques to be taught to the mental health staff. The training started with an introduction from the researcher and included the background and qualifications that led them to being able to deliver the training. Clear aims were provided at the start of each training day with an outline of what the content of the day would include (table 6.1 and table 6.2). At the end of each exercise during the training, time was given to allow for reflection and discussions, which were had in small groups and then as a larger discussion with the whole group. Each training day lasted approximately 6 hours, including time for breaks, so the entire training lasted around 12 hours over 2 days. More time was spent on certain mental toughness coaching strategies based on what the staff had discussed and prioritised in the NGT. For example, positive thinking involved six different activities and relaxation five different

activities, as these were discussed heavily and prioritised in the NGT. Whereas visualisation only involved two activities as the staff had not prioritised this in the NGT.

Table 6.1: The aims and content of training day 1.

Training Day 1	
Aims of Training Day 1	**Content of Training Day 1**
1. Learn about the background to the training (burnout and mental toughness).	• Definitions of mental toughness and burnout. • Brief outline of the literature and NGT and how led to the decision of what would be included in the training.
2. Understand why positive thinking is important and learn techniques to help with this.	• Positive thinking quick task-5 things that well and 5 things struggled with in last week. • Procrastination questionnaire-a positive thinking exercise. • Turning automatic negative thoughts into positive enabling thoughts. • US basketball exercise-a positive thinking and concentration exercise. • Positive thinking planner. • Posing for success-A confidence building exercise which shows the importance of body language.
3. Understand why anxiety control/relaxation is important and learn techniques to help with this.	• Progressive muscular relaxation. • Breathing and calming exercise. • Making a fist-muscle relaxation. • Ear tapping. • Guided relaxation.
4. Think about why it is important to practice techniques and have an opportunity to do this.	• Brief discussion on the importance of practicing techniques. • Practice session and reflection.

Table 6.2: The aims and content of training day 2.

Training Day 2	
Aims of Training Day 2	**Content of Training Day 2**
1. Understand what attentional control is, why it is important and learn techniques to help with this.	• Definition of attentional control and questions on 'what is the average attention span?'. • Concentration card trick task. • Stroop test-to develop concentration. • Number grid concentration exercise.
2. Understand why goal setting is important and learn techniques to help with this.	• Why goals can be useful-discussion. • 'What is my goal?' SMART goals exercise. • 'Not to do list' exercise-identify distractions from goals.
3. Understand why visualisation is important and learn techniques to help with this.	• 'what is visualisation'-discussion. • 'The scent of a lemon' visualisation exercise.
4. Summarise the two days training.	• Underlying principles of each technique recapped. • Questions and answers from the group.

6.4 Rationale for the timings, duration and location of the training

The training consisted of two days from 10am-4pm on both days. These timings also included time for consent forms and questionnaires for this research on both days. The implementation of the training was selected to be over two days due to previous literature suggesting that training such as this can be beneficial from as little as one day (Salyers *et al.*, 2011). Furthermore, two days was decided as suitable with the services due to the practicalities of staff being able to have time away from normal working hours to attend the training. A

recognised problem of using interventions to improve burnout in mental health staff, is that individuals do not always get the opportunity and time out of normal working duties to attend sessions and they are not always regularly available (White and Roche, 2006). Therefore, an intervention or training that teaches staff to look after their own wellbeing, over a short two days was selected as a suitable timeframe.

The training took place at a private office unit in a large training room, approximately 30 minutes travel time away from each of the services. This was selected as appropriate as the NGT had highlighted that staff 'away days' were important for staff wellbeing and that training focussing on their wellbeing should be away from the unit in which they worked. This can help to minimise distractions and allow staff to me fully immersed in the training and the techniques (Salyers *et al*., 2011).

6.5 Refinements of the training: practice before implementation

Once the techniques to use as part of the training had been decided on and the PowerPoint presentations were completed, a practice of the training package was carried out with four mental health workers before it was implemented as part of this research. The rationale behind carrying out this was to refine the training before implementation, in particular in terms of practicalities and timing of the training. Two suggestions were made following this and two refinements were made to the training (table 6.3). These refinements were specific to the content of the training and included suggestions such as adding group activities to replace some of the individual activities. This was taken on board to increase group participation and engagement. Specifically, for the relaxation component of the training, relaxation music was suggested to be added as background music to enhance this experience. Therefore, background relaxation music was added for when the staff were engaging in the relaxation techniques. A group video on guided relaxation was also added to this section.

Table 6.3: A step by step summary of how the training was decided on and when and how the training was refined.

Process	What was found	How training was refined
Literature Review	**1.** Mental toughness coaching strategies (positive thinking, relaxation/anxiety control, goal-setting, visualisation, attentional control) can be used to develop mental toughness. No research on using these strategies for developing mental toughness in mental health staff. **2.** Individuals with higher mental toughness reported lower levels of burnout. **3.** New training and initiatives should be informed by staff views and ideas. **4.** Previous training has focussed on teaching staff new ways of working to improve wellbeing rather than focussing on teaching ways for staff to improve their own wellbeing.	**1**.Considered using mental toughness coaching strategies for the training. **2.** Further informed decision to consider using mental toughness coaching strategies. **3.** Decided to use a NGT to incorporate staff views on what could improve their wellbeing. **4.** Decided focus should be on techniques staff can use to improve own wellbeing and not just new ways of working with service-users.
The NGT	**1.** Staff ideas/themes to improve mental toughness and burnout included: culture/organisation, staff wellbeing, education, teambuilding, positive thinking/feedback, support, relaxation, communication and the environment.	**1.** Decided on using mental toughness coaching strategies in the training. Decided on prioritising these strategies and time spent on these by using the staff ideas and discussion i.e. staff discussed positive thinking in depth and the importance of this, so first day of training to include this.
Practice before implementation	**1.** Asked for more group activities and discussion when completing some of the handouts and worksheets rather than completing these individually. This makes it more engaging and helpful as can share ideas and experiences with other people. **2.** Include background music when doing relaxation techniques to create a more relaxing and calmer environment.	**1.** Added more group activities to the training rather than individual activities. **2.** Added relaxation music to the training to be played in the background while practicing relaxation techniques.

6.6 Summary

This chapter has successfully met part of objective 3 of this thesis which was:

3. To develop and implement staff wellbeing training informed by literature and mental health staff ideas.

It has done this as it has outlined the training package that was decided on and implemented this with the mental health staff. It has described how the training was decided on from both the literature and NGT and when and how the training was refined. It also provides an outline of the content used for training day 1 and 2 and a brief rationale for the timings, duration and location of the training. The next chapter will go onto to describe the methods used for the intervention of this study which was the wellbeing training.

CHAPTER 7

METHODS- THE WELLBEING TRAINING

7.1 Introduction

This chapter describes the methods used for the intervention of this study which was the wellbeing training. The aim was to explore the perceptions of mental health staff of participating in a mental toughness training package focussed on findings ways to help with their wellbeing.

7.2 Ethical Considerations and Approval

The intervention (wellbeing training) was submitted for approval to the University of Central Lancashire ethics committee and received approval on 22/09/17- Ref: STEMH 706 (appendix 11). This study involved human participants and involved identifying the ethical considerations for implementing a staff wellbeing training package with mental health staff and using outcome measures and semi structured interviews to explore the experience of the staff being involved in this training.

Written consent was obtained from all participants who wished to take part (appendix 12). A copy of the written consent form was sent to the participants along with the initial letter of invitation (appendix 13) and information sheet (appendix 14). Written consent was collected from all individuals wishing to take part at the start of the first day of training prior to any research taking place. One copy was kept for research records and one copy was given to the participant to keep.

To ensure that consent was informed, participants were provided with information regarding the study. The information sheet was provided during recruitment. This provided participants with information on what was involved in

the study, why the study was taking place, what would happen with the information, how participants would be selected and recruited, how much time it would take and where the study was taking place. It also covered what to do if they did not want to take part, what to do if they did not want to continue with the study, the potential risks and benefits of taking part, who was doing the research and who the research had been approved by.

Participants were made clear about their right to withdraw. The information sheet given to participants contained a section titled 'do I have to take part?' and 'what will happen if I don't want to continue with the study?'. It was clearly explained on the information sheet that participation in this training was completely voluntary and that they were under no obligation to take part. Participants were informed that they were free to withdraw at any point, without question. They were informed that they could decide not to take part at any stage and were informed that their decision to withdraw would not affect their current job role in any way. After each phase (training, interviews and the three month follow up) data was anonymised and therefore participants were made aware that it would not be possible to retract the data. Therefore, withdrawal was essentially not possible after data was aggregated and participants were made aware of this on the participant information sheet.

Participants were informed that If they changed their mind after the training, anonymous data that could not be traced back to them would be continued to be used. The consent form asked participants to consent that they understood that their participation was completely voluntary and that they understood that they could withdraw at any time without giving a reason. Participants were also made aware that it would not affect their future relations with the University of Central Lancashire or their current job role if they withdrew.

Other considerations for the study included considering participants who might not adequately understand verbal explanations or written information given in English, or who may have special communication needs. The researcher was informed that there were no staff at the services at the time of the study who

did not adequately understand verbal or written English, as it was a requirement for staff at these services to be able to do this. However, any information that was printed out on paper for participants to read including worksheets and handouts was available in larger font sizes for those who had any visual impairment. Information during the training was also provided on a PowerPoint presentation via a projector that everyone could see. All pertinent information in the study was also read aloud by the researcher. Therefore, if individuals had difficulty with the written text, they received the same information verbally.

It was made clear in the information sheet that due to the nature of the topic, sensitive issues may be discussed and that the opinions of some participants may differ to others of the group. An assistant was present during the training; this was the same individual that had assisted with the practicalities of the NGT. This individual had previous experience of working in these services, however was no longer a staff member there. She was a current PhD student, studying in the mental health field. This individual did not contribute to the delivery of the training, they only observed the session, as well as assist with practicalities of the training including handing out worksheets and handouts. The assistant being present during the training was also a measure in place in the unlikely event that any participants experienced any unexpected outcomes or adverse effects arising from their involvement in the training. All information that was shared during the training sessions was treated as personal and sensitive and it was vital that all group members respected this and the groups confidentiality. Participants were encouraged to talk to the researcher if they were worried or had concerns. In the unlikely event that an individual had displayed signs of emotional distress during any point of the training, a space outside of the group training room was organised. This would allow a quiet place for the participant to have time to themselves and reflect. The assistant (the PhD student helping with the practicalities of the day) was there to help check how the participant was doing or help set up the next part of the training if the researcher needed to speak to the participant. It was planned that a conversation would then be had to see if the participant wanted to drop out or continue with the training. If an

individual had wished to drop out of the training, they would be asked if they would still like to be interviewed. The participant would also be advised to seek local sources of support, e.g. their line manager or GP if further support was required.

All activities which involve personal data of any kind, in any way, must comply with the Data Protection Act 1998 (DPA). A DPA checklist (appendix 15) was used which outlined the requirements of the DPA and the measures that must be taken when processing personal data. Interviews were arranged with participants immediatley after the last training session, if this was apropriate for the participant (i.e they had their rota or diary to book a time for the interview in). Otherwise participants were contacted via the email they had provided on the consent form, in order to arrange a suitable date and time for the first interview. Participants were also contacted via email several weeks before the three month follow up, to arrange a date and time for the folow up interview to take place. Participants personal data was kept until the end of the study, all personal data was stored securely in line with the UCLan code of conduct for research and UCLan Data protection policy.

The study required travel to a training room in Manchester, this was an independent company training room that had been hired by the manager of the three services for the purpose of this training. A travel/fieldwork risk assessment was completed (appendix 16) to ensure that all possible hazards and risks were identified and an appropriate action plan was in place to minimise any possible risks.

7.3 Recruitment

For the wellbeing training an agreement had been made to recruit participants from the same two mental health rehabilitation units that had been used to recruit participants for the NGT. In addition, one other service, also a mental health unit, agreed to be approached for recruitment and was managed by the

same manager as the other two services. All three services supported service-users with psychosis as well as other conditions such as depression and anxiety. The organisation of these services was a registered charity which has around 101 services across the UK, with around 27 of these focused on mental health. The three services recruited from provided residential rehabilitation for service-users. One of these services had a maximum of 12 service-users, male or female, aged over 18. Another of these services had a maximum of 10 service-users, male only, aged over 18. The third service had a maximum of 16 service-users, male or female, aged over 18. The staff teams consisted of multidisciplinary teams of mental health nurses, occupational therapists, support workers, art psychotherapists and project workers.

Participants were sampled via convenience sampling to include individuals from the services who were available and willing to participate in the study. The inclusion criterion was:

-any mental health worker who had been working in mental health services for at least three months. This included managers and any staff member who had any patient/service-user contact within the service.

The exclusion criterion was:

- Staff who had no patient/service-user contact within the service, e.g. administration or finance staff.

Each service had approximately 18 members of staff. However, a maximum sample size of 25 had been set due to practicalities of the training, such as the size of the training room. Participants were recruited on a first come first serve basis. The manager of the services agreed that staff who wanted to attend would be allowed time away from work and locum/cover staff would be brought in to cover their shifts.

In the first instance, a poster (appendix 17) was advertised in the services in staff areas, indicating the title of the training and where it would take place. This was to ensure that staff were aware of the training in advance of it taking place and

to allow staff to be able to organise shift patterns and attendance accordingly. The staff were approached with further information regarding the study via a letter of invitation, information sheet and consent form in their individual staff letterbox, which all staff had provided by the organisation at the service in which they worked. The manager had indicated this as the best way to recruit across these services, due to varying shift patterns. The letter contained details on how to get in touch with the PhD student or supervisors for more information, or if they would like to actively opt in and volunteer to take part. If no response had been received from participants a follow up letter (appendix 18) was posted in the staff letterbox after two weeks.

7.4 Data Generation Methods

A training package was implemented. This involved using the adult version of the mental toughness development toolkit available from AQR website, created by Douglas Strycharczyk. This included learning positive thinking, visualisation, attentional control, relaxation and anxiety control and goal setting (see table 6.1 and 6.2). The researcher administering the training was the PhD student.

The outcome measures, the MTQ48 and MBI-HSS were completed by participants on the first day of the training as part of the introduction and again at the end of the last day of training and also at a three month follow up. As the PhD student, I administered the outcome measures myself. Semi-structured interviews were also carried out with the participants, during the immediate weeks that followed the training and again at a three month follow up. As the PhD student, I conducted the interviews myself.

7.4.1The Mental Toughness Questionnaire 48 (MTQ48)

Participants completed the MTQ48 immediately before the start of the training on day one and immediately after the training had finished on day two and took around ten minutes to complete in a pen and paper format.

The MTQ48 is a 48 item psychometric measure of mental toughness. It breaks mental toughness down into the 4C's-challenge, commitment, control and confidence. Individuals respond to questions on a 5 point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The MTQ48 calculates an overall mental toughness score between 1-10 (with 10 being the highest mental toughness). High scores are scores of 8, 9, and 10. Low scores are scores of 1, 2, and 3. Scores of 4-7 represent the middle range. This is where 2/3 of the populations will score.

Two or more people may have exactly the same score but are actually reasonably different. For instance, two people can have the same overall score of mental toughness, for example a score of 6, but one may have a high commitment score and a low challenge score. The other person might have a low commitment score and a high challenge score. So, at first sight they might have the same overall score of mental toughness, but the nature of their respective mental toughness will be quite different (Strycharczyk and Clough, 2015).

When looking at the normal distribution for mental toughness, the outliers are in the 1-3 range or 8-10 range. Scores of 5 and 6 are the scores which almost 40% of the population will achieve.

The MTQ48 is found to have an overall test-retest coefficient of 0.90, therefore suggesting excellent reliability of this scale. All subscales of the MTQ48 reached the minimum acceptable level (0.70) as recommended by Kline (1999) when investigating the reliability of the psychological constructs. This supports the homogeneity of each subscale and the MTQ48 as a whole. The MTQ48 has also demonstrated validity, the concurrent validity for the MTQ48 and its scales ranges from 0.25 to 0.42, which is generally accepted as a high or acceptable

score, therefore indicating that it measures what it claims to measure (Clough *et al*., 2002). The measure is also normative; the tests results are compared to results for a relevant norm group which represents the general and larger population. This means that the measure can also be used for evaluation by measuring progress and the impact of interventions. It can also be used for research, such as assessing which interventions are most useful and with different people (Clough *et al*., 2002).

7.4.2 The Maslach Burnout Inventory-Human Services Survey (MBI-HSS)

Participants completed the MBI-HSS immediately before the start of the training on day one and immediately after the training had finished on day two and took around ten minutes to complete in a pen and paper format. The raw data was collected and inputted onto Microsoft Excel. Each participant was scored for the three scales of burnout as proposed by these outcome measure and includes emotional exhaustion, depersonalisation and personal accomplishment.

The MBI is the most widely recognised measure of burnout and the MBI-HSS is the original and most widely used version of the MBI to assess burnout in the human services professions. This measure of burnout is specifically designed for use for anyone who works in the human services sector including health professionals such as nurses, therapists, social workers and any professional that helps people by offering guidance, preventing harm and working with physical, emotional or cognitive problems. This measure contains 22 items with three scales of emotional exhaustion, depersonalisation and personal accomplishment.

The nine items in the emotional exhaustion scale describe feelings of being emotionally overextended and exhausted by one's work. The item with the highest factor loading (0.84) is the one referring directly to burnout, "I feel burned out from my work." For this scale the higher mean score corresponds to higher degrees of experienced burnout.

The five items in the depersonalization subscale describe an unfeeling and impersonal response towards recipients of one's care or service; for example, "I've become more callous toward people since I took this job." For this scale the higher mean score corresponds to higher degrees of experienced burnout.

The eight items of the personal accomplishment subscale describe feelings of competence and successful achievement in one's work with people; for example, "I feel I'm positively influencing other people's lives through my work." The higher mean scores on personal accomplishment correspond to lower degrees of burnout.

Maslach *et al*. (1996) reported internal consistency estimate of reliability of 0.90 for emotional exhaustion, 0.79 for depersonalisation and 0.71 for personal accomplishment. Therefore, the three dimensions on this outcome measure which propose to measure burnout produce similar scores (Maslach *et al*., 1996). Test-retest reliability of the MBI-HSS has reported a high degree of stability between the MBI-HSS scale scores and these do not vary markedly from a period of one month to a year (Leiter, 1990; Demerouti *et al*., 2009). Therefore, this stability is consistent with the MBI aim of measuring an enduring state.

Validity of the MBI-HSS has been demonstrated in research that confirm hypotheses about relationships between experienced burnout and job characteristics (Maslach and Pines, 1977; Alarcon, 2011). Convergent validity of the MBI-HSS has also been demonstrated by correlating the scale scores with observations of others e.g. observed by co-worker or spouse. Observers were able to predict the dimensions of the MBI-HSS based on the frequency of behaviours (Jackson and Maslach, 1982).

7.4.3 Semi-structured Interviews

Semi-structured interviews were carried out with the participants, during the immediate weeks that followed the training and again at a three month follow up. The interviews were conducted by the PhD student. Participants were given

the option of completing the questions via a form and emailing this to the researcher if they were unable to attend a face to face interview. This was to allow individuals who could not attend an interview to still have the opportunity to answer the questions. Semi-structured interviews are widely used by different healthcare professionals in their research, as these in-depth interviews require the participants to answer preset open-ended questions. Semi-structured interviews are based on a semi-structured interview guide, which is a presentation of questions or topics that need to be explored by the interviewer. It allows the main research question to be explored as well as associated questions that help to explore the main question or topic in further detail (DiCicco-Bloom and Crabtree, 2006).

The interview questions (appendix 19) were decided upon as appropriate to answer the research question and were approved by the UCLan ethics committee. The questions started with an introduction into their job role and the sort of work that they do. This first question was used as a type of icebreaker question, a chance for participants to feel more relaxed and comfortable and to gain some information about the individual being interviewed. It is considered important in interviews to allow participants to feel at ease and feel able to talk freely (Dornyei, 2007).

The main content covered why they wanted to attend the training, aspects of work they find challenging and effects or any impact of the training on their work and the service. It also covered their experience of being involved in the wellbeing training and what they found most helpful to them from the training. An opportunity was given towards the end of the interview to discuss anything else regarding the topic that the participant wished too. It is important to give participants an opportunity at the end of an interview to bring up any further comments that they wish to regarding the topic (Berg, 2009).

The questions were practiced before being used with the participants in order to build confidence and familiarity with the interview questions. After the completion of the first interviews the follow up questions were revisited in order

to scrutinise the questions and check that no refinements were required before the follow up interviews. No refinements to the questions were required at this time.

The interview questions at the three month follow up (appendix 20) mirrored the questions used at the interviews carried out straight after the implementation of the training. The only differences were with regards to the first question, where the participants were asked about if anything had changed in the last three months with regards to their job role. The question was used to help the participants relax and feel comfortable and to also gather information about the individual and their job role in the last three months. The questions were used to gather information on the participant's experience of being involved in the wellbeing training three months previous and also with regards to how the training three months previously had impacted on themselves, their job role and their service. A three month follow up was decided as appropriate for this study. This was because previous research using a type of wellbeing workshop, training or retreat with mental health staff over a similar timescale of one or two days, had emphasised the benefits of a follow up study (Salyers *et al*., 2011; Razzaque and Wood, 2016; Carson *et al*., 1999). This previous research also highlighted that a longer follow up study would be beneficial, with follow up studies varying from one week (Razzaque and Wood, 2016) to six weeks (Salyers *et al*., 2011) for the one or two-day training/workshops. These follow up studies that took place six weeks or under following the training, highlighted that a follow up several months after the implementation of training would be more beneficial. This would allow for any longer term effects to be explored. Other research using wellbeing support groups for mental health staff used a follow up of six months, however found that attrition levels were high (Carson *et al*., 1999). Therefore, based on previous evidence a follow up at three months was decided as appropriate for this study. This was to allow for enough time to pass to potentially explore more long-term benefits but also not so long to try and minimise dropout rates and reduce attrition levels.

The timeline for the data collection for the wellbeing training can be seen in figure 7.1 and displays clearly the process from before the implementation of the training to the end of the three month follow up.

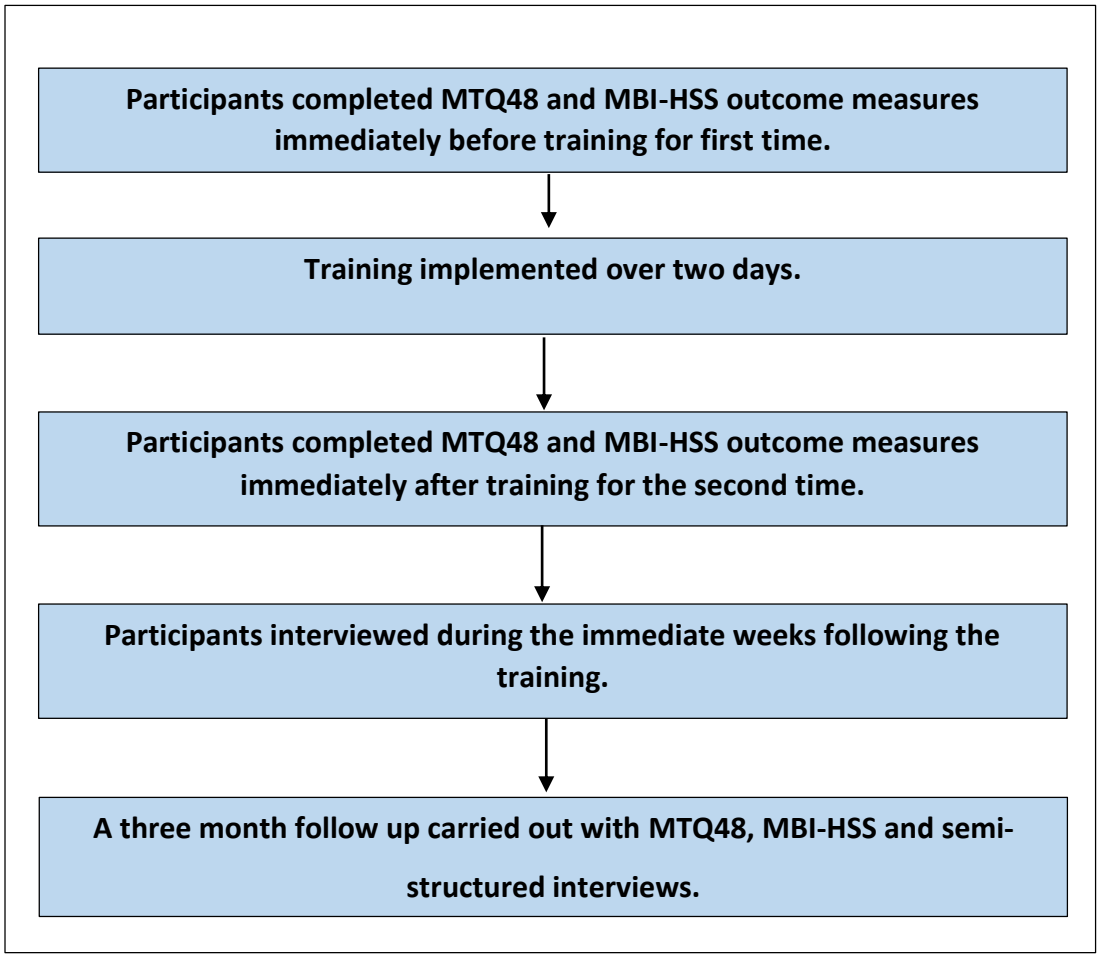


Figure 7.1: Timeline for data collection for the wellbeing training.

7.5 Data Analysis Plan

The data from the outcome measures was used to see if any patterns were found in the outcome measures after piloting the intervention. Please note the participant names presented in this thesis are pseudonyms in order to protect the identity of the participants. The MTQ48 data was scored into the

subcomponets of mental toughness; control, emotional control, life control, commitment, challenge, confidence, confidence in abilities and interpersonal confidence. An overall mental toughness score was also calculated for each inidvidual.The MBI-HSS data was scored into three components of burnout; emotional exhaustion, depersonalisation and personal accomplishment. Descriptive statistics were used to show any patterns from the outcome measures including mean and standard deviation. As the outcome measures were only used to display patterns no power calculation was required for sample size.

Thematic analysis was used to help explore the interviews. It is recognised that is important to report the process and detail of the anaylsis used (Attride-Stirling, 2001) (the rationale for using this analysis is discussed in chapter 3 section 3.7) Therefore, the steps used in this analytical process will now be outlined. **Step 1-** once the text was transcribed from the audio-recordings taken at the time of interview, the first step was to reduce the text into more manageable and meaningful sections using a coding framework. In this study a coding framework was developed based on recurrent patterns/themes in the interviews rather than following a criteria of pre-established ideas or themes. Transcripts were first coded by hand using a pen and paper format to become familiar with the text. An individual in a supervisory role coded one of the same transcripts so that we were able to compare codes and see if similar codes had emerged. This was then added to the software NVivo to aid in this process of analysis. Core codes were dervied from sub-codes that were stored in a code log book for interviews directly after the training (appendix 21) and interviews at the three month follow up (appendix 22). **Step 2-** once all the text had been coded, themes were abstracted from the text segments. These themes were refined by re-reading the text and ensuring that each theme summarises the text succinctly and appropriatley. At this stage the supervisory team also read the text to compare and discuss the themes in detail. This was done to strengthen the analysis by having two inidviduals in a supervisory role check the themes matched the text segments. The name of the themes were chosen to best describe what the

theme actually related to from the text from the interviews. **Step 3-** thematic networks were constructed by arranging the themes into similar groups and exploring how each theme related to each other. These were then arranged into basic themes, organising themes and global themes which are represented as a thematic network (figure 8.15 and figure 8.16). The thematic network was developed starting with the basic themes and working inwards toward the global theme. Once the collection of basic themes was derived, they were then classified according to the underlying story they were telling and these became the organising themes. The organising themes and basic themes, were then brought together to illustrate a single conclusion or super-ordinate theme that became the global theme (Attride-Stirling, 2001). The development of the themes into the thematic network were discussed in detail with the supervisory team to add clarity to the chosen themes and to discuss where in the text the themes had developed from.

Step 4- this final stage involved describing and exploring the thematic networks in more detail with the support of direct quotes from the interviews to reinforce the themes.The thematic network was used as a tool for analysis and to help find deep meaning and insights in the texts.

7.6 Summary

This chapter has outlined the methods used for the intervention of this study which was the wellbeing training. The next chapter will present the results from the wellbeing training.

CHAPTER 8

RESULTS-THE WELLBEING TRAINING

8.1 Introduction

This section contains the results from the intervention of this study which was the wellbeing training. The results from the outcome measures before and after the training and at the three month follow up will be presented. The chapter will then go onto to present the resulting thematic analysis from the interviews with the participants the immediate weeks following the implementation of the training, as well as from the interviews at the three month follow up. The quantitative outcome measures and the qualitative interviews have also been combined in order to look for patterns or contradictions.

8.2 Demographics of the participants in the staff wellbeing training

A total of 11 participants took part in the training, this included a mix of staff from the three services that were initially approached. Each service had approximately 18 members of staff employed at the service in total, including management staff. There were 5 participants from one service, 3 from another and 3 from the third service. Of these participants 4 had been part of the NGT. The staff were from a multidisciplinary team and included 6 support workers, 2 mental health nurses, 1 senior mental health nurse, 1 project worker and 1 clinical lead. Of the 11 participants, 6 were female and 5 were male. The overall mean age of the participants was 43 years. The overall mean time working in the mental health service which they were recruited from was 5 years 5 months. The mean age of the female participants was 39 years and the mean age of the male participants was 48 years. The mean time working in the mental health service which they were recruited from was 6 years 1 month for the female participants and 4 years 6 months for the male participants.

The overall mean length of time of the participants working in mental health services as a whole was 9 years 7 months. The mean length of time of the female participants working in mental health services as a whole was 10 years 5 months. The mean length of time of the male participants working in mental health services as a whole was 8 years 7 months.

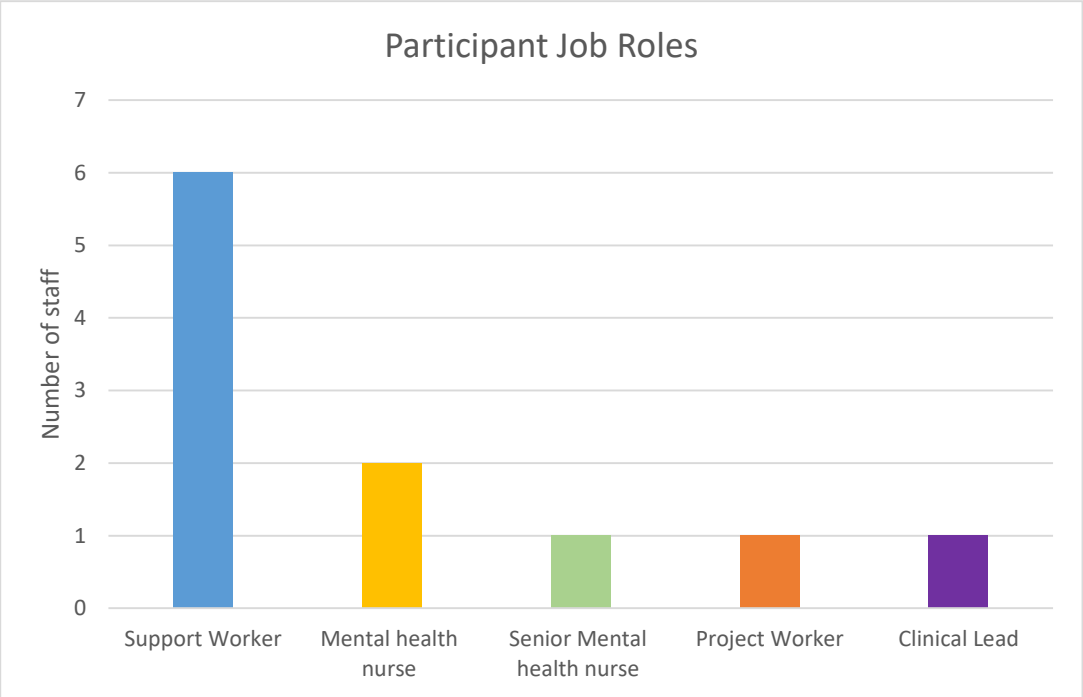


Figure 8.1: Mental health professions that participated in the staff wellbeing training.

8.3 Demographics of participants at the three month follow up

A total of 9 participants took part in the follow up study. Two individuals were unable to take part in the follow up study due to being on maternity leave and through leaving the current job and being uncontactable. Of the 9 participants, 4 had been part of the NGT as well as the training. One participant completed the questions in written form rather than as a semi-structured interview, this was due to night shift work making the participant unavailable to be interviewed. Participants were given the option of completing the questions via a form and

emailing this to the researcher if they were unable to attend a face to face interview.

The staff were from a multidisciplinary team and included 6 support workers, 1 mental health nurse, 1 senior mental health nurse and 1 project worker. Of the 9 participants, 5 were female and 4 were male. Of these participants at the follow up, 4 individuals had been part of the NGT and the training and 5 participants had been part of the training but not the NGT. The overall mean age of the participants was 45 years. The overall mean time working in the mental health service which they were recruited from was 5 years 7 months. The mean age of the female participants was 43 years and the mean age of the male participants was 51 years. The mean time working in the mental health service which they were recruited from was 5 years 8 months for the female participants and 5 years 5 months for the male participants.

The overall mean length of time of the participants working in mental health services as a whole was 10 years 2 months. The mean length of time of the female participants working in mental health services as a whole was 10 years. The mean length of time of the male participants working in mental health services as a whole was 10 years 5 months.

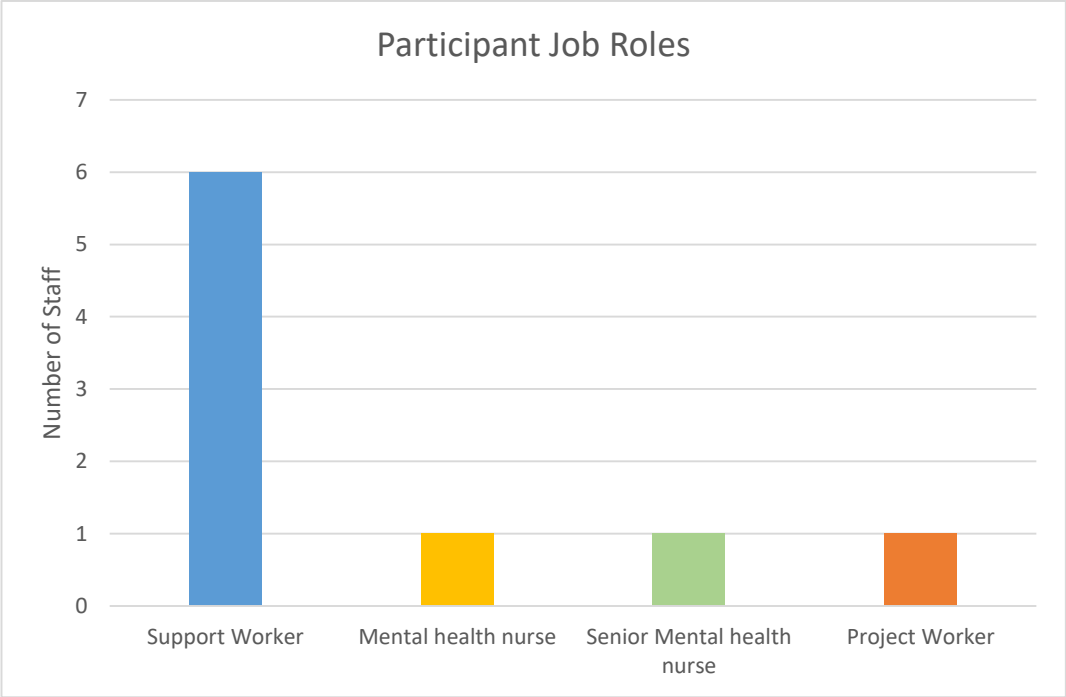


Figure: 8.2: Mental health professions that participated in the three month follow up.

8.4 MTQ48 and MBI-HSS results before and after the wellbeing training and at the three month follow up

In order to indicate which participants scored high and low on the outcome measures before and after the training and at the three month follow up, individual participants scores for their overall mental toughness and for the three scales of MBI-HSS are presented in table 8.1 and table 8.2. Please note the participant names presented are pseudonyms in order to protect the identity of the participants. The results for the overall mental toughness and the four components of mental toughness-control, commitment, challenge and confidence are presented as means for the group and in graph form further on in this chapter. Following this the results for the MBI-HSS for the three scales of burnout- emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) are also presented as means for the group and in graph form. Each participant's three scale scores from the MBI-HSS should be determined and these scale scores should be interpreted separately. It is not

appropriate to add the three scale scores to create a total burnout score (Maslach *et al*., 1996).

Means and standard deviations have been used to present the data so that the results of the outcome measures can be compared to the mean values from the literature. For example, the data for the participants of this study can be compared to data from other samples of mental health staff who completed the MBI-HSS. Using data such as this allows the participants relative degree of burnout to be compared to the average for their group. Similarly, where possible the means and standard deviations can be compared from the mental health staff in this study, to literature which has presented the means for the subscales of the MTQ48. Means and standard deviations have been presented throughout this thesis to two decimal places in order to be consistent with existing literature that has presented MBI-HSS and MTQ48 data.

Table 8.1: Participants scores for their overall mental toughness from the MTQ48 before and after the training and at the three month follow up.

Participant	MTQ48 Mental Toughness **BEFORE**	MTQ48 Mental Toughness **AFTER**	MTQ48 Mental Toughness **FOLLOW UP**
Sophie	4	4	4
John	6	7	7
David	6	6	6
Rob	7	7	8
Lauren	1	3	5
Lucy	6	6	7
Amy	3	4	6
Richard	5	5	5
Emma	6	9	10
Ben	7	9	nights
Jo	9	10	maternity
MEAN	5.45	6.36	6.44
SD	2.16	2.29	1.81

*MTQ48=Mental Toughness Questionnaire 48

Table 8.2: Participants scores for the three dimensions of burnout from the MBI-HSS before and after the training and at the three month follow up.

Participant	MBI-HSS EE **BEFORE**	MBI-HSS EE **AFTER**	MBI-HSS EE **FOLLOW UP**	MBI-HSS DP **BEFORE**	MBI-HSS DP **AFTER**	MBI-HSS DP **FOLLOW UP**	MBI-HSS PA **BEFORE**	MBI-HSS PA **AFTER**	MBI-HSS PA **FOLLOW UP**
Sophie	7	6	4	3	2	2	19	19	19
John	22	19	17	4	1	1	34	35	35
David	16	21	19	1	2	1	39	38	38
Rob	10	9	10	0	0	0	40	40	43
Lauren	11	10	10	1	1	0	38	42	44
Lucy	16	13	13	0	0	2	40	40	44
Amy	19	21	13	10	9	4	23	37	44
Richard	30	20	16	8	2	2	47	47	47
Emma	19	10	10	2	0	0	44	47	47
Ben	11	3	left	3	0	left	46	47	left
Jo	9	6	maternity	3	0	maternity	39	40	maternity
MEAN	15.45	12.54	12.44	3.18	1.54	1.33	37.18	39.27	40.11
SD	6.80	6.65	4.55	3.18	2.62	1.32	8.86	7.9	8.83

*MBI-HSS=Maslach burnout inventory-human services survey, EE=Emotional exhaustion, DP=Depersonalisation, PA=Personal accomplishment.

8.5 MTQ48 results for before and after the wellbeing training and at the three month follow up

This next section will present the results from the MTQ48 outcome measure before and after the wellbeing training and at the three month follow up. It will display the means for the group of participants for the overall mental toughness and the components of mental toughness-confidence, control, commitment and challenge.

8.5.1 Overall Mental Toughness

The MTQ48 calculates an overall mental toughness score between 1-10 (with 10 being the highest mental toughness).

From the group of 11 participants that took part in the wellbeing training the overall mental toughness mean score was 5.45 (SD=2.16) before the training and the overall mental toughness mean score was 6.36 (SD=2.29) after the training (figure 8.3).

Of the 11 participants 6 individuals scored higher on the MTQ48 after the training than before the training, with improvements in score between 1 and 3 points higher.

Of these 11 participants 5 individuals scored the same on the MTQ48 after the training as before the training. No individual scored less on the MTQ48 for overall mental toughness after the training. Before the training 2 participants scored below the middle range for the MTQ48 (between a score of 4 and 7) and no individuals scored higher than this. After the training 1 of these individuals still scored below the middle range. After the training 3 individuals scored above the middle range for the MTQ48.

From the group of 9 participants that took part in the follow up, the overall mental toughness mean score was 6.44 (SD=1.81) (figure 8.3).

Of the 9 participants, 5 individuals scored higher on the MTQ48 at the follow up compared to before and after the training, 2 of these individuals scored 2 points higher and 3 of these individuals scored 1 point higher at the follow up compared to after the training. Of the 9 participants 4 individuals scored the same at the follow up as they scored after the training.

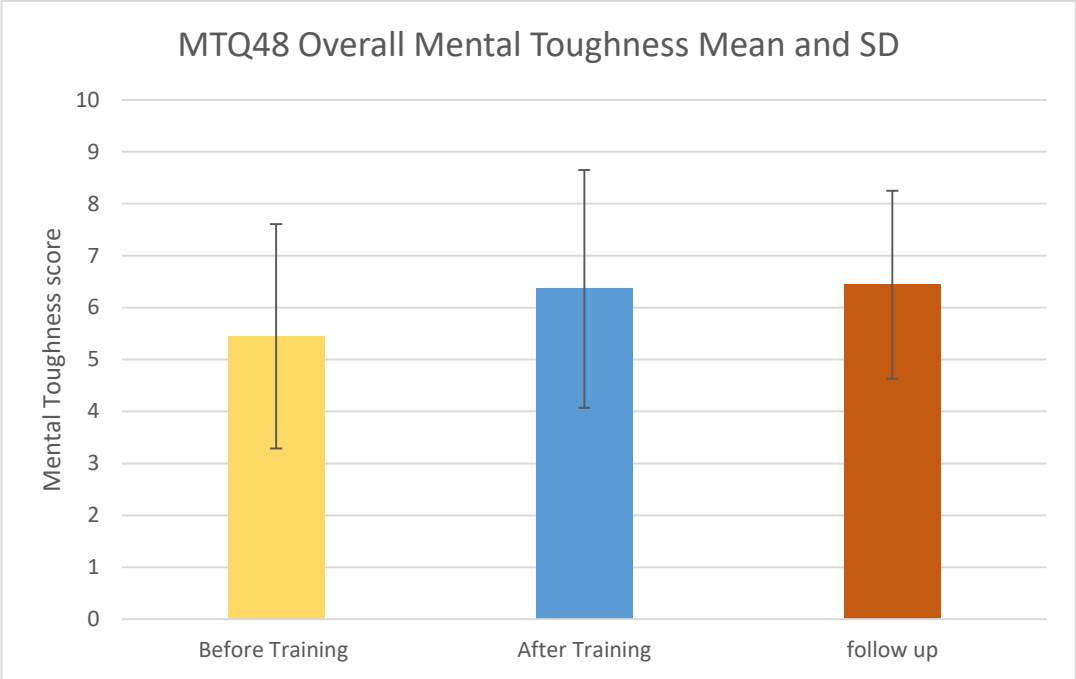


Figure 8.3: MTQ48 overall mental toughness mean and standard deviation before and after the training and at three month follow up.

8.5.2 Control

Overall mental toughness can be broken down into the 4C's of mental toughness - control, confidence, commitment and challenge. The component control can be divided into life control and emotional control. From the group of 11 participants that took part in the wellbeing training the mean score for 'control' was 5.45 (SD=2.29) before the training and 6.09 (SD=2.30) after the training (figure 8.4).

Of the 11 participants 5 individuals scored higher on the MTQ48 for the component of 'control' after the training than before the training, with improvements in score between 1 and 5 points higher.

Of the 11 participants 4 individuals scored the same for 'control' after the training as before the training. Also 2 individuals scored less for 'control' after the training than before, with a decrease in score of 1 and 2 points.

From the group of 9 participants at the follow up the mean score for ‘control’ was 6.33 (SD=2.29) (figure 8.4). Of these participants 4 individuals scored higher for ‘control’ at the follow up compared to before and after the training. The other 5 participants scored the same at the follow up as they scored after the training.

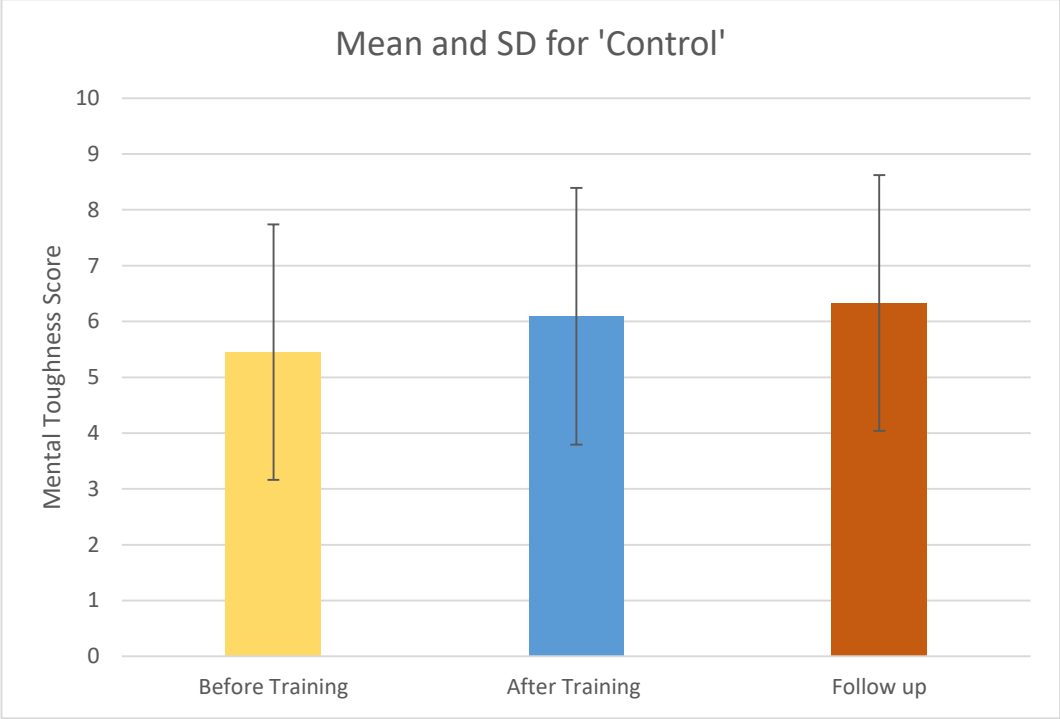


Figure 8.4: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the component of ‘control’ from the MTQ48.

‘Emotional control’ mean was 5.18 (SD=2.08) before the training and 5.18 (SD=2.27) after the training (figure 8.5). Of the 11 participants 5 individuals scored higher for ‘emotional control’ after the training, with an increase in score between 1 and 3 points. Of the 11 participants 3 individuals scored the same for ‘emotional control’ after the training as before and 3 individuals scored less for ‘emotional control’ after the training than before, with a decrease in score of 1 to 2 points.

‘Emotional control’ mean was 5.66 (SD=1.73) at the three month follow up. Of the 9 participants 6 individuals scored higher for ‘emotional control’ at the follow up. The other 3 individuals scored the same for ‘emotional control’ at the follow up as after the training.

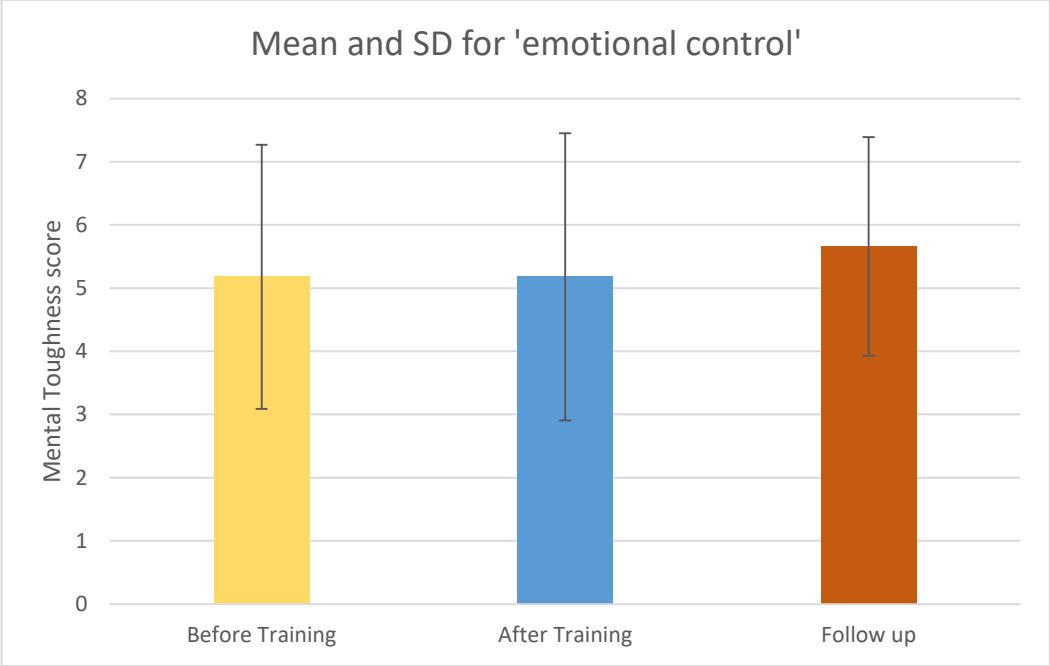


Figure 8.5: Mean and standard deviation before and after the training and at the three month follow up for the subcomponent of ‘emotional control’ from the MTQ48.

‘Life control’ mean was 5.36 (SD=2.15) before the training and 6.45 (SD=1.91) after the training (figure 8.6). Of the 11 participants 7 individuals scored higher for ‘life control’ after the training, with an increase in score between 1 and 3 points higher. There were 3 individuals that scored the same before and after the training for ‘life control’ and 1 individual scored less after the training than before with a decrease in score of 1 point.

‘Life control’ mean was 6.44 (SD=2.12) at the three month follow up (figure 8.6). Of the 9 participants 3 individuals scored higher for ‘life control’ at the follow up. There were 5 individuals that scored the same for ‘life control’ at the follow up as

after the training and 1 individual that scored lower at the follow up for 'emotional control' compared to after the training.

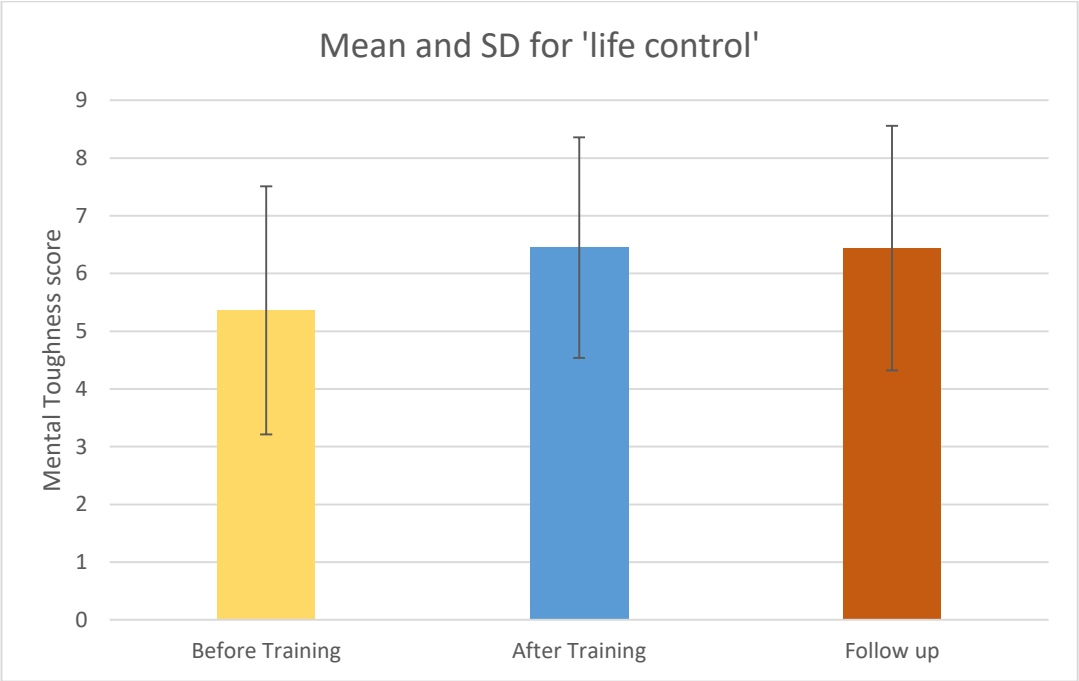


Figure 8.6: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the subcomponent of 'life control' from the MTQ48.

8.5.3 Commitment

For the component of 'commitment' the mean score was 5.54 (SD=1.75) before the training and 6.63 (SD=2.06) after the training (figure 8.7).

Of the 11 participants 7 individuals scored higher on the MTQ48 for the component of 'commitment' after the training than before the training, with improvements in score between 1 and 4 points higher.

Of the 11 participants 3 individuals scored the same for 'commitment' after the training as before and 1 individual scored less for 'commitment' after the training than before, with a decrease in score of 1 point.

For the component of ‘commitment’ the mean score was 6.66 (SD=1.87) at the follow up (figure 7.5).

Of the 9 participants 4 individuals scored higher on the MTQ48 for the component of ‘commitment’ at the follow up compared to after the training. The other 5 participants scored the same at the follow up as they scored after the training.

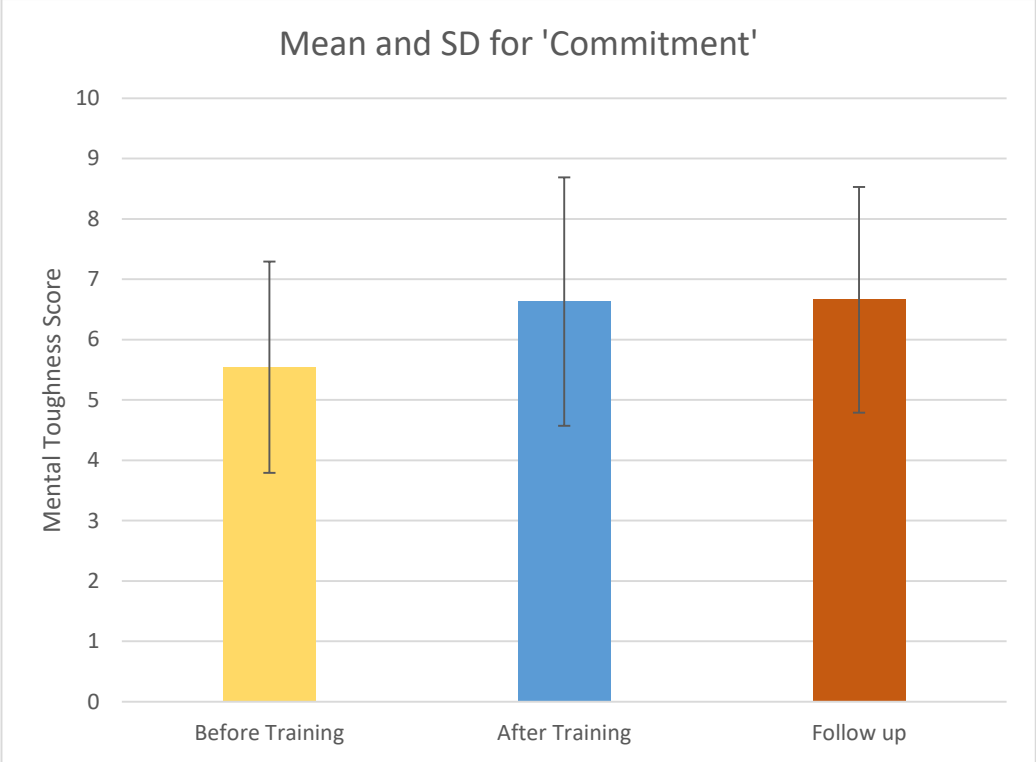


Figure 8.7: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the component of ‘commitment’ from the MTQ48.

8.5.4 Challenge

For the component of ‘challenge’ the mean score was 4.63 (SD=1.85) before the training and 5.0 (SD=2.32) after the training (figure 8.8).

Of the 11 participants 5 individuals scored higher on the MTQ48 for the component of ‘challenge’ after the training than before the training, with improvements in score between 1 and 3 points higher.

Of the 11 participants 2 individuals scored the same for ‘challenge’ after the training as before and 4 individuals scored less for ‘challenge’ after the training than before, with a decrease in score of 1 and 2 points.

From the group of 9 participants at the follow up the mean score for ‘challenge’ was 4.66 (SD=1.93) (figure 8.8). Of these participants 3 individuals scored higher for ‘challenge’ at the three month follow up compared to after the training. There were 4 individuals that scored the same for ‘challenge’ at the follow up as after the training and 2 individuals that scored lower at the follow up for ‘challenge’ compared to after the training.

Figure 8.8: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the component of ‘challenge’ from the MTQ48.

8.5.5 Confidence

The component ‘confidence’ can be divided into ‘confidence in abilities’ and ‘interpersonal confidence’. For the component of overall ‘confidence’ the mean score was 5.45 (SD=1.91) before the training and 6.45 (SD=2.16) after the training (figure 8.9).

Of the 11 participants 7 individuals scored higher on the MTQ48 for the component of ‘confidence’ after the training than before the training, with increases in score between 1 and 4 points higher.

Of the 11 participants 2 individuals scored the same for ‘confidence’ after the training as before and 2 individuals scored less for ‘confidence’ after the training than before, with a decrease in score of 1 point.

At the three month follow up the mean score was 6.87 (SD=1.81) for the component of ‘confidence’.

Of the 9 participants in the follow up study 4 individuals scored higher on the MTQ48 for the component of ‘confidence’ at the follow up compared to after the training. There were 4 individuals that scored the same at the follow up as after the training and 1 individual scored lower for ‘confidence’ at the follow up compared to after the training.

Figure 8.9: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the component of 'confidence' from the MTQ48.

For 'Confidence in abilities' the mean was 5.27 (SD=1.67) before the training and 6.63 (SD=2.20) after the training (figure 8.10).

Of the 11 participants 9 individuals scored higher for 'confidence in abilities' after the training, with an increase in score between 1 and 4 points. Of the 11 participants 2 individuals scored less for 'confidence in abilities' after the training than before, with a decrease in score of 1 to 2 points.

'Confidence in abilities' mean was 7.0 (SD=1.41) at the three month follow up (figure 8.10). Of the 9 participants 5 individuals scored higher for 'confidence in abilities' at the follow up compared to after the training. There were 4 participants who scored the same for 'confidence in abilities' at the follow up as after the training.

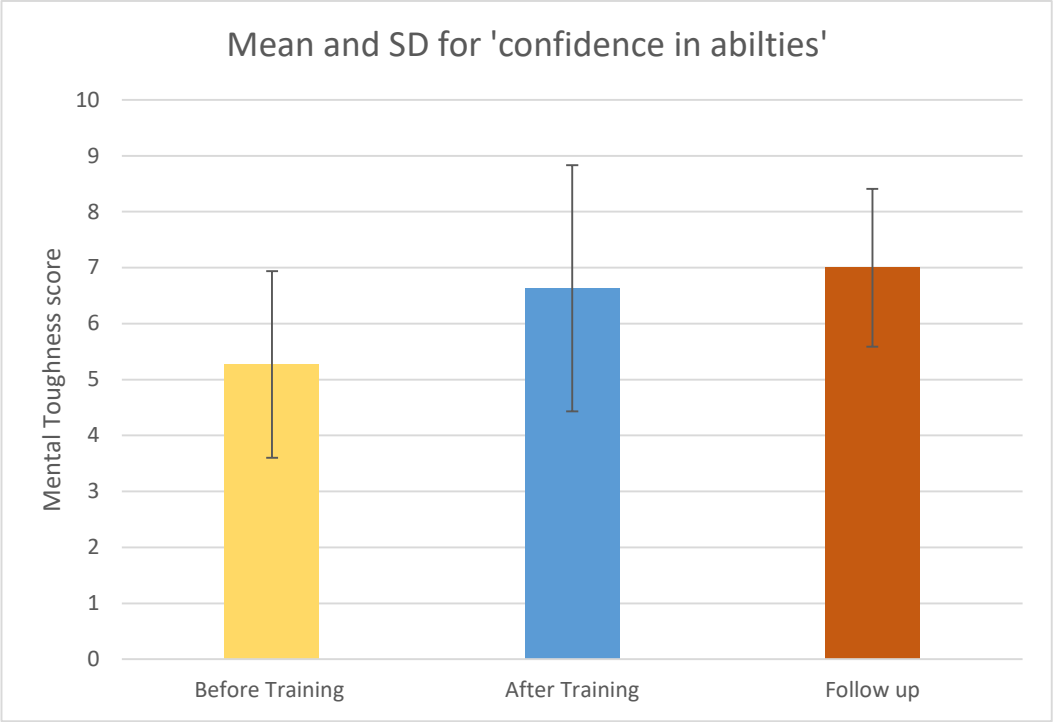


Figure 8.10: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the subcomponent of 'confidence in abilities' from the MTQ48.

'Interpersonal confidence' was 5.09 (SD=1.64) before the training and 5.81 (SD=1.99) after the training (figure 8.11).

Of the 11 participants 5 individuals scored higher for 'interpersonal confidence' after the training, with an increase in score between 1 and 4 points higher. There were 5 individuals that scored the same before and after the training for 'interpersonal confidence' and 1 individual scored less after the training than before with a decrease in score of 1 point.

'Interpersonal confidence' was 5.88 (SD=1.83) at the three month follow up (figure 8.11).

Of the 9 participants 3 individuals scored higher for 'interpersonal confidence' at the follow up compared to after the training and 6 individuals scored the same at the follow up as they scored after the training.

Figure 8.11: Mean and standard deviation mental toughness scores before and after the training and at the three month follow up for the subcomponent of 'interpersonal confidence' from the MTQ48.

8.6 MBI-HSS results before and after the wellbeing training and at the three month follow up

This next section will present the results from the MBI-HSS outcome measure before and after the wellbeing training and at the three month follow up. It will display the means for the group of participants for the three dimensions of burnout-emotional exhaustion, depersonalisation and personal accomplishment.

Each participants three scales scores from the MBI-HSS should be determined and these scale scores should be interpreted separately. It is not appropriate to add the three scores to create a total burnout score (Maslach *et al*., 1996).

Means and standard deviations have been used to present the data so that the results of the outcome measures can be compared to the mean values from the literature. For example, the data for the participants of this study can be compared to data from other samples of mental health staff who completed the

MBI-HSS. Using data such as this allows the participants relative degree of burnout to be compared to the average for their group.

8.6.1 Emotional Exhaustion

From the group of 11 participants the mean score for 'emotional exhaustion' before the training was 15.45 (SD=6.80). The mean score for 'emotional exhaustion' after the training was 12.54 (SD=6.65) (figure 8.12).

Of the 11 participants 10 individuals scored lower for 'emotional exhaustion' after the training than before. The 1 other individual scored higher for 'emotional exhaustion' after the training.

From the group of 9 participants that took part in the follow up study the mean score for 'emotional exhaustion' was 12.44 (SD=4.55) (figure 8.12).

Of these 9 participants 5 individuals scored lower for 'emotional exhaustion' at the follow up compared to after the training. There were 3 individuals that scored the same at the follow up as after the training and 1 individual scored higher at the follow up compared to after the training for 'emotional exhaustion'.

Figure 8.12: Mean and standard deviation before and after the training and at the three month follow up for the dimension of 'emotional exhaustion' from the MBI-HSS.

8.6.2 Depersonalisation

From the group of 11 participants the mean score for 'depersonalisation' before the training was 3.18 (SD=3.18). The mean score for 'depersonalisation' after the training was 1.54 (SD=2.62) (figure 8.13).

Of the 11 participants 7 individuals scored lower for 'depersonalisation' after the training than before. There were 3 individuals that scored the same for 'depersonalisation' before and after the training and 1 individual that scored higher after the training for 'depersonalisation'.

From the group of 9 participants that took part in the follow up study the mean score for 'depersonalisation' was 1.33 (SD=1.32) (figure 8.13).

Of these 9 participants 3 individuals scored lower for 'depersonalisation' at the follow up compared to after the training. There were 5 individuals that scored

the same at the follow up as after the training and 1 individual scored higher at the follow up compared to after the training for ‘depersonalisation’.

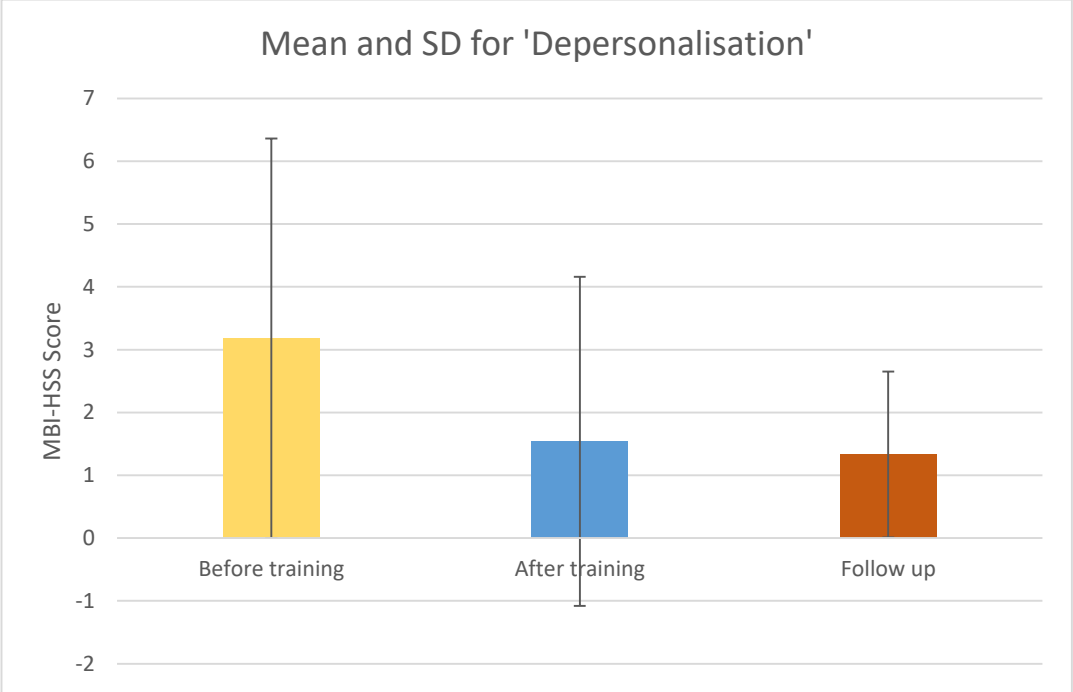


Figure 8.13: Mean and standard deviation before and after the training and at the three month follow up for the dimension of ‘depersonalisation’ from the MBI-HSS.

8.6.3 Personal Accomplishment

The mean score for ‘personal accomplishment’ before the training was 37.18 (SD=8.86). The mean score for ‘personal accomplishment’ after the training was 39.27 (SD=7.9) (figure 8.14).

Of the 11 participants 6 individuals scored higher for ‘personal accomplishment’ after the training than before. There were 4 individuals that scored the same for ‘personal accomplishment’ before and after the training and 1 individual that scored lower after the training for ‘personal accomplishment’.

From the group of 9 participants that took part in the follow up study the mean score for ‘personal accomplishment’ was 40.11 (SD=8.83) (figure 8.14).

Of these 9 participants 4 individuals scored higher at the follow up compared to after the training for 'personal accomplishment'. There were 5 individuals that scored the same at the follow up for 'personal accomplishment' as after the training.

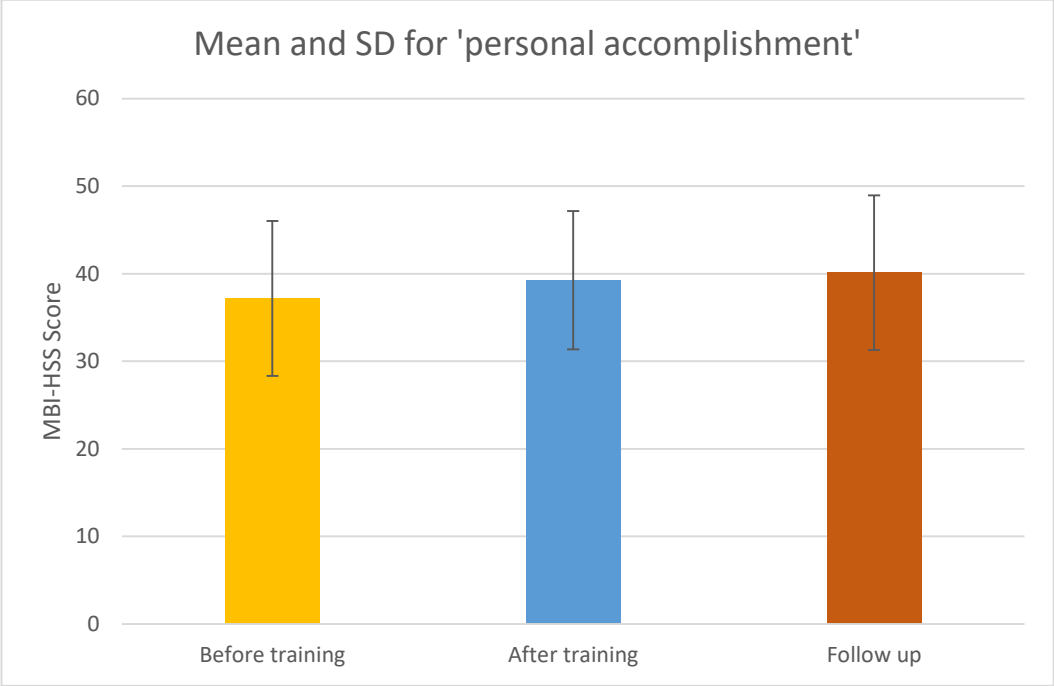


Figure 8.14: Mean and standard deviation before and after the training and at the three month follow up for the dimension of 'personal accomplishment' from the MBI-HSS.

8.7 Summary of the results from the MTQ48 and MBI-HSS

This section has presented the results from MTQ48 and MBI-HSS before and after the wellbeing training intervention and at the three month follow up. In order to summarise the findings and highlight some of the key take homes messages an outline is provided below. Section 8.14 provides a discussion of the results from the wellbeing training and chapter 9 will discuss these results in more detail along with implications and recommendations for future training and research.

8.7.1 Take home messages-from the MTQ48 and MBI-HSS

- The component **challenge** from the MTQ48 had the lowest average group score (mean=4.63).
- The component **confidence in abilities** from the MTQ48 had the highest average group score (mean=7.0)
- The group mean scores for the burnout dimensions of **emotional exhaustion and depersonalisation** were lower after the training than before the training.
- The group mean scores for the burnout dimension of **personal accomplishment** was higher after the training than before the training.
- Participants who scored higher on the ***confidence*** subscale of the MTQ48 after the training also displayed a higher score on the ***personal accomplishment*** subscale of MBI-HSS.

8.8 Staff Interviews directly after the training

All 11 participants completed the interview questions, however 2 of these completed the questions in written form rather than as a semi-structured interview. This was due to maternity leave and night shifts making the participants unavailable to be interviewed after the training. As described in chapter 7 (section 7.43) participants were given the option of completing the questions via a form and emailing this to the researcher if they were unable to attend a face to face interview. The other 9 participants completed the interviews during the three weeks following the training.

The resulting thematic analysis created ten basic themes which were then clustered into three organising themes. These organising themes were then summarised into one main resulting global theme (table 8.3). The next section will detail these themes and provide supporting evidence for these from the participants. In addition, how some of the quantitative data fits with the themes has also been incorporated in this section.

As stated in Chapter 7 section 7.5 the name of the themes were chosen to most transparently describe each theme that had been derived from the participant interviews. Evidence is presented in this thesis to be fully transparent about the process of development of these themes. This includes a mental representation of codes (appendix 23) which shows the thought process behind naming the themes and the development of these (this was a stage in the analysis process, and not the final version of thematic analysis). Also extracts from my supervision records illustrate some of the conversations with the supervisory team regarding the generation of the themes (appendix 24).

Table 8.3: Themes generated from interviews with staff after the wellbeing training.

Basic Theme	Organising Theme	Global Theme
Confidence	Self	Staff perceptions from the training
Changes in thinking patterns		
Motivation		
Beliefs about mental toughness and burnout		
Self-awareness		
Wider application with service-users	Inside the service	
Wider application with colleagues		
Culture of the service		
Wider applications for life after work	Outside the service	
Wider team/other services		

8.8.1 Global theme: Staff perceptions from the training

The main theme resulting from the staff interviews was 'staff perceptions from the training' with figure 8.15 detailing the thematic network for this theme. Other feedback gained from the interviews regarding the system and processes of the actual training package and its delivery are described and discussed later on in this chapter.

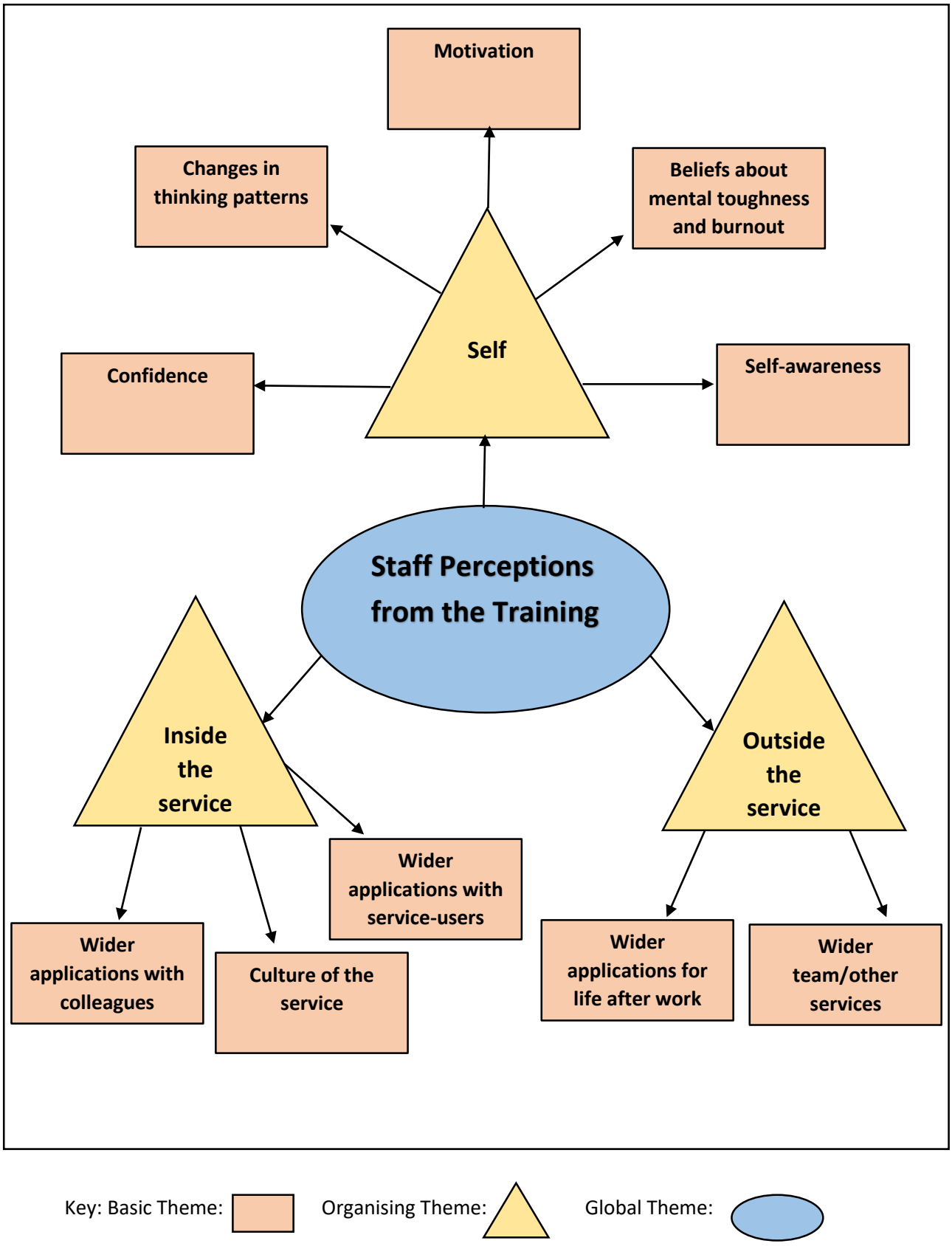


Figure 8.15: Thematic network for staff perceptions directly after the training.

8.8.2 Organising Theme: Self

The first organising theme from the interviews was related to staff perceptions of 'self' following the training. The definition of 'self' in these results refers to a person's individual thoughts, feelings and behaviours that distinguish them from others. It includes an individual's confidence, motivation, beliefs and feelings.

Staff discussed their perceptions of their ***confidence*** following the training. Several of the staff discussed confidence as an area that they perceived had changed or improved in some way following the training. Confidence is a main component of mental toughness. Individuals that discussed confidence in relation to changes in confidence in themselves said:

> *"it was very interesting and I left feeling more confident about myself."* (Sophie)

> *"some of my confidence has gone and sometimes I think that it's only me that feels this way and only me that's behaving like this and its only me with these issues and you know other people feel like this, I learned its common, there are solutions out there and that's raised my confidence."* (Richard)

More individuals spoke about confidence in abilities as oppose to self-confidence. One commented on how their confidence in using the techniques improved during the training through practice:

> *"I loved the exercise um with the numbers, I got well confident as it went on, I thought I'm going to do rubbish first but the more we did it I was like wow my concentration actually improved, I was well happy, I think things like that are good for your confidence you know…you like get better at it in a short time."* (Emma)

Confidence in abilities was also reported through using a specific technique called 'power poses' (a powerful physical posture such as standing with arms in the air), which was a technique taught to help individuals feel more confident:

> *"the power poses made me feel so confident, I was like yeah I can do this, like you said before something like a meeting or presentation makes you feel well confident."* (Amy)

This same individual reported feeling more confident in their abilities at work following the training:

> *"just having a chance to talk about wellbeing, we chatted about how we feel at work sometimes and it was nice, it made me feel more confident that I'm doing a good job."* (Amy)

A senior member of staff also reported confidence in their job role following the training:

> *"I think doing this has helped me feel more confident in my work, I feel I'm doing a good job."* (Ben)

Participants who talked about improving confidence also displayed an increase on the mental toughness confidence subscale of the MTQ48. Of the 11 participants 7 individuals displayed an increase in score on the MTQ48 for overall confidence after the training compared to before. Sophie, Lauren, Richard and Ben increased in 1 point for overall confidence after the training. Amy increased by 2 points, Jo by 3 points and Emma by 4 points after the training. Where there were no improvements of the score from the MTQ48 in the overall confidence subscale or the sub components of interpersonal confidence and confidence in abilities these individuals did not discuss confidence in any form.

In addition, participants who increased on the confidence subscale of the MTQ48 also displayed an increase on the 'personal accomplishment' subscale of MBI-HSS. Of the 11 participants 6 individuals displayed an increase on the 'personal accomplishment' scale of the MBI-HSS as well as an increase in 'confidence' on the MTQ48 after the training compared to before. The biggest increase in

'personal accomplishment' was Amy who scored 23 before the training and 37 after the training.

The higher mean scores on personal accomplishment correspond to lower degrees of burnout. Therefore, there was a pattern between an increase in confidence and a reduction in perceived burnout.

Another theme which emerged from the staff talking about their perceptions of themselves following the training was ***changes in thinking patterns***. Positive thinking is one of the tools and techniques that may help improve mental toughness and was used in the training as a mental toughness coaching strategy. Therefore, individuals spoke about mental toughness in relation to their changes in thinking. This included turning their negative thoughts into positive thoughts and in general thinking more optimistically:

> *"thinking about mental toughness in general is helpful, but I really like the positive thinking, I really like it and I like the turn ANTS to PETS, the automatic negative um thoughts you know to positive thoughts. I found like I thought about how I should take a different view on things sometimes, you know maybe think better, think more positive."* (Sophie)

One individual spoke about their change in thinking in relation to this increasing their self-belief:

> *"I should think I can do this I can, believe in myself, it's kind of changed the way I think about things. I mean like give myself credit and think positively of how well I'm doing instead of thinking the worst."* (Lauren)

Change in thinking patterns was also discussed in relation to how thinking more positively also impacted on how they behave with others:

> *"I think coming on this course has made me think about myself more and putting myself first. Doing the positive planner made me change how I think about things and realise what's important and how much support I have from family, friends and colleagues. I think now people are trying to help so don't push them away, think of this as a good thing."* (Richard)

Staff talked about perceived ***motivation*** following the training. Motivation refereed to the reasons the staff had for acting or behaving in a particular way. This included being motivated to talk about wellbeing more. One member of staff discussed about how they wanted to talk about wellbeing more with their colleagues and how they felt more comfortable in doing this:

> *"it makes you want to talk about it, talk about wellbeing and spread the word, because me and two other colleagues we talked amongst ourselves. We found it interesting and motivated each other to make these changes and you know it felt ok to do this."* (Richard)

Motivation to open up dialogue about staff wellbeing seemed apparent in some of the staff and the staff perceived this as an outcome of the training:

> *"it's a few simple things and it is simple things, not difficult or complicated to do and I believe it makes a difference. Who would have thought even just opening up that conversation… that dialogue about how you feel could make such a difference? It changes your perception on things and puts you in the lime light but that's good because we then reflect on this and talking about this is such a good thing."* (John)

> *"I think for me the best part of it, the nicest outcome was that it was nice to just um talk about ourselves or like how staff feel about situations. I think we need to talk about staff wellbeing to be honest."* (Amy)

Staff expressed how staff wellbeing is not a topic discussed much in the workplace. They reported that even with supervision meetings sometimes touching on the subject, they reported how they can be reluctant to talk about how they feel. The motivation to talk about their wellbeing seemed evident in several of the staff and the perceived impact this would have was also addressed:

> *"we just don't talk about it really, we should but we don't, I'm not sure why but even in my meeting with my supervisor I would be like everything's fine, even if it wasn't [laughs]. Talking to my colleagues I*

thought it's good to talk about your wellbeing and what's wrong with doing that, so I'm going to, not like moan or anything just like in my meetings if I'm asked I will say how I'm really feeling." (David)

Staff that spoke about the self-motivation to talk about wellbeing more also expressed the motivation of making staff wellbeing a priority:

"I realised my wellbeing should be a priority, we should talk about this more at work." (Lucy)

"I've learned that I need to change in some way, I've got motivation to keep myself well more now and keep my family well. This is where my focus should be, this is my priority." (Richard)

"It has been an eye opener and made me motivated to take some of the things I learned away with me and use these to put my wellbeing first and consider my own wellbeing more." (Ben)

The staff perceptions of the training on themselves highlighted some individual ***beliefs about mental toughness and burnout***. Although not talked about by every participant, those who did talk about it discussed it in detail. Two individuals in particular talked about becoming mentally tough and reducing burnout at work:

"I also thought it would be interesting to know more about mental toughness, I'd not heard of it really before but I had thought about burnout before and if you could be tougher um mentally like tougher then maybe this would stop you burning out. I thought maybe like make you mentally stronger…so that interested me really because if I was mentally stronger, tougher, then this might make me feel more relaxed about situations, you know less stressed or under pressure." (Amy)

"for me it was interesting because I had never heard before about the mental toughness and I thought yeah I could increase my mental toughness and maybe this might keep me well, um maybe it stops me from stressing or maybe burning out." (Lauren)

> *"It is completely right to do this, I believe we should have already, maybe earlier on in our professional training but anyways I think now learning how to be mentally tougher, trying to reduce the chance of burning out, I believe this is vital in my role."* (Lauren)

These individuals that talked about mental toughness and burnout and their beliefs about these two concepts had lower overall mental toughness scores (below the average 4-7 that represents the middle range that 2/3 of the population will score between) on the MTQ48 compared to those who did not talk about these.

Also related to the theme 'self' was ***self-awareness***. This emerged from the interviews and included self-awareness of the connection between the physical body and feelings (e.g. stretching and stress) and visualisation and physical movement (e.g. visualise stress and physically shake away from the body).

One individual spoke about how they felt the training made them more aware of how their physical movements can affect how they feel. They discussed this in relation to how when using physical stretching techniques at work this could make them feel more relaxed and reduce stress:

> *"if I had to take something away with me, it would be if I'm sitting down in a chair again I hope I'm thinking about my hands and my muscles and stretching my legs. I hope to think about myself and what I'm feeling and I think it makes you feel calmer and more relaxed about things."* (John)

Another individual spoke about a mind and body connection in relation to using visualisation and physical movement to remove stress from the body. They described visualising stress and physically shaking this away from the body:

> *"I could feel my anger right here in my fist and I could feel me letting it go. I was trying to bring it down my arm in my head, I was trying to bring it down my arm and visualise it as well as doing it, it's a visual one like in your mind and a physical one. I think I can feel my anger or my stress*

coming down my arm and I can flick my fingers and let it go, throwing my stress away." (Lauren)

The final mind and body connection talked about was regarding the body, mind and biology (hormones). This individual spoke about how using a physical 'power pose' (a powerful physical posture such as standing with arms in the air) could help them feel better:

"You know if you can alter your body chemically I find that really interesting, you know with the power poses and was it the cortisol? I think even just sort of doing that before I'm working so I'm feeling more positive and able to cope. I think the fact that your body and biology and mind are connected, I find that fascinating and I believe that these are connected." (Emma)

8.8.3 Organising theme: Inside the service

The second organising theme from the interviews was related to staff perceptions of the training 'inside the service'. The definition of 'inside the service' in these results refers to a person's perception of the internal environment in which they work. This includes service-users, colleagues and the service culture.

Staff discussed their perceptions of the ***wider applications with service-users***. One individual reported that teaching the service-users similar coping strategies is one way in which they think the training would be useful:

"I've thought I could use that, I could use that with the service-users, give them advice on how to identify stressors themselves and how to develop some coping strategies themselves." (David)

Another individual spoke specifically about how they had tried using relaxation techniques with the service-users since the training:

> *"you could use some of the techniques with the service-users, um….[pause] I'm trying to think of one I used yesterday, well the relaxation we did, we used this yesterday saying sometimes in the evenings, it's helpful to relax before going to bed."* (Lucy)

The importance of staff having the appropriate coping strategies and tools to teach service-users, as well as staff being able to use these effectively before expecting service-users to was outlined by an individual:

> *"if we know the right tools to use for ourselves, we can pass that information, that knowledge, on to the patients and try and help them with their coping skills and techniques and relax and you know if we can't follow that advice ourselves, we can't expect them to do it."* (Amy)

In addition, the wider applicability of using some of the coping strategies from the training in order to not be negatively affected by the service-user's feelings and problems was outlined:

> *"maybe sometimes if you're going to interact with a service-user, it would be good to not be affected by their feelings, their problems…it's hard because sometimes you feel too much involved. It would be good to not be too involved and could be very um useful for both. This is what I think is the hardest thing for me sometimes…I've learned that I could use the coping strategies like relaxation or positive thinking to help with this."* (Sophie)

Other staff spoke about the link between staff wellbeing and service-users wellbeing from the perspective of how staff feeling well has a positive impact on service-users. The training was described as having a positive impact on their mental health which in turn could lead to a positive impact on service-user's mental health too:

> *"I think um if staff are well then we can look after our service-users better, you know our wellbeing probably effects their wellbeing. The training and learning the techniques, all this is positive for us and so it's positive for our service-users too."* (Amy)

> *"the training makes us feel better, helps with our mental wellbeing and then service-users pick up on this and it helps with how they feel too."* (Rob)

Staff perceived that the training had ***wider applications with colleagues*** that they worked with 'inside the service'. This included individuals who had also been on the training and those who had not attended but were from the same service.

One individual spoke about how they would encourage all their colleagues to use the techniques from the training, including teaching their colleagues these tools that did not attend the training:

> *"I think as a team we could make some positive changes to our service using the techniques and I intend to encourage my colleagues to use these…and I will try to teach them if they didn't come. I think in terms of been more positive, mindful and thinking about each other more and our wellbeing."* (Richard)

Another spoke about how they would like to teach their colleagues some of the practical techniques as part of a staff group:

> *"I'm wondering if we could do a group at work, taking all this back and do a group with individuals. I was thinking that staff could be involved in that, put on a group once a week and teach them the techniques."* (Lauren)

The staff also spoke about the ***culture of the service*** in relation to perceptions of how the training could potentially change the ideas, customs and behaviours within the whole service in which they worked.

One individual provided detail on how they perceived the training impacting on the culture of the service in which they worked:

> *"it has a knock on effect really, even if only a few of us from the service went on the training, what happens is new ideas go back to the service, to the team and you can share these. I think it helps change the atmosphere, like positivity spreads positivity, so like I will go in all positive and remind people to take a breather sometimes and this passes on to other people. Then hopefully the whole team starts taking a step back and not getting over stressed."* (Richard)

Another individual from a senior role stated quite clearly that they were keen to implement new changes within their service. In particular, they talked about creating a new role within the service titled 'wellbeing lead' or 'wellbeing champion'. They thought a role like this would be useful within the service and would encourage all staff to be motivated to look after their wellbeing at work:

> *"I am going to make some changes in the service, I like the idea of creating a wellbeing lead role or wellbeing champion role for one of the staff, where they try to encourage staff wellbeing. I am enthusiastic about these new changes and getting staff on board with these."* (Jo)

In terms of making changes to the culture of the service, in particular with regards to staff wellbeing, staff expressed having reminders or refreshers of the training would help to have a positive impact on the ongoing service culture:

> *"I really think it would be useful to be rolled out on a more regular basis, maybe as part of our training or like some kind of reminder sessions of this training. I think doing that keeps you thinking about it and keeps everyone motivated to do it."* (David)

> *"It changes everyone's perception so that we are all working from the same page, which just makes the whole place better to work at*." (Richard)

8.8.4 Organising theme: Outside the service

The third organising theme from the interviews was related to staff perceptions of the training 'outside the service'. The definition of 'outside the service' in these results refers to a person's perception of the external environment outside of the service at which they work. This includes life after work and the wider team from other services but within the same organisation.

Staff discussed their perceptions of the ***wider applications for life after work***. The staff discussed how they could recognise that they could take away from the training, techniques to use at home to improve their wellbeing, as well as taking home with them how they perceive and think about wellbeing. A couple of individuals talked specifically on using the techniques at home:

> *"you can understand how to use the techniques in your life in reality so definitely, it's not just for work it can be very useful for your life in general."* (Sophie)

> *"very useful, last night I had a candle lit bath, with that soft music going and tried the breathing techniques and even my kids said are you alright because usually I'm stressed. I went home de-stressed, not my usual day like when I go home."* (Lauren)

Whilst other individuals commented on how the training had changed their perception and mindset on their wellbeing and made them reflect on this at home:

> *"I've thought more about my wellbeing at home too, not just at work. I never use to think about how I feel, how I feel after work, especially if it's been one of those days, you know where I may have felt wound up. It made me go home and think I should take a minute to just absorb how I feel from the day and take a minute for myself."* (Amy)

> *"I've changed my perception on talking about how I feel after work, I use to just try and ignore it, ignore if I'm stressed but I shouldn't. I can apply what I took from the training about taking time for yourself if your*

stressed and use this at home when everything seems to be piling up." (Lucy)

Another individual spoke about how they considered their own wellbeing and that of their families following the training:

"I've learned that I need to change in some way, I've got to keep myself well more now and keep my family well, this is where my focus should be." (Richard)

Staff also discussed how they perceived the training could impact 'outside the service' on the ***wider team from other services***. As the training consisted of participants from three different services from the same organisation, some staff thought that the training could impact across the services, in addition to impacting on their own service in which they worked. One member of staff spoke about how the training allowed for team bonding with other services. They reported this as beneficial to see how they had common goals and objectives with these other services and staff:

"it's nice as your away as a team as well and connecting with the other units, which I do but I think it's been good for others as well, to see that were all the same, were all on the same common objective to look after the service-user's welfare. I think it's been really good and useful for that you know… team bonding." (Rob)

Another two individuals spoke about how connecting with staff from other services on the training allowed them to share experiences of working in this setting:

"It was nice to come together with staff from other services…it makes you feel more normal about things, like you share similar experiences with each other, which just makes you feel better about things…like it's not just me." (Lucy)

"nice to have chance to talk on a different level to the rest of the team as well. I think we all benefited from this from a team building sort of perspective." (David)

One individual who worked across multiple services within this same organisation, discussed how group work is a vital part of their role. They reported that they would like to try and create a group for the staff across all of the services in which they work, whereby they could practice some of the wellbeing techniques:

"group work is key in my role and you see that it works…the service-users become more comfortable with each other and more open in these. I was thinking that maybe at work we should have a group for all staff, you know like the techniques we used, we could practice these, basically I'm thinking like a staff wellbeing group. It would be for all the different services… I'm not sure entirely if it would be just a chance to talk about how we feel or like using the actual things we have learned like relaxation, but either way I'd be keen to try that." (Rob)

8.9 Summary of the interviews directly after the wellbeing training

This section has presented the results from the semi-structured interviews after the wellbeing training intervention. In order to summarise the findings and highlight some of the key take homes messages an outline is provided below. Chapter 9 will discuss these key messages and ideas in detail along with implications and recommendations for future training and research.

8.9.1 Take home messages-from the interviews directly after the wellbeing training

- Staff were ***motivated*** to be involved in the wellbeing training.

- Staff perceived the training as having an impact on themselves as individuals including their ***confidence***, their ***thoughts*** and their ***behaviours***.
- Staff valued the time to ***think and talk*** about how they feel.
- They suggested that there may be a possible ***link between mental toughness and burnout.***
- They found learning the ***techniques to focus on their wellbeing*** useful and were enthusiastic about making this a ***priority*** in their lives.
- Staff talked about how the training impacted on ***life outside of work*** and at home.
- Staff talked about the impact of going on this training on the ***service-users*** they work with.
- Staff believed by keeping themselves well they would be able to ***work better*** and ***care for their service-users better.***

8.10 Staff Interviews at the three month follow up

Of the original 11 participants that took part in the training 9 completed the interview questions at the follow up. However, 1 of these participants completed the questions in written form rather than as a semi-structured interview. This was due to night shift work making the participant unavailable to be interviewed. As described in chapter 7 (section 7.43) participants were given the option of completing the questions via a form and emailing this to the researcher if they were unable to attend a face to face interview. The other 8 participants completed the interviews during the three month follow up face to face.

The resulting thematic analysis created 9 basic themes which were then clustered into 3 organising themes. These organising themes were then summarised into one main resulting global theme (table 8.4). There were many similarities between the themes at the follow up as the interviews after the training. Therefore, this resulted in the same global theme and organising themes being developed with slight variances in some of the basic themes. The

next section will detail these themes and provide supporting evidence for these from the participants. It will also compare and contrast the themes at the follow up to the themes developed in the interviews directly after the training. In addition, how some of the quantitative data fits with the themes has also been incorporated in this section. This chapter concludes with feedback from the follow up regarding the delivery of the training, its content and the setting.

Table 8.4: Themes generated from the interviews with the staff at the three month follow up.

Basic Theme	**Organising Theme**	**Global Theme**
Confidence	Self	Staff perceptions from the training
Changes in thinking patterns		
Control		
Beliefs about mental toughness and burnout		
Self-awareness		
Wider application with service-users	Inside the service	
Culture of the service		
Wider applications for life after work	Outside the service	
Wider team/other services		

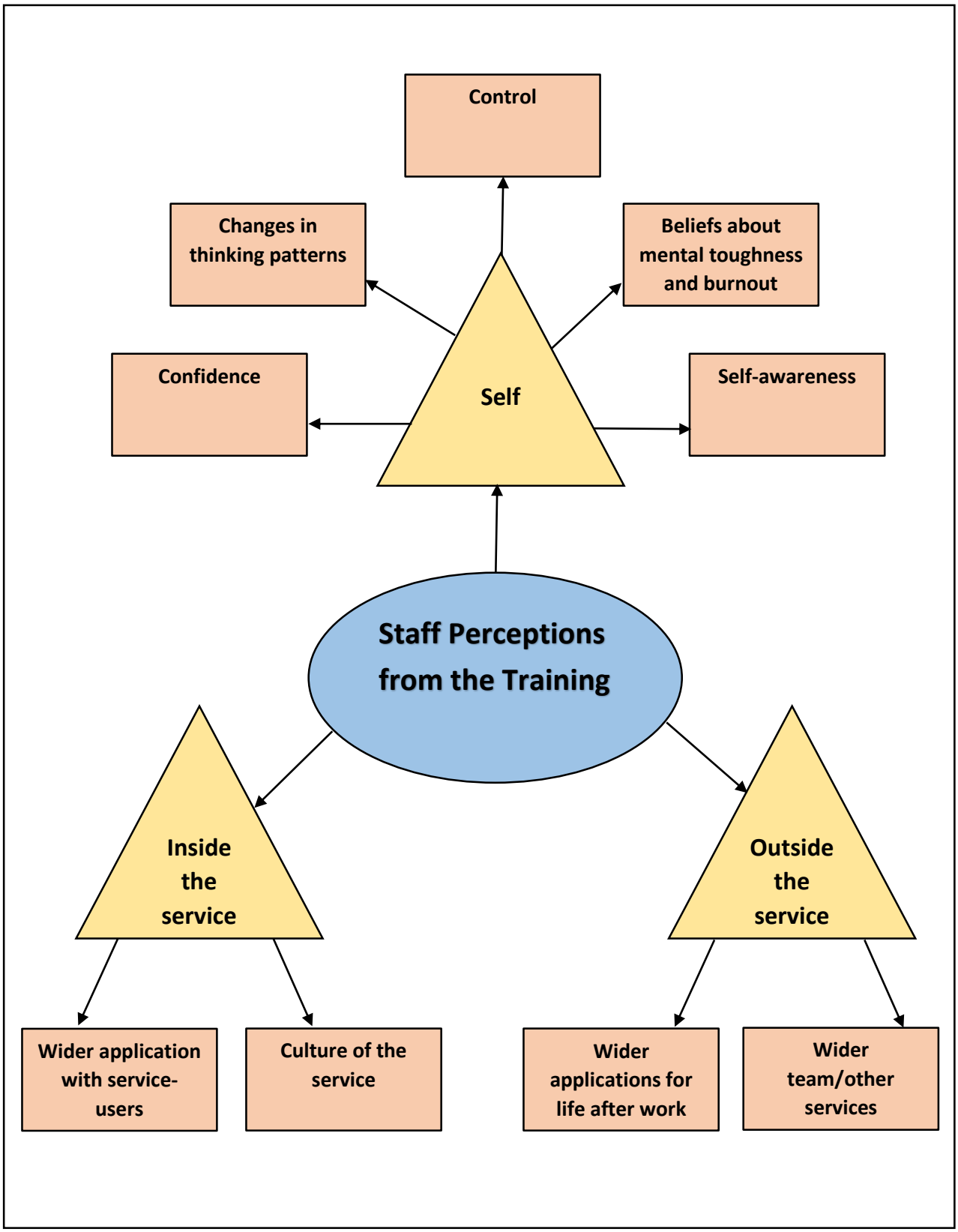


Figure 8.16: Thematic network for staff perceptions from the training at the three month follow up.

8.10.1 Organising Theme: Self

The first organising theme from the follow up interviews was related to staff perceptions of 'self' following the training. The definition of 'self' in these results uses the same definition as used for 'self' in the interviews after the training and refers to a person's individual thoughts, feelings and behaviours that distinguish them from others. It includes an individual's confidence, thoughts, beliefs and feelings.

Staff discussed their perceptions of their ***confidence*** following the training and again at the three month follow up. Several of the staff discussed confidence as an area that they perceived had changed or improved in some way during the three months following the training. Confidence is a main component of mental toughness and it was talked about regarding self-confidence and confidence in abilities. Individuals that discussed confidence in relation to changes in their self-confidence said:

> *"I just feel like how I see myself is better, I'm more confident in me, about myself."* (Amy)

> *"It's not just about how you think about things and how well you do things but also about how you feel and I know now that I'm feeling much more able, I believe in myself."* (Lucy)

When asked about what made them feel this way. They responded:

> *"I feel better about myself because if I feel rubbish I can just think well what did we do when we were talking about feeling more confident and I think of them power poses and I think yeah stand proud, head high, you can do this. The difference is I guess before I wouldn't not know what to do if I felt rubbish about myself, but now I think I may as well give it a go."* (Lucy)

In the same way individuals spoke about confidence in abilities after the training, at the follow up participants once again spoke about confidence in relation to their abilities:

> *"I just feel happier and probably because I'm more confident in my work."* (Amy)

> *"I feel now I'm absolutely capable of doing it, I think it's over the years having to use different systems, you know the systems have changed and it's become more involved more thorough. This is a good thing but it took me until now to feel more confident with this and to be honest the training helped because it made me realise that I am capable at doing it and I do have the skills. I would say it made me doubt my ability less."* (Lucy)

Two other individuals spoke about confidence at the follow up. In particular, with regards to how the techniques learned at the training were still being used to help with their confidence:

> *"I'd say even now like, however many months ago the training was, that I'm still using stuff that I think helps me feel better about the work I'm doing. I feel like that the work I'm doing with the service-users is important and valued and I would say that's because of all those positive exercises. I use them still and I just pinpoint all the good stuff I'm doing really and like for example the other week how I taught a service-user a relaxation technique that they now use lots and I thought that's good, what I taught them really helped."* (Rob)

> *"I use the confident poses, power poses, before any sort of meeting or like my one to one with my supervisor, to just you know go in thinking yeah I am doing a good job and I'm confident that what I'm doing is good."* (Lauren)

In the interviews following the training participants who talked about improving confidence also displayed an increase on the mental toughness confidence subscale of the MTQ48. This same pattern was displayed in the follow up interviews, as participants who scored higher for overall confidence at the follow up compared to after the training, also talked about this improvement in confidence at the follow up interview. Rob, Lauren, Lucy and Amy all displayed an increase in score for confidence on the MTQ48 at the follow up. Amy and Lauren displayed an increase in confidence score after the training and again a further increase in confidence score at the three month follow up. Amy's score for confidence before the training was 2 points, after the training was 4 points and 6 points at the follow up. Lauren's score for confidence before the training was 3 points, after the training was 4 points and 5 points at the follow up. Rob and Lucy who also talked about confidence at the follow up had not increased in confidence score after the training, however had increased in score at the follow up. Rob's score for confidence before the training was 6 points, after the training was 5 points and 8 points at the follow up. Lucy's score was 6 points before and after the training and then 7 points at the follow up. Where there were no improvements of the score from the MTQ48 in the overall confidence subscale, or the sub components of interpersonal confidence and confidence in abilities, these individuals did not discuss confidence in any form during the interviews.

Similarly, to after the training, at the follow up participants who increased on the confidence subscale of the MTQ48 also displayed an increase on the personal accomplishment subscale of MBI-HSS. Of the 9 participants, the same 4 individuals who displayed increases in their MTQ48 confidence score also displayed increases in their MBI-HSS personal accomplishment score. Amy scored 23 before the training, 37 after the training and 44 at the follow up for personal accomplishment. Rob scored 40 before the training, 40 after the training and 43 at the follow up. Lucy scored 40 before the training, 40 after the training and 44 at the follow up. Lauren scored 38 before the training, 42 after the training and 44 at the follow up. The higher mean scores on personal

accomplishment correspond to lower degrees of burnout. Therefore, there was a pattern between an increase in confidence and a reduction in perceived burnout.

In addition to the pattern of increased confidence score and increased personal accomplishment score, is the link between these two areas and the MTQ48 component of control. The same 4 participants who displayed an increase in confidence score and personal accomplishment score at the follow up also displayed an increase in the MTQ48 component of control. Amy's score for control before the training was 3, after the training was 4 and at the follow up was 5. Rob's score for control was 7 before the training, 8 after the training and 9 at the follow up. Lucy's scored for control was 7 before the training, 5 after the training and 8 at the follow up. Lauren's score for control was 1 before the training, 3 after the training and 4 at the follow up. Additionally, participants that displayed an increase in score in the component of control on the MTQ48 at the follow up also talked about control during the follow up interviews. The theme of control was not evident in the interviews directly after the training.

The staff discussed their perceptions of ***control*** at the follow up interviews***.*** Control related to an individual's feelings of power to influence their own behaviour in the work place. This included feeling in control of stressful situations at work and their view on the level of control they have in the work environment in relation to their wellbeing. Two individuals spoke about being in control when under stress or pressure:

> *"I feel more in control and if you let it get to you then it can wear you down, so I know to now stop, get control of the situation and deal with it before the pressure builds."* (Amy)

> *"I now feel in control of stressful situations at work, I'm less likely to run away or like get worried, I'm able to think if I take handle of this situation I will feel like it's less stressful and it often is."* (Lauren)

Another two individuals spoke about control in relation to where they worked and how the training made them feel more in control in their job and work environment:

> *"I'd say what was good for me, was that since then, I've felt like I'm able to speak my mind a bit more, like for example if I'm going to supervision or to a meeting. I think I will say what I'm not happy with or like what's stressing me out and I guess by doing this I'm just feeling that I'm in charge of my role and making my job better for me."* (Rob)

> *"I feel less influenced by other people's behaviours at work, so for example in the office, I feel less bogged down if people worrying about things, because I think well I know what I'm doing in my role is right so I shouldn't be worried. I have tried to think what went well rather than what didn't, and it's quite empowering thinking this way and feeling much more in control of your work and how your feeling."* (Lucy)

> *"it's like we said at the training, you feel more in control when you feel well, so if you know how to look after yourself which we learned, then all in all I'm feeling better, more sort of centred and together and in control."* (Lucy)

Another theme which emerged from the staff talking about their perceptions of themselves following the training and again at the follow up interviews was ***changes in thinking patterns***. Thinking patterns referred to a way of thinking about something and their attitudes towards it. After the training this was in relation to thinking more positively and changing negative thoughts into positive thoughts using specific techniques that were taught. Again at the follow up staff reported changes in their thinking patterns in relation to think positively and also thinking more about their wellbeing.

Staff spoke about their perceptions of the training on their thinking patterns in relation to how the training techniques had taught them to think positively:

> *"thinking positively about things has helped me organise my day better, help take things in my stride a bit better. The technique in particular I liked was the positive planner list, actually remembering to do this is so important and makes you realise things are positive and not always as bad as you initially think."* (Richard)

> *"like I said I find the breathing really helpful, I find it gives me time to like think before I act at work and things like that. It is important because it makes you pause and you come up with better solutions when you give yourself time to think, you may have gone in with a like negative stressful thought, but relaxing first with the techniques makes me think calmly and positively."* (Amy)

Staff also spoke about how the training changed their perceptions on thinking about wellbeing. Three participants stated similarly that they had learned and continued to remember that they should think about their wellbeing and how they are feeling more:

> *"it was an experience I hopefully won't forget, as it made me think about me more and looking after me and I do still do this even now."* (Lauren)

> *"definitely it makes you think about yourself, your mental wellbeing and others mental wellbeing. I would say that before this I wouldn't have perceived this as something I needed to do, but now I've changed how I think about my own wellbeing, in that I put it as a big importance."* (Richard)

> *"it will help you think more about yourself, in a good way… and it is good to make you think about your wellbeing and suddenly it doesn't seem so strange to be thinking about how your feeling. I think instead it just makes it feel normal and ok to think about your feelings.*" (Sophie)

The staff perceptions of the training highlighted some individual ***beliefs about mental toughness and burnout***. In the interviews after the training two individuals in particular talked about becoming mentally tough and reducing burnout at work. At the follow up interviews more individuals spoke about their beliefs about mental toughness and burnout.

Staff talked about their perceptions of a possible link between mental toughness and burnout:

> *"I think like you burnout quite quickly if you're not taking time for yourself and you can't be mentally tough all the time. I think people do get worn down and time away from work I think is really helpful because it gives you a break. I think you can get worn down and so will your mental toughness and this could lead to burnout. I reckon people need to take more time for themselves in order to think and reflect that it will be ok. If we can learn these tools to help with mental toughness, then this could be great to keep us from burning out."* (Amy)

> *"yeah when I learned about what mental toughness was, I thought yes there must be some sort of correlation, like between how mentally tough you are and your stress and your burning out."* (Sophie)

> *"I think your mental toughness and burnout might be linked."* (Lucy)

Mental toughness and burnout were also talked about with regards to working in mental health services:

> *"I think in this profession yes, to be mentally tough is needed as it can be stressful and like with the burnout and the stress being high in these jobs. If your more prepared, more mentally tough this could help prevent this stress and this burning out."* (Sophie)

> *"most people work full time for years, at least I've gone part time. I've been working in the same place for 18 years so you know, I don't feel necessarily like I have burnout but I am aware of it more and I thought it's not unusual if people did feel burnt out after this amount of time working*

in this job. We haven't been taught before this training how to be mentally tough in this job but after this I now think we should be." (Lucy)

The final basic theme relating to staff perceptions about themselves was relating to ***self-awareness.*** This referred to having conscious knowledge of their own character and feelings. This theme also emerged from the interviews after the training. At the follow up staff spoke about developing self-awareness with regards to the training making them self-aware of their own feelings and wellbeing and the importance of this:

"you know it makes you more self-aware. I think it makes you think more about the environment around you…because you're often doing a job but you're not thinking about yourself. I think I'm there for the clients but I think it's made me more aware that you've got to be in a good place yourself and to be coping. I think you've got your own life and stresses so you've got to be aware, look after yourself and use techniques to help with this and your job, all this is so important, your wellbeing is important." (Lucy)

"it makes you more aware, makes you self-aware and makes you think about you and this is a good thing… because sometimes if you don't know how you are feeling then you could react differently in stressful situations. I think if you are aware that you feel stressed then this is better, as you can do something to help and then this is good as you react better in the stressful situation. I've learned its best to be calm and I think if your self-aware that something is making you stressed you prepare better." (Sophie)

One individual gave an example of what they had learned about themselves and how they act differently now because of the training making them more self-aware:

"So overall I learned a lot about myself from the experience… I feel I can recognise in myself when I need to take time out. I recognise this with regards to my own mental wellbeing, like I know to take regular breaks

and I'm much better now at being aware of my mental wellbeing and making this a priority. I would say for example taking breaks when I need to and really recognising when I need to take a time out is important. I think sometimes this might be five minutes to myself at work, just to relax a bit, it's made me more self-aware of this and recognising when to do this." (Richard)

8.10.2 Organising theme: Inside the service

The second organising theme from the interviews was related to staff perceptions of the training 'inside the service'. The definition of 'inside the service' in these results refers to a person's perception of the internal environment in which they work. This includes service-users and the service culture. While the staff discussed wider applications with colleagues during the interviews following the training at the follow up this theme did not emerge.

Staff discussed their perceptions of the ***wider applications with service-users***. This was in relation to how they had used or taught some of the techniques from the training with their service-users:

"I think it's been good for us and I know we aim to use some of the techniques with our service-users too. I'm not sure about the others but I told mine about taking time and just not rushing and using some breathing techniques if they feel under pressure. There is someone I work with that gets anxious easily and I suggested some of the breathing techniques and just taking a step back if they feel overwhelmed, so yeah I think that was good." (Lauren)

"you learn things like relaxation, goal setting and positive thinking techniques to use for you and your service-users." (Sophie)

"it was like this is for you or the service-users, you can use it either way, it was a lot more inclusive so it was for everyone which was nice. I have

used the relaxation in sessions with service-users which is nice to think they benefit too." (Amy)

One individual also reported that they felt the training had at times made it easier when working with service-users. They reported that they felt they could apply what they had learned to when service-user behaviour is difficult to work with:

"a few have personality disorder and this can be challenging, I can think of one resident in particular I find challenging to work with, but I do love my job but sometimes the behaviours can be quite challenging. I think what I've done differently now is probably two things, I try to go into sessions more relaxed by using the techniques we learned and also I'm more prepared with goals before sessions. I would say that this means I already have a plan and that helps even with motivating service-users to actually come to the session, where before this was more difficult." (Emma)

They also spoke about being able to relate to service-users more based on their experience during the training:

"yeah I can relate to methods of relaxing with a client now who uses CBT, now I know why they find relaxing useful, it's really good." (Emma)

The staff at the follow up interviews spoke about the ***culture of the service*** in relation to perceptions of how the training could potentially change the ideas, customs and behaviours within the whole service in which they worked. This was also a theme at the interviews that followed in the weeks after the training. At the follow up, individuals gave examples of how the culture had changed following the training and discussed specific changes that had been implemented in the last three months following the training.

"I know that there is going to be a yoga class session for staff to come to at some point, this was one of the ideas they came up with. It is starting

soon I think, the manager was arranging it, they were deciding on a good time, so its starting really soon off the back of talking about the training to the manager." (Sophie)

"Yeah well we have definitely talked more to each other about how we are feeling. I would say that those who came on the training are a little bit closer and feel we can talk to each other more. I think it's been good for us and I know we have been using some of the techniques at work together as a group." (Lauren)

"I feel I'm more organised in my role, I ensure I take regular breaks, and discuss any problems within my meetings with my line manager. I try not to let tasks overwhelm me and I can be more open about things now, like concerns, worries or difficulties and I feel that my manager is completely open to this and us that came on the training talk about this together." (Richard)

"in meetings now we have sort of tried putting a bit of time a side to discuss more about how everyone is doing, how they are feeling." (David)

In addition to cultural changes that have been implemented since the training, staff also spoke about how their perceptions of staff wellbeing had changed within the service:

"it's like changing attitudes really, like I actually feel that I probably thought of talking about mental health as a bit of a taboo before. I thought because I'm the staff I need to be strong and I shouldn't really say if I'm not great, but I think now that is daft and its fine to say if you're not so good." (Emma)

Staff spoke about how the cultural of the service had changed mainly because of the staff that attended the training and was reliant on them going back and making these changes. They reported that although changes were made that it was limited due to only a few individuals from each service attending. They

spoke about more staff needing to attend the training for it to have a bigger impact on the culture at the service:

> *"I don't know if it's me and my perception on things or if I feel better about working and more positive but either way I think it's an impact of the training. I'm not sure the training has an impact on everybody because only a few people from my service have done the training and I think it would benefit more if everyone could go."* (Amy)

> *"I think it would benefit more if everyone could go because other people might not feel that way, they might still be very stressed or not feeling good at all. I might be like from my perception its fine, I might be calmer because of the training, but others who didn't go might still be stressed. It would change the atmosphere more if everyone was feeling better."* (Amy)

> *"I think that other staff should be offered the opportunity to attend this training…yeah definitely, from this service and other services, I think the more people that could go on it the bigger the impact to the service and also the organisation."* (Richard)

> *"yeah I think for changes in the service to really happen then it needs to filter through to all staff so everyone thinks the same way, I think everyone needs to be on the same page."* (Lucy)

With regards to changes in the culture of the service, staff spoke about one of the reasons it may be difficult for changes to occur easily. They spoke about how they had found remembering to use the techniques difficult:

> *"some of the techniques I learned I think I've forgotten if that makes sense, like the ones about your focus and attention and I've forget how to do them…but I'd like to. I think I need more practice but you don't always get time, if I could go on the training again now I'd find it helpful as like a recap and make me think about using the techniques again."* (Emma)

"It was difficult to just sort of go back and say like we should do this differently now, like even though individually I felt benefits I thought trying to get others on board isn't always that easy and then you can forget some of the techniques and so it's hard to try and persuade others to be doing them." (Richard)

8.10.3 Organising theme: Outside the service

The third organising theme from the interviews was related to staff perceptions of the training 'outside the service'. The definition of 'outside the service' in these results refers to a person's perception of the external environment outside of the service at which they work. This includes life after work and the wider team from other services but within the same organisation.

Staff discussed their perceptions of the ***wider applications for life after work***. Similarly, in the interviews after the training this theme at the follow up interviews related to how staff had used the training outside of work including at home. Staff discussed how they had used techniques at home:

"when I go home I really try and be quite mindful and relax and take deep breaths and unwind so I let go of things that have worried me or stressed me during the day. I find that then I can go in the next day with a fresh attitude and not hold onto things." (Amy)

"when I go home I'm definitely not going to complain to like my partner and stuff because it can just build up. I've learned to let it go and work through it myself and I'm very conscious of not complaining about work and things like that. I think that I try and be more positive and I do find the breathing really relaxes me, it helps with anxiety." (Amy)

"I like the relaxation techniques like at home after work." (Emma)

"I like taking a bath and listening to music, its lovely and also the relaxation we did at the training, I've tried some of that at home and at work as well. It was [pause] the breathing and that, you know breathing and letting the stress leave your body through like your hands, that is good to use at work if its busy and stressful, or at home when I need to be relaxed." (Lauren)

One member of staff spoke specifically about how they used the techniques on their journey to and from work to help them to be positive before and after work:

"so if it's been a negative day I try and think what went well and go home thinking of this rather than all the negatives, you know like when I'm in the car driving and also on the way into work. I can sometimes be like oh no I've got that on today but I try and think more positively about it." (Sophie)

In addition, individuals spoke about how the techniques had helped with the challenge of not taking negative feelings from work home with them:

"I think when you leave work and go home at night sometimes you can take it with you and that's really not good because it can affect your home life as well. I think that I can end up in this negative cycle, so when I go home I really try and relax now." (Amy)

"I would say it is difficult working with people where you take on how they feel and if they are negative this can sometimes make you feel negative too. I think it is easy to then take this negativity home and it is difficult not be affected by this sometimes. I know at least now that I feel like I can use some of the things we learned to help with this...like I use the breathing at home and try to separate work from home life." (Sophie)

"I think being anxious and going home feeling stressed is difficult sometimes, it's just hard not to be affected by work if its negative. I've used the techniques to help with this, like the relaxation we did I loved it, I

used it that day straight away when I got home. I still use it now and my family couldn't believe it, they were like you seem different, your calm and relaxed and I was like I am as well, I thought it's nice being this relaxed." (Lauren)

One individual spoke about a better work life balance:

"I take time out for things that I enjoy doing outside of work so I feel I've got a much better work life balance." (Richard)

Whereas another reported that there is not always time to use the techniques when they get home and that this can be difficult:

"It is difficult to have the time to actually use all the techniques, you need to actually put aside time to do this after work but with family and other commitments this can be difficult to do." (David)

Staff also discussed at the follow up interviews how they perceived the training could impact 'outside the service' on the ***wider team from other services***. This was a theme noted at the interviews after the training and was similar in that participants felt they were able to bond with staff from others services from the same organisation. In addition to this at the follow up interviews, participants also reported that they now felt they had a wider support network outside of their own service.

Staff spoke about the team bonding opportunity with other services:

"The training gave us a chance to bond with the people we work with but also the staff from others services too which was nice to do." (Rob)

They also spoke about a wider support network outside of their service they worked at since being on the training:

"since then its helped to have connections, like I've emailed others from the training at other services and chatted and it's just nice to have better connections with other staff at other services. I have spoken to them and

asked them have you tried this or have you tried that and it can be useful." (Sophie)

"also with other staff too I made friends on the training really and its nice just to have like-minded people to talk to and it's not just in your bubble at work, but having those people to talk to who work at the other places is good too." (Emma)

One individual spoke about the limitation of only the three services from the organisation having the training. They spoke about a possible disadvantage for other services and the difficulty of making changes to other teams at other services:

"the thing I would add right, is the only problem is, if this training doesn't go to all the services, like all mental health in (organisation name) then it's good for our team and the other two services teams, but then you might speak to staff from another service and they haven't had it so they might not be on the same page. I think they might not get why I am doing certain things, so if I was like I'm having a time out to do relaxation, then they might be thinking how lazy or something if you know what I mean. I think that all the teams need to be on the same page with this." (Rob)

8.11 Summary of the three month follow up

This section has presented the results from the wellbeing training three month follow up study. In order to summarise the follow up study and highlight some of the key take homes messages an outline is provided below. Chapter 9 will discuss these key messages and ideas in detail along with implications and recommendations for future training and research.

8.11.1 Take home messages-from the three month follow up

- Staff talked about ***key learning points*** including that they feel it is ok to talk about wellbeing and that it is ok to admit if not feeling well.
- That the ***practical side*** of the training (learning the techniques) was ***equally*** as important as having the ***time to talk and think about their wellbeing.***
- Being ***mentally tough*** when working in mental health services is beneficial and knowing how to be more mentally tough is useful.
- Staff reported talking more openly and comfortably about their wellbeing at work and being more ***self-aware*** of their wellbeing at work.
- Participants that scored higher on the MTQ48 for the component of ***confidence*** at the follow up also talked about confidence during the follow up interviews.
- Participants that scored higher on the MTQ48 for the component of ***control*** on the MTQ48 at the follow up also talked about control during the follow up interviews.
- ***Remembering*** everything from the training is ***difficult*** and staff have offered suggestions on having more sessions of a similar nature.
- Staff talked about how the training impacted on ***life outside of work*** and at home.
- Staff talked about the impact of going on this training on the ***service-users*** they work with.
- ***Changes/implementations*** to the service following the training were made e.g. talked about staff wellbeing in team meeting, yoga sessions set up for staff.

8.12 The training package and its delivery

As well as the key themes described and detailed with regards to the staff perceptions of the training, the staff also spoke at the interviews after the training and at the follow up about the processes of the actual training package and its delivery. Although less was spoken about these processes at the follow up compared to the interviews after the training, this feedback from the staff regarding the practicalities of the training is useful and will be discussed in further depth with regards to future training implementation and recommendations in the discussion chapter. A brief outline of the results regarding the training package delivery and the setting/environment of the training will now be presented.

8.12.1 Delivery of the training and its content

Feedback was given from the staff with regards to the delivery of the training. The delivery of the training in the interviews directly after the training has taken place was described as 'informal', 'practical' and 'relaxed'. On many occasions staff made a direct comparison of this wellbeing training with other forms of training they had been on in the past. Previous training had been described as 'boring' where this training was described as 'interesting':

> *"at first I thought two days of training might be two days of boredom because of what training is normally like. I usually find it quite boring and I haven't taken things in and I'm none the wiser, but this one interested me when I saw it and its been the best training I've been on."* (Lauren)

Other training had also been described as 'formal':

> *"I have something to say right, I don't think I'm going to see training like this for a quite a long time now because with most training we've been on it is too formal."* (John)

The wellbeing training was also described as having purpose and being an appropriate training course for the staff:

"there are lots of training packages offered that don't have their place, you know they don't seem to have purpose, but this is well placed." (Rob)

Another comparison to other training courses was regarding the level at which the training was set. Feedback was given that the training was suitable for all different mental health staff of different professions, as it was delivered in a universal way that all would be able to understand:

"seriously you talked on my level, I've been to a lot training courses where they talk on this high level of um intelligent words you know and I don't understand…I don't understand and if I'm in that training I feel left behind, but this I feel has been on my level which is good." (Emma)

"Its universal, it's for everyone, all the staff from all different roles would understand this and that helps people be on board with it." (David)

The delivery of the training was described at the follow up as 'inclusive', 'practical', relaxed' and 'easy to understand'.

One individual reported the training being inclusive and for everyone:

"it was a lot more inclusive than other training, so it was for everyone which was nice." (Amy)

Another spoke about the training being practical:

"I would say it is a practical way of learning ways to look after your wellbeing… it is good to have training like this; it is nice to have time to learn coping strategies for ourselves practically." (Sophie)

Several individuals spoke about the training being relaxed in terms of its delivery and content:

"I enjoyed the training, I found it wasn't stressful and I didn't feel any pressure to answer anything or join in if I didn't want to. I found I did join in and I wasn't stressed at all." (Emma)

"well for an anxious person it actually kept me quite calm, I just enjoyed it and had quite a relaxing couple of days." (Lauren)

"I'd say it's a good learning environment with a relaxed approach from you…there is a lot of good information that is easy to follow… there is just enough small group work to make everyone feel comfortable and relaxed." (Richard)

Individuals also made comparisons of this training to other training that they had attended. Two of these individuals highlighted that training is usually focused on service-users rather than the staff:

"I think it was really good, it was time that staff took for themselves, training we usually attend is so service-user focussed that it can be quite stressful, like this is what we need to do in this situation. This training was more about staff and how they can help themselves in situations, it was really pleasant, I really liked it, I found it really relaxing." (Amy)

"other training the focus is not usually on you, it is not usually on staff but the service or service-users really." (Sophie)

The training content was also described as being suitable for this staff group:

"It was delivered well, in that I understood everything that was said, all the stuff we did was on my level and easy to understand and on training it's not always like that, so I felt it was suitable for me and the people I work with." (Emma)

8.12.2 The setting

Feedback was also given from staff with regards to the environment and setting in which the training took place. There was a general consensus that the venue for the two days of training was not only appropriate but also added to the training feeling relaxed:

"and the venue it's really been quite nice, being away from work and not been at the service or the head office. I think it has been relaxed and comfortable which helps with the whole feel of the day." (Rob)

The environment was also described as useful for this particular type of training where the focus was on staff wellbeing. Staff reported that when the training is about their wellbeing, that creating an environment where they feel they can focus on themselves and feel relaxed is important:

"it helps that this was such a calm, relaxed environment, spacious, airy, you know all that, you have to be out of work I think to really be able to focus on yourself, otherwise you'd be putting service-users wellbeing before your own." (Lucy)

The venue also provided opportunities for staff to have regular breaks and there was a separate space for this away from the tables where they were sat for the training. Staff noted that the layout of the room was useful to take breaks and also provided space to speak to colleagues:

"It's nice to be able to just chat to colleagues, know more about them, what they find difficult at work and that. I felt that we had time to do that, we went to the space at the back of the room, grabbed a coffee and this was all so nice to be able to do and we wouldn't be able to do this if we were doing this at work." (Lauren)

There were several key points about the setting that the follow up interviews highlighted. This included the environment being comfortable and calm with no distractions:

"it was just nice to be in that room in a different venue, it was comfortable and quiet and no service-users knocking on the door." (Lauren)

"I found it nice to be somewhere different for the day, I was calmer thinking that I'm not suddenly going to be disrupted." (Lucy)

It was also highlighted from two individuals that going to a different venue for the training made them feel valued by the organisation:

> *"It was nice to be there, such a nice place rather than squashed in the room at work, I thought wow [organisation name] are good sorting the training here."* (Lauren)

> *"you feel valued by [organisation name] because not all work places would send you to that nice venue for two of days of training."* (Rob)

This feedback regarding the training delivery, content and setting the training took place will also be explored and discussed further with regards to potential future implications and recommendations in chapter 9.

8.13 Discussion of the wellbeing training results

This chapter has successfully met objective 4 of this thesis which was:

4. To explore mental health staff's views on their participation in the training and to use measurement tools to measure the mental toughness and burnout of these staff.

It has done this by presenting the results of the wellbeing training including both the results from the semi-structured interviews and the MTQ48 measure of mental toughness and the MBI-HSS measure of burnout. A discussion of the wellbeing training results is now presented.

The wellbeing training showed that staff working in a mental health setting were motivated and enthusiastic about being involved in training aimed at improving their own mental health. However, in this study any significant difference in score was not explored as the outcomes measures were simply used to explore patterns and be used alongside the semi-structured interviews. These patterns will now be discussed with the themes that emerged from the interviews.

Patterns were identified from the MTQ48 and MBI-HSS in the participants before, after and at the three month follow up. The overall mental toughness of the group of participants showed an increase after the training and a further slight increase in the group's overall mental toughness at the three month follow up. The components of mental toughness-control, commitment and confidence, displayed gradual increases in the groups average scores for these components after the training and at the three month follow up. The component of mental toughness-challenge, displayed an increase in the group average score after the training, however at the follow up the average group score had decreased. The component of challenge refers to how well individuals respond to 'an activity or event that is seen as stretching' (Strycharczyk and Clough, 2015). The staff talked about challenges faced working in a mental health setting at the interviews. Several factors were identified including challenges in service-user behaviour, workload and not taking negative emotions home. This slight increase and then drop in challenge scores in this group of participants could be due to the training

providing time away from these day to day challenges and initially helping staff to feel more positive about them. However, the decrease in group challenge score could be due to the reoccurrence of these identified challenges once they had returned to work in those three months leading up to the follow up study. Crust and Keegan (2010) concluded that in mentally tough athletes a willingness to take risks was an important characteristic. However, with mental health staff being taught to manage risks on a daily basis and minimise these, it is perhaps no surprise that mental health staff scored lower for challenge than the other components of mental toughness.

Interestingly the largest increase to the group average score out of the components of mental toughness was found for overall ***confidence***. This pattern was particularly interesting because confidence was a theme that emerged from the interviews. It was talked about by 7 of the 11 participants after the training and by 4 of the 9 participants at the follow up interviews. These participants all displayed individual improvements in their confidence score on the MTQ48. Two of these individuals at the follow up initially did not display improvements in confidence directly after the training, however they did score higher for confidence at the follow up study. Confidence refers to the 'extend to which we have self-belief' (Strycharczyk and Clough, 2015). A theoretical construct linked to confidence is self-esteem (Strycharczyk and Clough, 2015). A pattern was found between the scale of confidence of the MTQ48 and personal accomplishment of the MBI-HSS. Of the 11 participants 6 of these increased their scores for confidence and personal accomplishment after the training and 4 of the 9 participants at the follow up. Carson *et al*. (2001) found that implementing self-esteem workshops with mental health staff displayed positive changes on the MBI-HSS. This included that the mental health staff had scored higher for personal accomplishment after this intervention. They also scored lower for emotional exhaustion and depersonalisation. Therefore, this supports the pattern found in this research between confidence and the personal accomplishment component of burnout. This is important as it suggests that

improving confidence could be a way of improving one of the dimensions of burnout in mental health staff.

At the three month follow up the theme ***control*** emerged from the interviews. The same 4 participants who displayed an increase in confidence score and personal accomplishment score at the follow up also displayed an increase in the MTQ48 component of control. Control in relation to the 4C's model of mental toughness refers to an individual feelings and 'the more likely they feel they can shape and influence what is happening around them, the more likely they are to feel that they can make a difference' (Strycharczyk and Clough, 2015). In the interviews this referred to how participants perceived their level of control in the work environment and how the training had made them feel more in control of their job. Control in the 4C's model of mental toughness is broken down into 'life control' and 'emotional control'. However, on analysis of these two subsections in the participants, no notable patterns were found, instead the increase in control related to overall control. Previous literature has displayed that feeling more in control my impact on burnout levels. In particular, this has been suggested through PSI training with mental health staff, which teaches multiple interventions for working with service-users including anxiety, depression, auditory hallucinations and delusions (Corrigan *et al*., 1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). These techniques have shown to be effective in teaching mental health staff new ways of working with service-users and have shown to reduce burnout. This literature relates to the results found in this study as staff reported finding the mental toughness techniques useful to use with service-users, as well as being able to relate to service-users better due to understanding the type of coping strategies which they may use. By teaching mental health staff new ways of working with service-users as well as the strategies for their own wellbeing this may add to feelings of control. Participants in this study showed a pattern between control and the burnout component-personal accomplishment. Therefore, when mental health staff learn new ways of working with service-users, this may reduce burnout, as they feel more in control and able to work effectively with these service-users (Corrigan *et al*.,

1997; Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). Therefore, this finding is consistent in suggesting that improving mental health staff feelings of control when working with service user is valuable. However, in addition, this research suggests that training should be targeted at providing staff ways of improving their own wellbeing as well as the service-users that they work with.

So far in this section the themes 'confidence' and 'control' that emerged from the interviews have been discussed. This next section will now go on to discuss the other themes that emerged from the interviews and how these findings are in line with previously published theoretical and empirical papers.

Similar themes developed from the interviews at the three month follow up as the interviews after the training. However, the theme 'motivation' only derived from the interviews after the training and the theme 'control' only derived from the interviews at the three month follow up. A possible reason that themes were similar at both of the interviews could be that the interview questions at the follow up mirrored the questions used at the interviews after the training. Therefore, participants may have given similar responses either from remembering what they had said previously at the interview and repeating this, or having similar opinions at the follow up as they did three months ago so simply reiterating this. It also made sense to name the themes at the follow up the same as the themes after the training where this was appropriate so that the interviews could be easily compared and contrasted to each other.

Positive thinking is one of the tools and techniques that may help improve mental toughness (Strycharczyk and Clough, 2015) and was used in the training as a mental toughness coaching strategy. The theme '**changes in thinking patterns'** emerged from both the interviews directly after the training and at the three month follow up. In the NGT, participants had rated ***positive feedback/thinking*** as a favoured suggestion as a way of improving mental toughness and reducing burnout. They had shared that learning to engage in positive thinking rather than negative thinking would be helpful. As already noted, training to manage negative emotions, thoughts and increase positive

thinking may reduce burnout (Scarnera *et al*., 2009). It is also suggested that minimising negative communication between staff and encouraging staff to think and have discussions that are helpful and constructive is beneficial in reducing burnout (Jenkins and Elliot, 2004). Training that focuses at an interpersonal level on elements such as negative emotions, negative thinking and communication may be effective in preventing burnout for people who work in the mental health field (Scarnera *et al*., 2009). The benefits of positive thinking include that individuals that think positively often perceive stress as less of a problem and less threatening, allowing them to cope more effectively and maintain better wellbeing (Naseem and Khalid, 2010). According to Carver and Scheier (1998) those who adopt positive thinking are able to cope effectively with stressful situations by appraising the situation as controllable. Positive thinkers can also use problem-solving skills and remain optimistic in the face of difficult situations or pressure. A meta-analysis showed that work performance, perception of self and others, coping, wellbeing and health all displayed benefits from positive thinking (Lyubomirsky and King 2005). This evidence is in line with the findings from this study as positive thinking was found to be a reoccurring theme with the participants directly after the training and at the three month follow up. Participants were able to give examples of how they were thinking more positively by turning negative thoughts into positive thoughts. They also gave examples of how they used tools such as the 'positive planner' to improve their positive thinking after the training.

The theme ***beliefs about mental toughness and burnout*** also emerged in the interviews directly after the training and at the three month follow up. This included individuals talking in particular about how becoming mentally tough may reduce burnout at work. These individuals that talked about mental toughness and burnout and their beliefs about these two concepts, directly after the training had lower overall mental toughness scores (below the average 4-7 that represents the middle range that 2/3 of the population will score between) on the MTQ48 compared to those who did not talk about these. It may have been that the concept of mental toughness was of interest to these individuals

due to their low mental toughness scores. Therefore, they may have had an underlying interest in these compared to someone who scored higher for their overall mental toughness. However, it is important to note that these individuals did not know their mental toughness score at the time of this interview. They only received their mental toughness scores at the end of the interview so as to not influence their answers to the questions that were asked.

The idea that there could be a possible link between mental toughness and burnout intrigued me from the very beginning when first exploring the existing literature and has been an influencing factor on this research. The group mean overall mental toughness score increased after the training and again at the follow up. The group mean score also decreased for the burnout dimensions of emotional exhaustion and depersonalisation after the training and again at the follow up. In addition, the group mean score for the burnout dimension of personal accomplishment increased after the training and again at the follow up. The participants (Jo and Ben) who scored low for perceived burnout, also scored the highest for overall mental toughness. The participant (Amy) who scored the highest for the burnout dimension of depersonalisation before and after the training and at the follow up also had the second lowest overall mental toughness score before and after the training. The link between mental toughness and burnout has been explored in a student population. Gerber *et al*. (2015) explored whether mental toughness protects against symptoms of burnout and if mental toughness moderates the relationship between perceived stress and burnout over time. In those students with high stress, those with high mental toughness remained below the cut-off for mild burnout, whereas an increase in burnout symptoms was observable among peers with low mental toughness. Recommendations for future research regarding this potential link between mental toughness and burnout is discussed in section 9.14.

Self-awareness was a theme that emerged in the interviews directly after the training and at the three month follow up. Directly after the training this related to being aware of mind and body connections. This included the connection between the physical body and feelings, as well as the importance of being

aware of their mental wellbeing. At the follow up this included having conscious knowledge of their own character and feelings. Clinical supervision may play a significant part in providing staff with a mechanism through which to address and ensure their mental well-being, partly by allowing an opportunity to reflect on their work and feelings related to this (Hyrkas, 2005; Edwards *et al*., 2006; Walsh, 2009; Walsh and Freshwater, 2009). Benefits of reflective practice due to clinical supervision, to manage emotions and enhance wellbeing have been found (Walsh and Freshwater, 2009). Therefore, this finding is consistent in suggesting that providing opportunities for mental health staff to be more aware of their emotions and how to manage this may be beneficial.

Wider applications with service-users were discussed after the training and at the follow up interviews. Staff spoke about how the training could be and had been used with the service-users. Previously published theoretical and empirical papers have suggested that providing staff with new techniques and strategies to work with service-users can be beneficial in reducing staff burnout. Training both educational and practical in nature, with a focus on changing staff attitudes to a more flexible therapeutic approach to service-user's mental health, away from a purely medical model can be beneficial (Ewers *et al*., 2002). The wellbeing training with mental health staff focused primarily on teaching the strategies to improve staff wellbeing. However, the training also had the added benefit of providing practical techniques for the staff when working with service-users. Therefore, suggesting that wellbeing training for staff may have applications for service-users. In addition, the MBI-HSS displayed a pattern in an overall reduction in the group average emotional exhaustion score and depersonalisation score and an increase in personal accomplishment score. This supports previous research that providing staff with new ways of working with service-users may reduce burnout (Ewers *et al*., 2002; Doyle *et al*., 2007; Redhead *et al*., 2011). This is also in line with the evidence that increasing staff knowledge of mental health may improve staff burnout (Ewers *et al*., 2002).

Wider applications with colleagues was a resulting theme from the interviews directly after the training but not at the follow up interviews. Similarly, to how

staff spoke about the applications of the training with the service-users they work with, they also expressed the training could be useful for their colleagues that had not attended the training with them, but worked in the same service. Applications included feeling able to provide coping strategies and support for their colleagues that they work with. Social support from colleagues has shown to impact on burnout, in particular having an effect on the emotional exhaustion dimension of burnout (Jenkins and Elliot, 2004).

The interviews portrayed that staff wanted to be more mindful and positive with their colleagues after the training, to impact on their colleagues wellbeing as well as their own. Fenlason and Beehr (1994) suggest that support for colleagues can be emotional, including the act of someone listening and caring sympathetically to another individual. Being able to teach their colleagues some of the techniques and coping strategies was also seen as an application from the training. This is line with other research that it may be beneficial to provide active and practical support to colleagues, including help and support with specific tasks at work (Fenlason and Beehr, 1994).

The basic theme of ***culture of the service*** that emerged from the interviews, in relation to perceptions of how the training could potentially change the ideas, customs and behaviours within the whole service in which they worked, can be compared to other research findings. Changing the culture of the organisation was rated as top priority during the NGT, in terms of improving mental toughness and burnout. This theme appeared to still be a priority to staff at the interviews. It is reiterated by Coates and Howe (2015) that new training and initiatives in an organisation should involve the staff ideas and input. Allowing staff to be involved in the wellbeing training, as well as the opportunity to give their feedback of their experience of this in the interviews, ensured staff could be involved in making changes to the culture where they worked.

Staff displayed high motivation for making cultural changes where they worked following the training. One way in which staff were motivated for change where they worked was by talking more about wellbeing, this included in team

meetings and supervision. Staff expressed wanting an open dialogue about wellbeing in the workplace and making their own wellbeing a priority. This motivation was particularly high directly after the training but was also evident at the follow up interviews. At the follow up interviews staff expressed how they were still motivated to talk more about wellbeing at work and some examples of how cultural changes were being made were given.

Practical changes were implemented following the training including a yoga class for staff. In addition, staff spoke more about the topic of wellbeing during meetings and supervision. It was also planned for a wellbeing champion role to be created for one of the staff, in order to encourage and promote staff wellbeing. However, the individual who planned to do this was not available for a follow up interview, therefore it is not certain if this role was implemented.

The other applications that emerged following the training for the staff were ***wider applications for life after work.*** This included being able to use the techniques at home or in any situation outside of work such as driving home from work. It also included applications of how the training impacted on their perceptions and how they behaved with family and friends. The interviews portrayed that applications of the training outside of work was beneficial. Staff discussed that working in mental health is a challenging environment and staff reported taking this pressure with them outside of work. High-volume work demands and targets in these mental health services have been found to make it a pressurised environment to work in (Dowthwaite, 2016). Therefore, mental health staff equipped to manage their wellbeing both inside and outside of work is important. Training that provides wider applications for the staff not just in work but also outside of work, could be beneficial in managing the demands associated with this area of work. Interventions that allow time to reflect and gain support on non-work as well as work related issues may be useful in reducing staff burnout (Kilfedder *et al*., 2001).

At the interviews how staff perceived the training could impact outside of the service in which they worked on the ***wider team from other services*** was

discussed. Staff felt they were able to bond with staff from others services from the same organisation. In addition to this at the follow up, participants also reported that they now felt they had a wider support network outside of their own service. Training that allows for networking and team bonding such as support sessions have been found to be beneficial for staff wellbeing, in particular reducing burnout (Jenkins and Elliot, 2004). This benefit that came from the staff attending the training is in line with studies that have found that social support between staff, including communicating with each other in a way that minimises negativity, can be beneficial for the team and levels of burnout (Jenkins and Elliot, 2004). However, a possible disadvantage for other services was discussed in relation to this theme. This included the difficulty of making changes to other teams at other services and having difficulty relating the training to staff that didn't attend. The more staff that attend training to reduce burnout in mental health services, the more likely this is to be successful (Scarnera *et al*., 2009).

As discussed these findings are in line with previously published theoretical and empirical papers. However, this study was unique in involving mental health staff in a wellbeing training intervention focussing on their mental toughness and burnout.

CHAPTER 9

DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

9.1 Introduction

This chapter consolidates the results and conclusions from this thesis and highlights how these results contribute to wider knowledge. The motivation behind this thesis was an insight into the world of mental health staff wellbeing, while working in this environment myself for many years and through deep discussions and observations of the need for staff wellbeing to be addressed in this area of work. The review of the literature in chapter 2, highlighted that staff wellbeing, in particular burnout in mental health services, is a current and important issue. With this motivation, first-hand experience and an identified gap in the current knowledge following the literature review, I set out to explore the experience of mental health staff in wellbeing training focussed on their mental toughness and burnout.

In this chapter the main research findings are synthesised and the thesis concluded. This includes detailing how the aims and objectives were met. The chapter then goes on to explore the methodological approach to the study, as well as reflect on the limitations of the study. Finally, implications for practice, research and policy, as well as recommendations and directions for future research are suggested. The thesis concludes with some final thoughts and take home messages in chapter 10.

9.2 Evaluating the thesis aim and objectives

In the background and literature review chapters the rationale for this research was detailed. This prompted the exploration of the main aim and objectives.

The aim and objectives of this study were as follows:

Aim: To explore the experience of mental health staff of participating in wellbeing training focussed on their mental toughness and burnout.

Objectives:

1. To highlight any gaps in the current knowledge base surrounding training and interventions for mental health staff wellbeing.
2. To develop an understanding of what techniques and strategies mental health staff think could improve their wellbeing.
3. To develop and implement staff wellbeing training informed by literature and mental health staff ideas.
4. To explore mental health staff's views on their participation in the training and to use measurement tools to measure the mental toughness and burnout of these staff.

All four objectives have been met in this thesis. Objective 1 was met by carrying out a literature review to explore existing training and interventions to reduce burnout in mental health staff, the summary and the discussion of this literature review can be seen in chapter 2 (section 2.8).

Objective 2 was met by carrying out a NGT with mental health staff. This provided insights into the top rated ideas mental health staff thought should be taken forward to help reduce burnout and improve mental toughness in mental health staff. Motivation from the staff in taking this forward was evident and these ideas and insights from the NGT and literature review were used in helping to decide on the training to be used. Details of the NGT results can be seen in chapter 5.

Objective 3 was met by using the insights from the literature review and NGT to decide on the training to be used. The decisions of the wellbeing training

because of the NGT and literature review can be seen in section 6.2. This training was then implemented with mental health staff.

Objective 4 was met by carrying out semi-structured interviews with the participants after the training and again at the three month follow up. The interviews were used to explore the staff overall experience of being involved in the wellbeing training. In addition, the MTQ48 was used to measure mental toughness and MBI-HSS was used to measure burnout in these staff. The methodological approach used to meet these objectives as well as the limitations of the study are discussed later in this chapter.

9.3 Comparison of the MTQ48 and MBI-HSS to previous findings

This section will now compare and contrast the results from the outcome measures used in this study with previous research that has used these measures with similar populations.

The company AQR who developed the MTQ48 with Peter Clough and Doug Strycharczyk have reported that with regards to the minimal important difference "when we work with groups we can often observe a difference in outcome or group behaviour with a change of average mental toughness scores of as little as ½ a sten" (personal correspondence with the publisher (AQR) on 24th Jan 2019). Therefore, based on this there was a minimal important difference in the group overall mental toughness average score after the training. However, at the three month follow up the minimal important difference was not reached as the average overall mental toughness had not increased by as much as ½ a sten. There was a minimal important difference in the group components of 'control', 'commitment' and 'confidence' average scores after the training. However, at the three month follow up the minimal important difference was not reached for these three components of mental toughness as the average group scores had not increased by as much as ½ a Sten. For the component of 'challenge' the group average scores had not increased

enough after the training or at the follow up to meet the minimal important difference.

The largest increase to the group average score out of the components of mental toughness was found for overall confidence. No comparable data of the MTQ48 administered with mental health staff was found at the time of writing this thesis in order to compare these results.

The burnout dimension of emotional exhaustion and depersonalisation decreased after the training and at the follow up. The burnout dimension of personal accomplishment increased after the training and at the follow up. According to the company that develops the MBI-HSS "the MBI is a research measure from which we can learn about the causes and outcomes of burnout, but it is not a clinical diagnostic tool and therefore there is not a minimal important difference score." Maslach and Leiter (2016) provide data from a sample of 730 individuals working in mental health that completed the MBI-HSS. According to Maslach and Leiter (2016) using data such as this allows an individual's relative degree of burnout to be compared to the average for their group. Table 9.1 highlights the means and standard deviations for emotional exhaustion, depersonalisation and personal accomplishment from the MBI-HSS with this sample of individuals working in this occupation. When comparing the results from this study to this data, it displays that participant's emotional exhaustion and depersonalisation scores were below the average for this population, before and after the training and at the follow up. Participants personal accomplishment scores were above the average for this population before and after the training and at the follow up. However, this may be due to other factors such as the small sample size in this study. In addition, the participants that opted to take part in this study may have been individuals who had lower levels of perceived burnout. There may have been individuals with higher levels of perceived burnout that chose not to participate in this study.

Table 9.1: Data from a sample of 730 individuals working in mental health that completed the MBI-HSS (adapted from Maslach and Leiter, 2016).

	MBI-HSS scales		
	Emotional Exhaustion	**Depersonalisation**	**Personal Accomplishment**
Mean	16.89	5.72	30.87
SD	8.90	4.62	6.37

9.4 Evaluation of the training package and its delivery

The intervention was the wellbeing training. The training package consisted of teaching the staff a variety of mental toughness coaching strategies that had already been developed to improve mental toughness in other areas such as sport and education (Strycharczyk and Clough, 2015). In addition to this, to meet the 'environment' theme from the NGT staff were given a fruit infuser water bottle for them to take back to work with them to help stay hydrated. The content of both days of training can be seen in chapter 6 (section 6.3). Previous research has displayed the effectiveness of developing mental toughness (Crust, 2008; Loeh, 1982; Clough *et al*., 2002). In this study a variety of the mental toughness coaching strategies were selected form the adult version of the mental toughness development toolkit (Strycharczyk and Clough, 2015). However, these were selected based on the findings of the NGT discussion and what staff prioritised during this discussion. This meant that although strategies were used in the intervention including positive thinking, relaxation, attentional control, goal setting and visualisation, that for some of these it may have been beneficial to use more techniques from the toolkit rather than just a selection. For example, only one technique was taught for visualisation, where teaching a larger variety of techniques may have been useful for the staff.

In addition, the length and time of the training is worth reflecting on. The timings of the training worked well into a 10am-4pm on both days. These timings also included time for consent forms and questionnaires for this research on both days. The implementation of the training was selected to be over two days due to previous literature suggesting that training such as this can be beneficial from as little as one day (Salyers *et al*., 2011). Furthermore, two days was decided as suitable with the services due to the practicalities of staff being able to have time away from normal working hours to attend the training. A recognised problem of using interventions to improve burnout in mental health staff, is that individuals don't always get the opportunity and time out of normal working duties to attend sessions and they are not always regularly available (White and Roche, 2006). Therefore, an intervention or training that teaches staff to look after their own wellbeing over a short two days was selected as a suitable timeframe.

Feedback was received from the staff regarding the training package and its delivery directly after the training and at the three month follow up interviews. The delivery of the training was described as 'informal', 'practical' and 'relaxed'. Feedback was given that the training was suitable for all different mental health staff of different professions, as it was delivered in a universal way that all would be able to understand. Interventions to improve the wellbeing of mental health staff should be accessible to all staff that work in this setting, including managers and all support staff working in this setting (Scarnera *et al*., 2009).

Feedback was given from the staff with regards to the environment and setting in which the training took place. There were several key points about the setting that the follow up interviews highlighted. This included the environment being comfortable and calm with no distractions. Training focussed on staff wellbeing should allow time for staff to fully immerse themselves in the training and techniques and should minimise distractions from everyday work and stresses (Razzaque and Wood, 2016).

9.5 Application and feasibility of the training for mental health staff

One way in which this thesis provides a unique contribution to knowledge is through using mental toughness coaching strategies in wellbeing training for mental health staff. Although these techniques have been used in many other areas, using them as part of wellbeing training in this setting for this population has not been done before. Therefore, this thesis has highlighted some useful and interesting information with regards to the application and feasibility of this type of training for mental health staff. These applications will now be discussed.

Firstly, it is important to note that the NGT that explored what techniques and strategies could be used to improve mental toughness and burnout in mental health staff, could be carried out as part of the implementation of this type of training. This would allow for other mental health services where this training may be implemented to see how the ideas and discussions of this differs to those found in this thesis. This would also add an element to the training which supports the involvement of staff from the very beginning of introducing this type of training. Involving staff in the development of such training can be beneficial in getting staff motivated and enthusiastic about taking part and is recommended when applying this training to other mental health staff and services (Posner *et al*., 2017; Coates and Howe, 2015).

The individual implementing the training ideally should be a mental health professional. This is because the staff reported that being trained by an individual that understood their working environment and the daily pressures and challenges that they may face was important and made the training feel more relatable to them (Posner *et al*., 2017). However, to implement such training to other mental health services on a wider scale, such as implementing the training nationally across all services, would require multiple individuals that could implement this training. In order to do this successfully a 'train the trainer' programme is suggested. Mental health professionals identified from different services could undergo training on how to implement this training with mental health staff, including appropriate timings and scheduling. These identified

individuals would also need to complete the MTQ48 licence user training if services were to use this measure to appropriately assess the mental toughness of individuals. The benefit of doing this, with this outcome measure, would be to create individual development plans and identify the techniques that might work best for that individual. In addition, by using the MTQ48 at regular intervals, this would help identify any changes in scores and hence further develop support plans for the staff.

This links in with the question regarding how often the training might be implemented within services with the mental health staff. Although this was a one off training over two days, it has identified possible ways for applying this training more regularly. Staff gave their input that the training would be beneficial to have regularly, in order to recap and remind themselves of the techniques. This may include making the training part of their yearly training requirements or as part of their supervision meetings. The training could be used for new starters to the service as part of the introductory training. Having the training scheduled in an as part of the monitored continuing professional development was identified as important. This was suggested as it would be then made a priority to them and they would be allowed time out of normal working duties to attend. This would also mean that in this setting where staff work different shift patterns, that there would be opportunities for all the staff to attend regardless of their work pattern.

It was also highlighted by staff that if the training was implemented earlier on in their career, while they were still training, e.g. nurse degree, occupational therapy degree course, that this could be useful. It was suggested that the earlier the training was implemented the more useful it might be, as there would be more focus on preventing poor wellbeing rather than trying to cure it. Another suggestion for implementation comes from the idea one member of staff suggested regarding having a 'wellbeing champion' role in their service. An individual in a role such as 'wellbeing champion' could help apply the techniques. They could do this by ensuring regular opportunities to engage in these such as having a 'feel good Friday', where staff wellbeing is made a priority.

The location of where the training is implemented is also a factor to consider for the application and feasibility of the training with mental health staff. This training was carried out a private training room in order to allow staff to fully immerse themselves in the techniques been taught. The staff had highlighted that 'away days' or opportunities to be away from the usual work environment was important (Posner *et al*., 2017). This allowed them to not be distracted by other tasks and also to really focus their priority on their own wellbeing. Therefore, it is recommended that the training would take place for other services in an environment outside of the service. The organisation where participants were recruited from in this thesis has a head office with several training rooms that are used for this type of training. These are free of cost for all services to use and would be an appropriate environment for other services to undergo the training.

By following the recommendations with regards to the implementation of this training, other mental health staff in other services could undergo this training and help further change the culture of these services.

9.6 Application of frameworks and models to the findings

Throughout this thesis I have considered how the results may fit with existing frameworks and models. Chapter 3 outlined the models that were initially used. This section will now discuss these models in relation to the results. In addition, other selected models or frameworks that also fit with the findings will be discussed.

Firstly, after the literature and NGT suggested using mental toughness coaching strategies as a way of improving wellbeing in mental health staff it was decided that the 4C's model of mental toughness would be used (Strycharczyk and Clough, 2015). As previously described in chapter 3, the 4C's breaks down overall mental toughness into four components, this includes challenge, confidence,

commitment and control. A variety of mental toughness coaching strategies were implemented as part of the wellbeing training, including techniques of positive thinking, goal setting, attentional control, visualisation, anxiety control and relaxation. However, the amount of each of these techniques included as part of the training varied depending on the priority and discussions had with staff during the NGT. A selection of techniques were implemented in the training to cover all four aspects of the 4C's model. From the interviews, two of the 4C's emerged as basic themes, this included confidence and control. The participants were not aware of the 4C's model at the time of the training and therefore this could not have influenced why these basic themes emerged. Confidence and control may have emerged as basic themes compared to commitment and challenge as there was not an equal weighting of the techniques used. For example, six techniques and activities were used for positive thinking and only one for visualisation. However, the fact that the mean overall mental toughness and mean of each of the 4C's of mental toughness increased following implementation of the training, in addition to these emerging basic themes, suggests that these findings fit with this model.

After exploring the results from this study, the findings also fit with Lewins change management model (1958) (figure 9.1), in particular when reflecting on changes that were made following the training. From the interviews directly after the training the theme 'motivation' emerged. This included the motivation the staff had to implement change, such as talking about wellbeing more and using the techniques from the training. Also at the interviews directly after and at the follow up the theme 'culture of the service' emerged. This referred to how the training could change the ideas, customs and behaviours within the whole service in which they worked. How this study and the results are in line with this model are now outlined:

Unfreeze- The NGT highlighted that the mental health staff believed that change was necessary and the topic of staff wellbeing needed to be improved. In addition to this, the organisation and service manager agreed for staff to be

approached for this research, as they believed this change was necessary and of interest to them as an organisation. There was a strong motivation and enthusiasm for this topic of staff wellbeing from the first time participants were approached. Lewins (1958) model suggests that without this motivation, participants to effect any meaningful change would be difficult.

Change- The NGT identified new ideas and ways that mental health staff wellbeing could be improved. The interviews identified that implementation of the wellbeing training made changes occur for individual staff, as well as the wider culture. These changes were evident at the three month follow up and according to Lewins (1958) model, change does not occur overnight and can take time for proactive participation in this change. An important issue was highlighted at the follow up interviews. This was that as some of the staff had not attended the training this made changes more difficult to implement. The change model supports that for change to be successful people need to understand how it will benefit them. Therefore, for those who were not part of the NGT or training, these individuals may have been less open to change and therefore did not take part.

Refreeze- According to this model when changes occur and these are being embraced, the organisation can refreeze and allow changes to become part of daily practice. At the follow up study, changes such as a yoga session for staff and time at meetings for staff to talk about wellbeing had been implemented into practice. Lewins (1958) change management model is a useful framework for managing change. This model suggests that by creating motivation to change (unfreeze) and by promoting and embracing new ways of working, in this case the wellbeing training (change), this can lead to organisation stability with this change (refreeze).

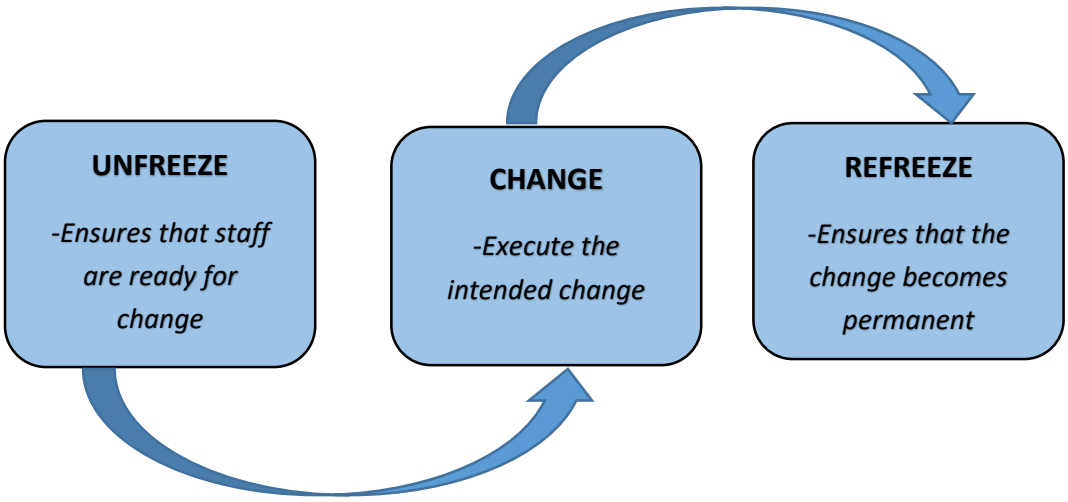


Figure 9.1: Lewins (1958) change management model

(adapted from https://www.change-management-coach.com/kurt_lewin.html)

Although this model was not used to implement the change in this study, on reflection it is clear how the model does fit with the implementation of the staff wellbeing training. Therefore, it is suggested that Lewins (1958) change model could be beneficial to consider when implementing changes with regards to staff wellbeing with mental health staff.

9.7 The methodological approach to the study

A pragmatic paradigm and mixed methods methodology was applied to this research. In this section the methodology applied to the study will be reflected on along with the use of mixed methods to answer the research question. Following this the limitations of the study including the methods will be discussed.

Reflecting on the journey of the PhD, I started as a predominantly quantitative researcher as I had a background in this. However, through this research process I have gained a greater understanding about my beliefs and the effect of these on the research I carry out. I have learned that people see things differently even

though they are engaged in the same experience and through this research I would now identify myself as a mixed methods researcher. Truly believing in the importance of both quantitative and qualitative research methods, in gaining a better understanding of the world we live in and peoples experience of this. Before this research I was originally interested in the quantitative side of research, in that I was interested in more deductive reasoning. However, through this research I have become interested in deductive and inductive forms of knowledge to explore the research aim. My focus has been on using the best ways to contribute to new knowledge.

From early on in this research I became aware that my beliefs fit well with those of a pragmatist. I realised that I believed in focussing on what works best to explore the aim and could identify with Tashakkori and Teddlie (2003) pragmatism definition that 'debunks concepts such as truth and reality and focusses instead on what works as the truth regarding the research question under investigation'. With this in mind I decided that reality can be renegotiated and debated and that my views did not fit solely with either the positivists (one single reality) or the interpretivists (multiple realities) paradigms. Viewing the epistemology as operating on a continuum rather than as two opposing sides is suggested by Tashakkori and Teddlie (2003) as how most researchers actually work. It soon became clear that I believed that the best methods are ones that answers and helps makes sense of a problem and that my focus was on selecting the most appropriate methods to explore the research aim.

A convergent parallel mixed methods design was applied to this research. This allowed data to be collected that was quantitative and qualitative. The quantitative which consisted of using the MTQ48 and MBI-HSS to measure self-reported mental toughness and burnout and the qualitative semi-structured interviews to explore the experience of the mental health in the wellbeing training. The qualitative and quantitative data was collected at the same time. Data analysis was conducted independently and results were mixed during the overall interpretation to look for patterns, contradictions or relationships of the two sources of data. The challenges of convergent parallel mixed methods are

that the researcher needs both expertise and knowledge of both quantitative and qualitative methods (Creswell and Plano Clark, 2011). In addition, appropriately merging the two types of data and how to deal with the situation in which quantitative and qualitative results contradict each other can be a challenge (Creswell and Plano Clark, 2011).

Mixed methods are not without their critics. For methodological purists, combining different methods and data types together remains philosophically incoherent (Johnson and Onwuegbuzie, 2004). Using mixed methods in research has sometimes been seen as controversial because of the view that quantitative and qualitative belong to separate and incompatible paradigms. Those in agreement with this opinion, argue that it is neither possible nor desirable to combine quantitative and qualitative methods in a study. This is because they represent essentially different and conflicting ways of viewing the world and how we collect information about it (Tariq and Woodman, 2013). However, as stated in this study a more pragmatic view was taken, believing that concerns about worldviews can be set aside, if the combination of quantitative and qualitative methods helps to best explore the research aim.

Mixed methods research is seen as appropriate for more collaborative research, involving more than one researcher. This is due to the complexity and time-consuming nature of using both qualitative and quantitative data collection methods (Tashakkori and Teddlie, 2003). However, this study was completed in the scheduled time frame with myself as a lone researcher. The quantitative outcome measures were quick and easy to administer and required the participants to complete themselves. The semi-structured interviews were scheduled in advance of them taking place, in order to account for the time frame in which they needed to be completed. Research rigour was ensured by following Lincoln and Guba (1985) suggested techniques for achieving credibility, transferability, dependability and confirmability (see chapter 3 section 3.11).

Combining the qualitative and quantitative data can be difficult and successfully integrating the different data can be a challenge. The approach taken in this study was to analyse the outcome measures and interviews separately and then these were compared, contrasted and combined (O'Cathain, Murphy and Nicholl, 2010). The importance in this thesis was to explore any meaningful links or contradictions between the outcome measures and interviews in order to explore the research aim. I recognize the importance of reflecting on combining the outcome measures and interviews and ensuring it has led to a more enriched understanding of the research question. The discussion of the results (section 8.14) highlighted the importance of combining these results in terms of how it led to a wider knowledge and understanding of the experience of mental health staff in the wellbeing training.

9.8 Limitations of the methods

The methods used in this study were identified as appropriate to answer the research question. However, limitations of these methods are acknowledged and will be outlined in this next section.

9.8.1 Limitations of the NGT

Despite the NGT been a successful method for data collection in this research, some limitations of this method are recognised. The NGT can be regimented in the way that it focusses on one question and has a single purpose in a one off meeting. Although during this group the staff engaged in discussion to share ideas and add clarity to points made, it is recognised that compared to other methods the NGT can minimise discussion. Therefore, it is sometimes argued that this can limit the full development of ideas and be less stimulating for the individuals involved (Cantrill *et al.*, 1996). However, the NGT suits research that includes health professionals, since it allows for the free exchange of opinions and the generation of ideas within a structured and non-hierarchical discussion

forum (Allen *et al*., 2004). The NGT is also easy to administer and a time efficient way of collecting information and ideas (Potter *et al*., 2004). Therefore, as this method allowed for effective data collection with the staff and positive feedback was received from individuals, this method was deemed as successful for this study.

9.8.2 Limitations of the outcome measures

The limitations of the MTQ48 and MBI-HSS outcome measures in this research are recognised and an attempt to make these possible limitations transparent are outlined here.

One person reported when completing these measures for the second time, that they thought they could remember how they had answered the questions the first time. This suggested that the time between answering the questions may not have been long enough and that they may have answered in a particular way. This may have been done in order to either show no change, or oppositely a lot of change in their scores. Response bias refers to the tendency of an individual to answer the questions of a questionnaire/outcome measure inaccurately or untruthfully (Furnham, 1986). For example, participants may have felt pressure to give answers that they viewed as socially acceptable, this may include scoring in a way in which they thought displayed improvements in their score. According to Maslach *et al*. (1996) response bias of the MBI-HSS can be minimised by following the guidelines to administering the questionnaire. This includes that the facilitator should not be someone who is viewed by the participants as being in power or authority, such as their manager or supervisor. In addition, to minimise the response bias in this study for both the MBI-HSS and MTQ48, when introducing these questionnaires, the importance of giving honest answers and reassuring participants about the confidentiality of their results was reiterated, which aimed to also help minimise response bias. It would be potentially worth considering giving the participants the questionnaires to complete in their own time and then give back to the researcher. This may

reduce social-desirability bias and answering the questions in a certain way, as they wouldn't feel like their responses were waiting to be collected and they may feel they can answer more honestly. However, this may give participants more time to think about their answers, compared to doing them at the training where they answered with immediate responses to the questions. The MTQ48 and MBI-HSS suggest that answers should not be overthought and that responses should be participant's immediate thoughts to the questions.

In addition, there could be the potential for acquiescence response bias. Whereby individuals may have the tendency to agree with questions or to indicate a positive response or connotation when in doubt of how to respond (Watson, 1992). Acquiescence response bias can impact on any question in which the response options involve confirming a statement, in particular it may be problematic with agree-disagree questions (Lavrakas, 2008). The MTQ48 responses are completed on a Likert scale (1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree) which can lead to extreme responding. Extreme responding is a form of response bias that may cause individuals to only select the most extreme options or answers available (Furnham, 1986). For example, the MTQ48 Likert scale with potential responses ranging from one to five, the individual may only give answers as ones (strongly disagree) or fives (strongly agree). There are several reasons for why this bias may occur in a group of participants. A reason why individuals might give extreme responses is that particular topics may cause them to respond in an extreme manner. This may occur if it relates to the motivations or beliefs of the participant and they feel particular strong about their views. In this research participants may feel especially strong about their view on their mental toughness and their beliefs about this. The opposite of this extreme response bias can also occur whereby participants score in the middle of the scale. This mild response style avoids scoring on any the extremes of the scale. This would mean that participants only select the intermediate responses as answers, in the

case of the MTQ48 this would be answering on the Likert scale threes (neither agree nor disagree).

These mentioned biases may have also been apparent in the MBI-HSS. The MBI-HSS responses (0=never, 1=a few times a year or less, 2=once a month or less,3=a few times a month,4=once a week, 5=a few times a week,6=everyday) could lead to extreme responding. In particular, as this questionnaire measures burnout, individuals may respond with 0=never, in order to get a perceived low burnout score as they think this is desirable. Therefore, there could be the potential for social-desirability bias. The mild response style, whereby participants would score a 3 on this scale is less likely to be a problem on this scale, as the middle option refers to feelings they have had 'a few times a month' and therefore differs to scales whereby the middle option is 'neither agree nor disagree' such as with the MTQ48.

Participants all selected to receive feedback on their questionnaires and in order to do this their questionnaire had to be identifiable to myself, in order to be able to give the feedback to the correct individual. On reflection I feel that this could have influenced how the participants answered on the questionnaires, as they knew that I would also know their score and they may have wanted to answer in a way that they perceived as more desirable, i.e. more mentally tough/lower burnout. Therefore, social desirability bias may have been present due to allowing the option of receiving feedback on their scores of the questionnaires. Social desirability refers to when participants answer in a way they deem to be more socially acceptable than would be their "true" answer (Lavrakas, 2008). This is done to portray a favorable image of themselves and to avoid receiving negative evaluations. This leads to over reporting of socially desirable behaviours or attitudes and underreporting of socially undesirable behaviours or attitudes (Lavrakas, 2008). Although ideally the MBI-HSS and MTQ48 would be completed anonymously, in order to make the participants feel more comfortable about conveying their true feelings, efforts were made to minimize the identification of participants. A code was initially given to each participant so that only myself as the researcher administering the questionnaires could identify them. Participants

were then given a pseudonym for the purpose of writing up these results for the thesis and to remain unidentifiable. Furthermore, participants were assured that their responses would be kept confidential and not used in any way that might have adverse personal consequences for them.

In terms of the feedback given, participants received their scores from the MBI-HSS and MTQ48 with a brief explanation as to what the score meant in terms of their self-reported score of burnout and mental toughness. The participants were given their overall score as well as the scores for the individual components of mental toughness-challenge, control, commitment and confidence. No in depth details from the reports that the MTQ48 generates were given until after the three month follow up, e.g. development suggestions, as it was deemed inappropriate to the study, as this could have influenced the participants answers to the questionnaires and interviews at the follow up study if they had been given. However, during the training the importance of both reflecting on and practicing the techniques that they personally found helpful was emphasized.

According to Maslach *et al*. (1996) researchers should avoid sensitization to burnout while using the MBI-HSS. As people have varying beliefs which are often strong, participants should be unaware the MBI-HSS is a measure of burnout in order to minimize the reactive effects of their personal beliefs. In order to do this, it is suggested that the questionnaire should be presented as a survey of job-related attitudes (Maslach *et al*., 1996). However, in this study participants would have been aware that the measures they were completing were to measure burnout and mental toughness. This is because from the information they were given on the information sheet during the recruitment process, it was made aware to the participants that the aim of the study was 'to explore the experience of mental health staff in wellbeing training focussing on their mental toughness and burnout'. Information regarding why the study was taking place including background on burnout in mental health staff was also given. This was deemed appropriate as to provide sufficient background information to the study, as well as not to deceive as to the purpose of the research.

9.8.3 Limitations of the semi-structured interviews

One of the difficulties of conducting the semi-structured interviews was organising the time for these to take place. Due to varying shift patterns of all the participants it was difficulty organising a time for the interviews. The participants also reported very busy shifts, whereby it is difficulty to take time out of their day to be interviewed. Two participants completed the questions following the training in written form and sent these to me via email. This was due to going on maternity leave immediately after the training and the other individual going on night shifts immediately after the training for three months. One participant also completed the interview questions in written form for the three month follow up study, this was due to night shift work making the participant unavailable to be interviewed.

It is also important on reflection of the interviews directly after the training, to note that participants were highly motivated from the training and for many still had a 'buzz' from being on this training and away from work. Therefore, the interview responses from the participants felt very positive. Although still positive at the follow up interviews, participants appeared to offer more 'real life' examples of the benefits of the training. In addition, they discussed some challenges or difficulties of the training after being back at work for three months. Therefore, this is important to acknowledge as the timings of the interviews could have impacted on how the staff interpreted their experience of the training.

Also, social-desirability bias and acquiescence bias as mentioned above for the outcome measures may also be present in the interviews conducted. As three of the participants had known myself through working at the same organisation or service, there is a possibility that they may have answered in a way they felt was more socially desirable. This may have been either in terms of creating a more favorable image of themselves, or to answer in a way they felt was more favorable to me and the research I was conducting.

It is important at the start of the interview to make participants feel at ease and make sure they are clear on the purpose of the interview (Gomm, 2004). In this study participants were asked an initial question regarding their job role to help make participants feel more comfortable and relaxed before answering the main body of questions.

The interviews may also have limits in that the comparability of the interviews may be reduced as the wording and sequencing of the questions is likely to have varied slightly to each other. However, this did allow for interviews to develop their own coherence and allow for the interview to develop more naturally.

Of the total 11 participants that took part in the interview questions directly after the training, only 9 of these individuals took part in the three month follow up. This was due to maternity leave making one individual unable to be part of the follow up. The other individual that did not take part in the follow up had left the service and organisation at which they worked. The manager agreed to email this individual to offer them the ability to still provide feedback or take part in the follow up. However, they were unable to be contacted and therefore no responses were received from this participant. An issue with carrying out a follow up study is that there were participants who dropped out of the study.

Previous research (Razzaque and Wood, 2016; Salyers *et al*., 2011) has highlighted that follow up studies taking place six weeks or under following the training may be too short. They also highlight that a follow up study that is several months after the implementation of training would be more beneficial to explore any longer term effects. Other research using wellbeing support groups for mental health staff used a follow up of six months, however found that attrition levels were high (Carson *et al*., 1999). Therefore, based on previous evidence, a follow up at three months was decided as appropriate for this study. This was to allow for enough time to pass to potentially explore more long-term effects but also not so long to try and minimise dropout rates and reduce attrition levels. However, as there were two individuals that dropped out of the study (18% drop out) it is recommended to have a larger sample size. In

addition, it is beneficial to provide an opportunity for those unable to attend the follow up, to still complete the outcome measures and interview questions in a timeframe that may suit them best.

During the analysis of semi-structured interviews, the researcher has to avoid bias in the analysis (Braun and Clarke, 2006). As I had worked in the same organisation as the participants and had worked alongside three of the individuals before commencing on this study, it is possible that this may have biased interpretation of the interviews. However, reflexive practice has allowed me to try to be transparent in my interpretation and analysis. Data analysis could have been strengthened by an independent researcher also undertaking the thematic analysis and seeing if similar thematic networks emerged. However, to help minimise this an individual in a supervisory role coded one of the same transcripts, so that we were able to compare codes and see if similar codes had emerged. How the role of having myself as the researcher could impact on this study and how I have been reflexive in this research will be discussed in the next section.

9.9 Reflexivity and the role of the researcher

A person's beliefs, values and assumptions can impact on research and I have attempted to be reflexive throughout this research process. Reflexivity refers to reflecting back on the research and one's own role in the process (Bryman, 2001). This is important because researchers are implicated in the research that they conduct (Bryman, 2001). The research area chosen to be explored and investigated, the angle of investigation, the methods used, the interpretation of the results and the delivery of the conclusions are all affected by a researcher's background and positon (Malterud, 2001). I entered into this research as a person who had experienced and seen the need for mental health staff to improve their wellbeing. I had beliefs that in order for mental health staff to truly work effectively and overall look after the service-users to the best of their ability, that their own wellbeing needed to be looked after. It was this experience

and these beliefs that was the underlying motivation for the choice of research topic that developed into this thesis.

By thinking reflexively, it is possible to help reduce the risk of being misled by our own experiences and interpretations. In this study the research involved an emotive subject of staff wellbeing, which I already had beliefs about. Therefore, it is acknowledged that in research involving emotive subjects, that researchers may project their own feelings into the interviews by wording or phrasing questions in a certain way or with a particular tone. In addition, researcher's reactions to participant's answers might impact on how participants answer the questions that follow (Koch and Harrington, 1998). This can also influence how results are interpreted, especially those of a qualitative nature. Furthermore, how these results are then reported and disseminated may also be effected (Koch and Harrington, 1998). Steps have been taken during the research process of this study to minimise this occurring and these shall now be outlined.

During the interview process I thought reflexively by considering what I was thinking and feeling at the time of the interviews. I did this by acknowledging my own assumptions and beliefs about the topic, thinking about what influence this might have on the findings and then re-evaluating the findings. This reflexive feedback was then used for the next interview that followed to allow a continuous process of reflexivity (figure 9.2 displays this reflexive process).

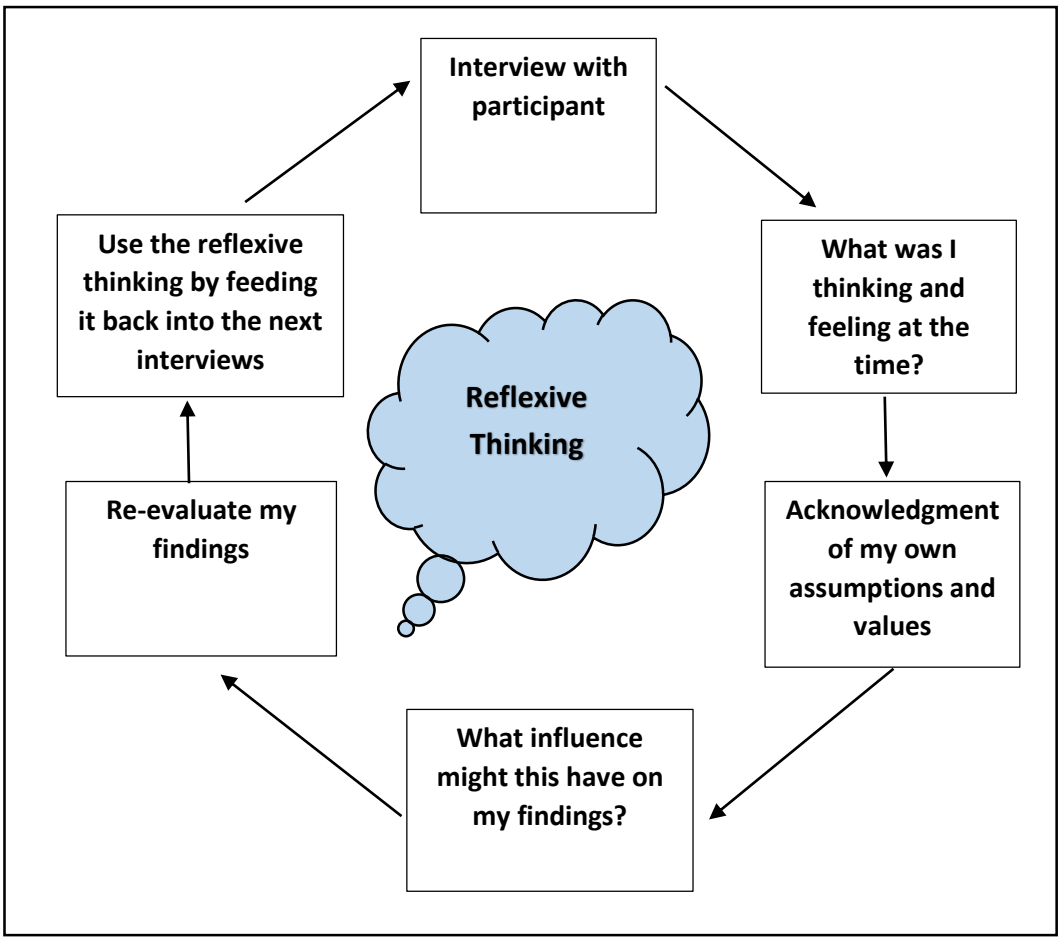


Figure 9.2: My reflexive thinking process for the interviews.

As part of the reflexive cycle as outline in figure 9.2 I acknowledged my own assumptions during the interviews. When a response in research is different to what the researcher might expect, the researcher should acknowledge these preconceived ideas and assumptions (Koch and Harrington, 1998). In order to help minimise my own assumptions impacting on the interviews I kept a brief diary of how I was feeling on the day of the research. This included how I felt on the days of implementing the staff wellbeing training, as well as the interview process. I made note of my feelings and emotional state before the training, during the lunch break and after each day of training. I also kept a note of this before and after each interview. When I came to write up my results in this

thesis I made reference to these diary notes in order to consider how my own feelings may have impacted on what I found in the results. In addition to this, I also contemplated how my experiences and beliefs could affect how I interpreted the results. For example, as this was an emotive topic of staff wellbeing I had to be aware that even though I believed burnout to be a problem in mental health staff and that I felt wellbeing training could be useful, that I did not reflect these opinions on the participants during the interviews. I also ensured that I did not only report views in the results that matched my own expectations. Instead being reflexive I made sure I was aware of my own beliefs and documented all opinions and beliefs, whether positive or negative, about the research topic and whether or not they matched my own beliefs.

Another practical technique that was used to be reflexive in this research, was practicing the semi-structured interview questions with a mental health worker, who was not part of this study. I video recorded myself in this interview and then both the individual being interviewed and myself made notes on my behaviour in the interview, including my body language, the tone of voice and my facial expressions. This was done so that we could discuss this and to increase my self-awareness of my interviewing technique. This was aimed to minimise how my reactions e.g. over-emphasising or enthusiasm, may have impacted on the participant's responses. By doing this I attempted to keep my interview behaviour neutral and minimise bias by not reacting in a particular way to participants.

I have acknowledged in this section my own preconceived ideas about the research and my reflexive thinking in order to minimise the risk of being misled by these ideas. As Malterud (2001) notes these preconceived ideas of a researcher are only detrimental and lead to bias if the researcher fails to acknowledge them.

9.10 Reliability and Validity

In this section the research is evaluated in terms of its validity and reliability. Reliability refers to the consistency of a measure, or whether if the study was

repeated the same results would be found (Bryman, 2001). Validity refers to how well research methods measure what it set out to and whether meaningful and accurate conclusions can be drawn from the research. It is concerned with trustworthiness and if the research is evaluating what it is supposed to be (Creswell and Plano Clark, 2007).

A pragmatic approach using mixed methods was used in this study to best explore the research aim. The outcome measures for mental toughness and burnout were selected based on their evidenced reliability and validity.

The MTQ48 is found to have an overall test-retest coefficient of 0.90, therefore suggesting excellent reliability of this scale. All subscales of the MTQ48 reached the minimum acceptable level (0.70) as recommended by Kline (1999) when investigating the reliability of the psychological constructs. This supports the homogeneity of each subscale and the MTQ48 as a whole. The MTQ48 has also demonstrated validity, the concurrent validity for the MTQ48 and its scales ranges from 0.25 to 0.42, which is generally accepted as a high or acceptable score, therefore indicating that it measures what it claims to measure (Strycharczyk and Clough, 2015). The measure is also normative; the tests results are compared to results for a relevant norm group which represents the general and larger population. This means that the measure can also be used for evaluation by measuring progress and the impact of interventions. It can also be used for research, such as assessing which interventions are most useful and with different people (Strycharczyk and Clough, 2015).

For the MBI-HSS, Maslach *et al*. (1996) reported internal consistency estimate of reliability of 0.90 for emotional exhaustion, 0.79 for depersonalisation and 0.71 for personal accomplishment. Therefore, the three dimensions on this outcome measure which propose to measure burnout produce similar scores (Maslach *et al*., 1996). Test-retest reliability of the MBI-HSS has reported a high degree of stability between the MBI-HSS scale scores and these do not vary markedly from a period of one month to a year (Leiter, 1990; Demerouti *et al*., 2009). Therefore, this stability is consistent with the MBI aim of measuring an enduring state.

Validity of the MBI-HSS has been demonstrated in research that confirm hypotheses about relationships between experienced burnout and job characteristics (Maslach and Pines, 1977; Alarcon, 2011). Convergent validity of the MBI-HSS has also been demonstrated by correlating the scale scores with observations of others e.g. observed by co-worker or spouse. Observers were able to predict the dimensions of the MBI-HSS based on the frequency of behaviours (Jackson and Maslach, 1982).

To help ensure reliability, Lincoln and Guba (1985) and Merriam (1998) recommend ensuring there is sufficient detail describing the rationale and design of the study and the participants involved. They also suggest collecting varied types of information through different sources to enhance reliability of the results. In addition, they suggest that there should be detail on how the data was collected, analysed and how different themes were derived. This detail can then help replicate the research and contribute to the reliability of the study. Burns (1999, p.20-21) note that with regards to external reliability 'could an independent researcher reproduce the study and obtain results similar to the original study?'. There are key aspects that are believed to increase external reliability and care has been taken to follow these in this study. Nunan (1999) suggest that it is important to clarify the status of the researcher. This refers to the social position of the researcher to the participants. The choice of participants should be described as fully as possible and this should be detailed. In addition, the different procedures of collecting the data need to be explicitly explained which has been done in this thesis.

My own values, beliefs and worldviews have been acknowledged throughout this thesis, this has been done to make clear the potential impact of my this on the research. By following all of the above guidance it has help to ensure reliability in this study.

9.11 Implications

This next section will outline the implications of this research. It starts by discussing the implications from the NGT and then goes on to discuss the implications of the staff wellbeing training intervention for practice and policy. Following on from that, recommendations and direction for future research are made.

9.11.1 Implications of the NGT

The NGT primarily aimed to find out what strategies and techniques mental health staff thought could be helpful to improve burnout and mental toughness. The findings of this study was used to help decide on the the staff wellbeing training to be used with the mental health staff. However, in addition to developing ideas for the training the study had other possible implications which will now be discussed.

9.11.2 Including staff in the development of training

An important factor throughout this process is that staff thought it was beneficial for them to be included in the decision making process of what should be included in the wellbeing training package for mental health staff. The importance of making the staff feel their opinions and ideas were valued and that the training would be relevant to them was apparent. According to Coates and Howe (2015) it is important to include mental health staff in developing and designing wellbeing initiatives. The staff reported and agreed that if they were more involved in developing training for themselves, that they would feel more committed and invested in the training. If training is seen as something that is compulsory or 'a means to an end' then staff expressed that they are not fully immersed in the training. Evidence shows that initiatives adapted to the needs and preferences of individual clinical services and staff are more effective (Coffey *et al*., 2004; McCray *et al*., 2008). It was clear that from being involved in the

NGT, that the staff were interested and enthusiastic about implementing wellbeing training and taking it forward.

9.11.3 Using the NGT to start discussions on wellbeing

The NGT proved to be a beneficial method for aiding the group discussions. It also had additional benefits that were not known prior to the implementation of the NGT. This included the benefits of starting a discussion with the staff about their own wellbeing and what they thought could help improve this. Simply allowing the staff space and time to have the opportunity to discuss wellbeing as a topic, was evidently important to the staff that attended. With staff finding that simply talking about the definitions of burnout and mental toughness, sparked enough interest to get them starting to think about their own wellbeing and how to improve this. Discussing wellbeing and a burnout prevention plan with colleagues can be a beneficial tool and is recommended in burnout prevention training (Salyers *et al*., 2011). Therefore, the NGT as a research tool provided a beneficial group for staff to think and talk about wellbeing, as well as being an effective tool for data collection.

9.12 Implications for practice

The study has implications for the practice of mental health workers. Although I am an occupational therapist by background, I acknowledge the implications for all mental health staff. Although this chapter has already discussed the application and feasibility of the training, this section further discusses implications for practice.

The study has revealed the importance of staff being involved in any training or intervention that may impact on their wellbeing. Where possible staff should be included in the decision making process of what could be including in the training (Coates and Howe, 2015). In addition, by allowing staff to be involved in this process this may benefit the staff, as it starts an open dialogue. It also promotes

an environment where they feel that their wellbeing is not only allowed to be talked about but actually encouraged. This can make mental health staff feel valued by the service or organisation in which they work.

All individuals working in mental health services should be given opportunities to focus on their wellbeing (NICE guidelines, 2015, p8). By allowing staff time away from the work environment, this in itself can have a positive effect on their feelings towards the organisation in which they work. This can allow time and space away from work to reflect on their job and how they feel. The environment for staff wellbeing training should be different to the normal setting in which they work. This allows staff to really immerse themselves in the training and not be distracted by their usual job role and daily work (Razzaque and Wood, 2016). This environment away from the usual work setting also provides an opportunity for team bonding and for staff to feel able to talk to their colleagues about other topics and not just their daily work (Posner *et al*., 2017).

It would be beneficial for normal practice in mental health services to allow staff the opportunity to understand more about their wellbeing, in particular with regards to their own mental toughness and burnout. By allowing staff to do this they can reflect on how they are feeling and how they might improve this. Staff should also be taught techniques that may help to focus on their perceived mental toughness and burnout. By providing mental health staff with a variety of techniques that may enhance their wellbeing, this provides staff with the correct tools they may need to take care of their own wellbeing.

This research also suggests that teaching mental toughness coaching strategies to mental health staff as part of their practice could be beneficial. The staff responded positively to the techniques been taught in the training and were enthusiastic and motivated to use these. By providing mental health staff with these tools it would provide an opportunity for staff to learn coping strategies to enhance their wellbeing. As well as providing them with tools and techniques that they can also use within their job role with service-users.

In addition, it would be beneficial in practice for mental health staff to have the opportunity to complete the MTQ48 and MBI-HSS. By doing so it would allow staff to reflect on their wellbeing, as well as develop a plan as to how they might improve their wellbeing. The MTQ48 used by staff in mental health services would allow them to be aware of their self-reported mental toughness scores. It would provide staff with information on their individual strengths and limitations, in terms of their mental toughness and how they might develop their overall mental toughness. By doing this at regular intervals it would also allow staff to monitor their mental toughness and it would highlight areas of need or areas of improvement (Strycharczyk and Clough, 2015). Recognising their mental toughness may benefit themselves as well as the service-users they are working with. It is important that if staff were to measure their mental toughness as standard practice in the workplace, that they were provided with a clear understanding of mental toughness. In particular, it would be essential that staff were aware that the opposite of mental toughness was not weakness but in fact mental sensitivity. In addition, the potential downsides for those with high mental toughness would also need to be made apparent such as the potential for individuals to take on too much, fail to see their own weaknesses or appear insensitive to others as they may show little emotion. This is particularly important to be made aware, as individuals who are mentally sensitive may be intimidated and be unable to relate to the mentally tough individual and even see their behaviour as insensitivity or bullying (Strycharczyk and Clough, 2015). Therefore, in practice, mental toughness needs to be fully described and understood by individuals and these potential downsides of being mentally tough can then be reduced by individuals being more self-aware.

Similarly, by providing mental health staff with the opportunity to complete the MBI-HSS, this would help staff to identify potential burnout. It would provide a tool for services and organisations to act upon these burnout scores with appropriate burnout reduction methods. Both the MTQ48 and MBI-HSS would allow mental health service managers to be more aware of their staff wellbeing levels and help them to act on this accordingly with positive measures.

This research has highlighted that the mental health staff were interested in receiving some sort of refresher or reminders of the wellbeing training. It was brought to attention that being reminded of some of the mental toughness coaching strategies, or being taught more of these techniques at a later date following the training would be beneficial. By doing this it would reiterate to the staff the importance of staff wellbeing and how to improve this. Providing regular opportunities to learn such techniques in practice, could be beneficial for staff working in mental health services, in order to regularly review their wellbeing and use techniques to develop this. In addition, providing such techniques through accessible staff wellbeing toolkits either in hardcopy format or available in an online format, would also provide staff with continuous opportunities to recap themselves on these wellbeing techniques.

9.13 Implications for policy

It is recommended from this study that policy makers should give a greater consideration to the wellbeing of staff that work in mental health services. In particular, policies should focus on training and interventions for mental health staff. They should allow staff time and opportunities to engage in these outside of their normal working environment. Policies should consider both one off wellbeing training, as well as continuous and ongoing wellbeing support for staff in the form of refresher training sessions. The study also supports current NICE guidelines that recommend that workplaces should 'create a supportive environment that enables employees to be proactive when and if possible to protect and enhance their own health and wellbeing' (NICE guidelines, 2015, p8). The study also supports the recommendations to do this by providing opportunities for staff to feel more in control of their work, feel valued and supported by their service and manager and promote positivity in the workplace.

It is recommended that the wellbeing of mental health staff is embedded into policies, so that is becomes a part of daily business within this setting, as oppose to been seen as simply 'an add on' to normal practice. Public Health England

(2018) have provided expert guidance in the police force, where burnout of staff is high and the wellbeing of the staff is also seen as a priority. In a similar way to the guidance and frameworks been developed in other settings such as the police, it is recommended that policy makers consider embedding the type of training and intervention carried out in this study as regular practice.

9.14 Recommendations and directions for future research

Some recommendations have already been made in this chapter with regards to improving on the limitations of the methods used in this study (section 9.8). This next section will put forward recommendations for future research to help improve the current knowledge base on this research topic.

Firstly, it is suggested that any research focused on staff wellbeing should involve the staff throughout the development of any intervention or training. This enables staff to feel more involved in the decision-making and the development of any training or interventions aimed at improving their wellbeing. This helps to ensure the staff feel that the research is meaningful to them and are more engaged in the process (Coates and Howe, 2015).

The findings from the NGT was of great value in deciding on a wellbeing training package for staff burnout and mental toughness. It is recommended that the NGT is a beneficial method to capture mental health staff views on what could improve their wellbeing. Further recommendations would be to carry out the NGT with the same question at different services. This could include asking the same question to staff from other mental health rehabilitation services, including those from other organisations. This could include services and organisations from areas outside of the North West, across the rest of United Kingdom. It could also include carrying out the NGT with services other than mental health rehabilitation, such as with staff in hospital settings, on acute wards and those working in the community. This would allow for comparison of ideas from different mental health settings and different organisations. It would be

interesting to discover if the opinions on strategies and techniques to improve burnout and mental toughness were universal or are specific to services or organisations. This would allow more generalizable wellbeing training packages to be developed. Alternatively, it may suggest that each service has different opinions and that it would be beneficial to always directly include the staff in the development of a wellbeing training package for each individual service.

It is also recommended that research implementing a similar staff wellbeing training across more services and organisations is carried out. This would enable the larger impact of the staff wellbeing training to be explored across more services and the whole organisation. As it was acknowledged in the interviews, that it was difficult for staff to try and use the training at services and with staff who had not attended the training, exploring if the training would have a different impact if more of the staff attended would be beneficial. Similarly, to the recommendations from the NGT, the training could be carried out across different services and organisations in areas outside of the North West, across the rest of the United Kingdom. In addition to this, implementing the training with mental health staff working in different areas to mental health rehabilitation, such as in hospital settings or the community, could be beneficial. This would allow for the experience of the training to be explored across different services and organisations and to see if this experience differs or is universal across mental health services. This would also help to develop more generalizable wellbeing training packages.

In addition to this, it is recommended for future research to explore the link between mental toughness and burnout levels in mental health staff. This study explored the patterns of mental toughness and burnout levels in mental health staff before and after the training and at a three month follow up. However, it is recommended that research explores if self-reported mental toughness and burnout are significantly related in mental health staff. This would allow for a clearer understanding of the link between mental toughness and burnout for this population group. This may provide a means of identifying individuals that are more likely to experience burnout and stress-related physical and psychological

illness. In addition, interventions that may enhance mental toughness could have beneficial effects within this population group.

Based on the limitations acknowledged in this study, having a different individual implementing the training and carrying out the interviews could be beneficial in future research. This could help minimise social-desirability bias and allow participants to feel that they don't have to respond in a particular way, just because the trainer is the person asking the interview questions.

Future research could also explore the wider impact of the training. This could include the impact of the mental health staff attending this training on the service-users which they work with. For example, this might include exploring how service-users rate their care from the staff before and after the training. It could also explore the wider impact of the staff attending the training on the colleagues who they work with. This might include if the colleagues of people who attended the training, observed any differences in mood and behaviour of these individuals. This might also include if strategies from the training were shared with them and the wider impact on the culture of the service, including if any changes were implemented following the training. This would allow different perspectives to be gained on the impact of the staff wellbeing training.

The wellbeing training could also be implemented in settings outside of mental health services. This could include all other health care related settings such as hospitals and GP surgery's which focus on physical health as well as mental health. It is also recommended that the training could be implemented with other population groups in similar highly demanding and pressurised jobs. This could include staff who work in any of the emergency services such as the police, fire service and ambulance services. In addition, discussions during the NGT of this research suggested that the wellbeing training could be implemented during professional training and academic courses. It was suggested that while studying at university to become a mental health professional, that training that would focus on mental toughness and burnout would be useful. This was based on the idea that the staff would have liked to have learned how to maintain their

wellbeing before starting work. They believed this could help reduce burnout when working in these settings. Therefore, it is suggested that future research could explore implementing wellbeing training with students on degree courses, where they are training to become professionals such as nurses, occupational therapists and art psychotherapists. This would enable wellbeing training to focus on prevention of burnout as well as ways of reducing burnout. It would also as add to additional knowledge regarding the mental toughness and wellbeing of students before embarking on a career in mental health.

This study had a three month follow up. However, it may useful for future research to carry out an additional follow up, at six months or twelve months. This would help explore the experience of mental health staff on wellbeing training focussing on their mental toughness and burnout more long term and add to the existing knowledge. In addition to this, future research could look at using other techniques in addition to a one off two-day wellbeing training. This could explore the use of additional wellbeing sessions following the training or access to the techniques taught after the training such as via an online or manual wellbeing toolkit for the staff. This would provide additional knowledge regarding ways of focussing on and potentially improving mental health staff wellbeing.

It is recommended that future research exploring a similar research area could use a behavioural change model to guide the understanding of behaviour change to aid in the intervention/training design. This could include the COM-B model that sets out that behaviour comes about from an interaction of capability (C) to perform the behaviour and opportunity (O) and motivation (M) to carry out the behaviour (B) (Michie *et al*., 2014). New behaviour or behaviour change requires a change in one or more of these. Behaviour change involves doing something new or differently (Michie *et al*., 2014). In the case of this thesis, this was pragmatically looking at new ways of focussing on mental health staff wellbeing. Individuals may lack knowledge and/or skills to change behaviour. Coming to a new understanding of problems, of what maintains problems and of self-help

approaches to dealing with problems, can help change behaviour (Michie *et al*., 2014).

In the case of this thesis, mental health staff ideas helped to identify what strategies and techniques they thought could help focus on their mental toughness and burnout. The results highlighted that motivation was a key factor for the staff engaging in the wellbeing training. Motivation was also highlighted as a key finding resulting from training, in terms of staff being motivated to make their wellbeing a priority. The results also identified that the staff must be physically and psychologically able to engage in the intervention and the mental toughness coaching strategies (Michie *et al*., 2014). Social and physical opportunity to engage in techniques that could focus on staff wellbeing was also important for the staff, which the two day training provided. Further opportunities staff had to engage with what was learned at the training, was also identified at the three month follow up, including using the techniques and developing their own behaviour to focus on their wellbeing at work and outside of work. If a desired behaviour is not occurring, in this case staff are not trying to focus on their wellbeing, then an analysis of the determinants of the behaviour will help to define what needs to shift in order for the desired behaviour to occur (Michie *et al*., 2014). Therefore, future research could use the COM-B model to develop and evaluate interventions focussed on mental health staff wellbeing.

9.15 Original contribution to knowledge

This research explored the experience of mental health staff in wellbeing training focussing on their mental toughness and burnout. No other published studies have explored the idea of teaching mental toughness coaching strategies as a way of focussing on the mental toughness and burnout of mental health staff. In addition, mental health staff were involved in the decision making process of what to include in the wellbeing training and provided unique insights into what

strategies and techniques they thought could improve their mental toughness and burnout. This original contribution to knowledge was also published as an article in the Journal of Mental Health, Training, Education and Practice (Posner *et al*., 2017).

This research is important as it has revealed new ways of focussing on the wellbeing of mental health staff. It is important that mental health staff wellbeing is taken seriously and that new interventions are developed to help staff to keep themselves well. Interventions that focus on an individual's perceived mental toughness and burnout could be hugely beneficial for staff wellbeing as well as having an impact on the care and interactions provided to service-users.

This PhD is novel as it has explored mental health staff wellbeing training needs. A training package which involved teaching staff mental toughness coaching strategies was implemented, which has not been done with mental health staff before.

CHAPTER 10

CONCLUSIONS

This final chapter will bring together the thesis and highlight the main conclusions that have been made. Previous research had a strong focus on teaching staff different ways of working with service-users as a way of improving staff wellbeing, rather than focussing on how the staff actually feel and how to improve this. Alongside this the suggestion that mental toughness and burnout could be linked (Gerber *et al*., 2015) opened up a gap in the current knowledge. Research that could explore mental health staff wellbeing in relation to this was embarked upon for this thesis.

With first-hand experience working in mental health, an identified gap in the current knowledge and a keen motivation to explore mental health staff wellbeing, I set out with the aim: *to explore the experience of mental health staff of participating in wellbeing training focussed on their mental toughness and burnout.*

Interesting results were initially found using a NGT. Staff who engaged in the NGT discussion displayed a clear interest in the topic area of improving staff wellbeing. They offered many ideas and engaged in open discussion on the strategies and techniques that they thought could help improve self-reported burnout and mental toughness in mental health staff. They also valued being engaged in the decision making process and development of the proposed training package. This part of the study showed that mental health staff wanted to improve the organisational culture towards mental health and their wellbeing and want to be educated about this topic.

The NGT and literature review identified that mental toughness coaching strategies could be used to improve the wellbeing of mental health staff. The training package consisted of teaching the staff a variety of mental toughness coaching strategies that had already been developed to improve mental

toughness in other areas such as sport and education (Strycharczyk and Clough, 2015).

The wellbeing training showed that staff working in a mental health setting were motivated and enthusiastic about being involved in training aimed at improving their own mental health.

The results highlighted that the practical side of the training (learning the techniques) was equally as important as having the time to talk and think about their wellbeing. Being mentally tough when working in mental health services was identified as beneficial and knowing how to be more mentally tough useful. A potential link between self-reported mental toughness and burnout was highlighted, however for any significance between these two concepts to be found further research is required.

Staff reported talking more openly and comfortably about their wellbeing at work and being more self-aware of their wellbeing at work following the training. In addition, other changes/implementations to the service following the training were made to better the wellbeing of the staff. The benefits of this training using these techniques were identified for staff wellbeing at work and at home, as well as having additional benefits for the service-users they work with. Some difficulty remembering everything from the training was identified as a limitation. However, having regular refresher or reminders of this was identified as a recommendation to maximise mental health staff engagement.

Overall, it is important that mental health staff wellbeing is taken seriously and that new interventions are developed to help staff to keep themselves well. Using mental toughness coaching strategies could be one way of doing this. Interventions that focus on individual's mental toughness and burnout could be hugely beneficial for staff wellbeing, as well as having an impact on the care and interactions provided to service-users.

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APPENDIX 1-TABLE OF INTERVENTION STUDIES TO IMPROVE BURNOUT IN MENTAL HEALTH STAFF

Table 1
Intervention studies to improve burnout in mental health staff

Study	Population	Setting	Intervention	Condition	Outcome	Design
Corrigan et al., (1997)	35 direct care and clinical staff	Psychiatric Residential Program	interactive staff training program. carried out each month for 90 minutes for 8 months, staff identified rehabilitation program needs, as well as deciding on behavioural rehabilitation strategies to assist with these needs.	Interactive staff training group only, no control group	improvements found in emotional exhaustion element of burnout. Significant improved attitudes about behavioural interventions, less barriers to implementation and colleagues as more supportive.	Pre-post
Carson et al., (1999)	53 mental health nurses (UK)	Psychiatric inpatient ward	Social support group vs feedback-only on stress level plus stress management handout. Duration was 2 hours over 5 weeks	Social support group vs feedback only	No significant change in dimensions of burnout. Control group improved at post-test. No significant change at 6 months. 36% attrition at 6 months	RCT
Carson et al., (2001)	141 mental health staff	Various locations throughout England, 4 in NHS trusts, 3 social services departments, 1 voluntary sector provider, 1 private sector and one was an open course	self-esteem workshops that involved 10 modules delivered over a three day period.	Self-esteem workshop vs waiting list control group	Burnout reduced after participating in self-esteem workshop. Reduction in depersonalisation and emotional exhaustion and improvements in personal accomplishment. Biggest changes in staff self-esteem rather than burnout. Control group (waiting list) burnout scores were slightly worse	RCT

Table 1
Intervention studies to improve burnout in mental health staff

Ewers et al., (2002)	20 mental health nurses	Medium secure psychiatric unit in North West of England	Psychosocial intervention training for 20 days over 6 months. Each day a different topic e.g. interventions for anxiety, depression, auditory hallucinations and delusions. Aimed to change staff attitudes and move away from purely medical model.	PSI training vs waiting list control group	staff knowledge about mental health had increased, attitudes towards service-users had improved and burnout rates had improved in all measured burnout subscales	RCT
Doyle et al., (2007)	14 mental health staff in experimental group and 12 in control group	Medium secure psychiatric unit in North West of England	16 three-hour Psychosocial Intervention study sessions.	PSI training vs control group	Significant increase in knowledge score in post-test results and increase in attitude score. Increase in the personal accomplishment element of burnout using the MBI.	RCT
Walsh (2009)	9 nurses in the first stage of the study and 2 in the final stage	London prisons	Clinical supervision as a means of developing awareness of emotional labour in prison nursing.	Clinical supervision, no control	Evidence of the benefits of developing emotional intelligence and reflective learning.	Qualitative (semi-structured interviews and analysis of clinical supervision sessions.)

Table 1
Intervention studies to improve burnout in mental health staff

Walsh et al., (2009)	70 nurses	Prisons in England and Wales	Three phases of clinical supervision over a seven-year period.	Clinical supervision, no control	Actual changes in practice such as greater use of action learning and greater awareness of the purposes and benefits of reflective practice via clinical supervision. Clinical supervision helped nurses manage their emotions.	Action research followed by documentary analysis of a mixture of qualitative data sources.
Redhead et al., (2011)	42 staff (21 qualified and 21 unqualified)	NHS low secure unit in North west of England	The training programme for qualified staff consisted of 16 half-day sessions delivered over 8 months. The content covered a broad range of PSI including cognitive behavioural approaches for managing symptoms. The training for unqualified staff was delivered in 8 half-day sessions and focussed on understanding symptom related behaviours, relationship formation and helping services users to cope with symptoms. Teaching sessions were supplemented by small group supervision.	PSI training vs waiting list control group	Evidence of an increase in knowledge and a decrease in the depersonalisation element of burnout using the MBI.	RCT

Table 1
Intervention studies to improve burnout in mental health staff

Salyers et al., (2011)	84 mental health staff	Community mental health	Day workshop to improve awareness and skills. Education on the principles of burnout prevention, experimental exercises and skill building (mindfulness, meditation)	Mindfulness training and burnout prevention training only, no control group	Depersonalisation reduced, no significant change in personal accomplishment Improvements in optimism regarding service-users	Quasi-experiment, 2 pre-test, post-test (6 weeks)
Razzaque et al. (2016)	22 consultant psychiatrists, 2 middle grade doctors and 2 trainees	Psychiatrists from multiple settings volunteered, recruited via British Journal of Psychiatry	2-day mindfulness retreat, part silent and involved a range of mindfulness exercises, including meditation and mindful walking. Teaching was provided around establishing one's own regular practice, as well as how to teach patients to do the same	Mindfulness training only, no control group	significantly increased perceived mindfulness and therapeutic alliance and significantly reduced burnout	Pre-test, post-test and follow up (1 week)

APPENDIX 2-LETTER OF ETHICAL APPROVAL FOR THE NGT

uclan
University of Central Lancashire

26th September 2016

Jessica Janssen/Zoe Cartwright
School of Health Sciences
University of Central Lancashire

Dear Jessica/Zoe,

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 535

The STEMH ethics committee has granted approval of your proposal application 'Understanding mental health staff views on improving burnout and mental toughness'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer.

It is your responsibility to ensure that:

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely,

Ambreen Chohan
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

APPENDIX 3-INFORMED CONSENT FORM FOR THE NGT

Date: August 2016
Version number: 1

University of Central Lancashire

Informed consent form

Understanding mental health staff views on improving burnout and mental toughness

Researcher: Zoe Cartwright (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

After reading the participant information sheet please tick if you have read and understood the following and sign to give consent to participate in this study:

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

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I am aware that all information is anonymous and will be kept confidential throughout ☐

4. I give consent to take part in the group discussion ☐

5. I give consent to be audio recorded during the group discussion ☐

6. I understand that all data will be stored securely in line with the UCLan code of conduct for research and UCLan Data protection policy. ☐

7. I understand that reports from this study will not contain any identifiable personal information. Direct quotes may be used but will not be attributable to any participant. ☐

8. I agree to anonymised data being utilised within reports, publications and or presentations. ☐

9. If you would like to receive feedback on the findings from the group discussion please tick here and provide a correspondence address or email address that you would like these sent too. ☐

Correspondence Address:

_____
_____
_____
_____

Email Address:

_____

I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	**Date**	**Signature of participant**

_____	_____	_____
Name (Person taking consent)	**Date**	**Signature (person taking consent)**

When completed 1 copy for participant and 1 copy for researcher

APPENDIX 4-LETTER OF INVITATION FOR THE NGT

Date: August 2016
Version number: 1

University of Central Lancashire

Letter of Invitation

Understanding mental health staff views on improving burnout and mental toughness

Researcher: Zoe Cartwright (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

As you are a member of staff who has worked for a mental health service for 3 months or more, I am writing to invite you to take part in my study. I am a PhD student at the University of Central Lancashire carrying out research titled *'Developing a training programme to improve mental health staff burnout and mental toughness'*. The research will be carried out in 2 phases. Phase 1 (titled above on this letter) will involve a group discussion about mental health staff views on what should be included in a staff training package to improve on burnout and mental toughness. Phase 2 will be the development and pilot of the training package to mental health staff.

You are in the first instance been invited to phase 1- ***the group discussion***.

The group will give you the opportunity to meet and chat to your colleagues about burnout and mental toughness, which you may find beneficial as they may have similar experiences or opinions as your own. You will also be involved in the process of expressing what you think should be involved in a training programme to help with burnout and mental toughness, which may provide future benefits for many mental health staff, including yourself.

Before you decide whether to take part in the study I would like you to understand why the research is being done and what it would involve for you, therefore please take the time to read the participant information sheet and consent form.

It is completely up to you whether you choose to take part or not, it will not affect any future relations with the University of Central Lancashire or your current job role.

The group discussion is expected to take place in ***October 2016***. The dates and times will be confirmed with you nearer the time. The group will take place in a meeting room at your workplace or at your organisations head office**.**

If you have any questions or would like to take part please contact me the researcher at ZCartwright@uclan.ac.uk

Yours Sincerely
Zoe Cartwright
PhD Student
University of Central Lancashire

APPENDIX 5-INFORMATION SHEET FOR THE NGT

Date: August 2016
Version number: 1

University of Central Lancashire

Information Sheet

Understanding mental health staff views on improving burnout and mental toughness

Researcher: Zoe Cartwright (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Why I am being asked to take part?
You have been invited to take part as you are a member of staff that works in a mental health service and has done so for 3 months or more. The study aims to include a variety of individuals and professionals who work in mental health. In order to develop a training package to improve burnout and mental toughness, we would very much value your views.

Why is the study taking place?
The aim of this group is to explore mental health staff views on burnout and mental toughness and what should be included in a staff training package to improve self reported mental toughness and burnout rates. The information gathered will be used to develop and pilot a training package for my PhD study tilted 'Developing a training programme for improving mental health staff burnout and mental toughness.'

Staff burnout is increasingly identified as a problem in the mental health field (Morse et al. 2012). With burnout rates in staff being linked to an increase in staff stress levels then the development of new interventions to address this critical area is needed (Morse et al. 2012).

What is involved in the study?
You have been invited to take part in a group discussion to understand mental health staff views on burnout and mental toughness and what could help to develop these areas. A Nominal Group Technique (NGT) will be used to aid this discussion. A NGT is a structured variation of a small-group discussion to reach consensus. NGT gathers information by asking individuals to respond to questions posed by a moderator, and then asking participants to prioritize the ideas or suggestions of all group members. This group will consist of a maximum of 10 participants. There will be an assistant present during the group discussion, to record your views but they will not contribute to the discussion.

If you decide to participate in this group, I will organise a time and place for the group to take place at your workplace. The group discussion will take approximately 2 hours to complete. The discussion will be audio recorded and used for my PhD research.

How much time will it take?
The group discussion will take about 2 hours.

When and where is the research taking place?
The group discussion is expected to take place in October 2016. The group will take place in a meeting room at your workplace or your organisations head office.

What do I do next?
You have received a letter of invitation, participant information sheet and consent form. If you are interested in taking part please email ZCartwright@uclan.ac.uk to let me know.

What will happen to the information?
All data collected will be kept confidential and anonymous and used for research purposes only. All data will be stored on a password protected computer. Your name or any identifying characteristics will not be available to anyone, at any point. The information will become part of a research thesis and may be presented at conferences and in research journal papers. During the group discussion, all participants will be asked to agree to maintain the confidentiality of any information provided by others during the discussion. The group will be audio recorded, after it has been transcribed, the recording will be destroyed in accordance with the University of Central Lancashire guidelines. Direct quotes will be used but they will be anonymised so that you cannot be identified.

What if I am interested in the study results?
If you would like to receive written feedback on the results of this study, please tick that you would like this on the consent form and provide a correspondence address or email address in the space provided on the consent form.

Do I have to take part?
No, it is up to you to decide whether to take part or not, it will not affect your future relations with the University of Central Lancashire or your current job role if you do not take part. Please take time to read all the information provided and feel free to ask questions regarding the study. Participation in this group is completely voluntary, and you are under no obligation to take part. You are free to withdraw at any point, without question.

What will happen if I don't want to continue with study?
You can decide not to take part at any stage, even if you have signed the consent form. You don't have to tell us why you have changed your mind. Your decision to withdraw will not affect you current job role in any way. If you change your mind after the group discussion, we will continue to use information that is anonymous and cannot be traced back to you.

What are the potential risks and benefits of taking part?
Possible risks: We understand that due to the nature of the discussion topic, sensitive issues may be discussed and that the opinions of some participants may differ to others of the group. All information that is shared during the group will be treated as personal and sensitive and it is vital that all group members respect this and their confidentiality. I will

try my best to make all participants as comfortable as possible in terms of discussion and all participants will be encouraged to talk to the researcher if they are worried or have concerns. In the unlikely event that an individual displays signs of emotional distress during any point of the project, data collection will be stopped. The participant will also be advised to seek local sources of support e.g. their line manager or GP.

Possible benefits: The findings from the group discussion will help to develop a training package aimed at improving burnout and mental toughness in mental health staff. The group will give participants the opportunity to meet and chat to their colleagues about the topic area, who may possibly have similar experiences or opinions.

Who is doing the research?

The research is being carried out by myself (Zoe Cartwright) a PhD Student at the University of Central Lancashire.
If you have any questions you may contact me the researcher at ZCartwright@uclan.ac.uk
Or my supervisors Jessica Janssen via
Tel: 01772 89 4560 or Email: JJanssen@uclan.ac.uk
And Hazel Roddam via
Tel: 01772 89 5484 or E-mail: HRoddam@uclan.a.c.uk

Thank you for taking the time to read this information sheet

APPENDIX 6-DATA PROTECTION CHECKLIST FOR THE NGT

University of Central Lancashire

Data protection checklist: Teaching, research, knowledge transfer, consultancy and related activities

All activities which involve personal data of any kind, in any way, must comply with the Data Protection Act 1998 (DPA). This checklist outlines the requirements of the DPA and the measures you must take when processing personal data; it also provides a mechanism for recording the steps you will take to ensure the personal data you are using are safeguarded and the reputation of the University is upheld.

Ensuring personal data are processed fairly and lawfully with due regard for individuals' privacy and ensuring that personal data remain secure are paramount. Demonstrating that we have considered the requirements of the DPA when conducting our activities will provide assurances to students, employees and business partners that their personal data is protected at UCLan. Organisations can be fined up to £500,000 for breaches of the DPA which are considered to be as a result of negligence or recklessness; therefore it is important that we get it right from the outset. If it is possible to use anonymised data so that individuals cannot be identified from it and still achieve your aims, this is always the preferred method of operating. Truly anonymised data (which cannot be reconstructed or linked to any other data you hold or may hold in the future to enable you to identify individuals from it) does not constitute personal data because it cannot be used to identify individuals.

What is *personal data*?

Personal data are data relating to a living individual who can be identified from those data (or from those data and other information in our possession or likely to come into our possession). Personal data can be factual (such as name, address, date of birth) or can be an opinion (such as a professional opinion as to the causes of an individual's behavioural problems). Information can be personal data even if it does not include a person's name or other obvious identifiers; for example, a paragraph describing a specific event involving an individual or a set of characteristics relating to a particular individual may not include their name, but would clearly identify them from the set of circumstances or characteristics being described or represented. If you are unsure whether or not your activity involves personal data, please contact the Information Governance Officer to discuss on DPFOIA@uclan.ac.uk.

What is *processing*?

The DPA is concerned with the processing of personal data. Processing means obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data, including –

(a) organisation, adaptation or alteration of the information or data,
(b) retrieval, consultation or use of the information or data,
(c) disclosure of the information or data by transmission, dissemination or otherwise making available, or
(d) alignment, combination, blocking, erasure or destruction of the information or data.

If your proposed activity involves processing personal data, you must complete the following checklist. If you are unable to answer *Yes* to each applicable question, you must contact the Information Governance Officer for advice before proceeding. If you require any further information or guidance to enable you to answer *Yes* to each question, please contact the Information Governance Officer: DPFOIA@uclan.ac.uk.

Type of activity:	**Nominal Group Technique-Group Discussion**
Activity name/title:	**Understanding mental health staff views on improving burnout and mental toughness**

Processing personal data fairly
The DPA requires us to process personal data fairly and lawfully. In practice, it means that you must: • have legitimate grounds for collecting and using the personal data; • not use the data in ways that have unjustified adverse effects on the individuals concerned; • be transparent about how you intend to use the data, and give individuals appropriate *privacy notices* when collecting their personal data; • handle people's personal data only in ways they would reasonably expect; and • make sure you do not do anything unlawful with the data.

Have you checked and confirmed that the intended uses of personal data in your activity have a legal basis?	Yes
If your activity involves *sensitive personal data*, have you checked and confirmed that you can satisfy a condition for processing this kind of personal data from the DPA? Sensitive personal data includes data about racial or ethnic origin; political opinions; religious or similar beliefs; trade union membership; physical or mental health or condition; sexual life; commission or alleged commission of any offences; or any proceedings for any offence committed or alleged to have been committed.	Not applicable
If the intended use of the personal data would or would be likely to have an adverse effect on one or more individuals, have you considered and documented why that adverse effect is justified?	Not applicable
Have you documented why you are collecting the specific items of information to demonstrate that you have legitimate grounds for doing so e.g. if you are carrying out research into how students' music preferences affect their degree classification and also collecting participants' shoe sizes, can you show you have a legitimate need for this information?	Yes
Have you written an appropriate privacy notice to provide to individuals at the point you collect their personal data? A privacy notice tells individuals how we will use their personal data once we have it. It should contain your or your organisation's identity, as appropriate; the purpose or purposes for which you intend to process the information; and any extra information you need to give individuals in the circumstances to enable you to process the information fairly, such as whether or not the information will be disclosed to a third party. If you need assistance drafting a privacy notice, the Information Commissioner's Office (ICO) has produced a Privacy Notices Code of Practice.	Yes

Consent
One of the conditions from the DPA which you can satisfy to enable you to process personal data is '[consent]'. Consent is defined by the European Data Protection Directive as '*...any freely given specific and informed indication of his wishes by which the data subject signifies his agreement to personal data relating to him being processed.*' The ICO maintains that the fact that an individual must 'signify' their agreement means that there must be some active communication between the parties. An individual may 'signify' agreement other than in writing, but organisations should not infer consent if an individual does not respond to a communication e.g. from a customer's failure to return a form or respond to a leaflet. Consent must also be appropriate to the age and capacity of the individual and to the particular circumstances of the case. For example, if you intend to continue to hold or use personal data after your relationship with the individual ends, then the consent should cover this. Even when consent has been given, it will not necessarily last forever. Although in most cases consent will last for as long as the processing to which it relates continues, you should recognise that the individual may withdraw consent, depending on the nature of the consent given and the circumstances in which you are collecting or using the information. Withdrawing consent does not affect the validity of anything already done on the understanding that consent had been given. You must realise that consent must be *informed* and be freely given; this means it can be withdrawn at any time and you must have a process in place to manage this. If you are doing something which you are required to do by law and the individual has no choice about it, do not ask for their consent; this is misleading because you must do it by law anyway, whether or not they consent to it. Consent can either be explicit or implied: • *Explicit consent* is where an individual actively opts in to an activity e.g. Tick this box and sign here if you consent to us using your information in this way, then return this form. • *Implied consent* is where you tell an individual what will happen to their information unless they tell you they object e.g. Please sign and return this form. We will use your information for the additional purposes outlined in our privacy notice unless you tell us not to by ticking this box. **If you are processing *sensitive personal data* and relying on consent as your basis for doing so, you must obtain explicit informed consent from individuals.**

If you are planning to obtain consent from individuals before using their personal data, have you checked and confirmed that consent is necessary and is the most appropriate basis for your processing?	Yes
If you are processing sensitive personal data, have you planned to obtain individuals' explicit consent?	Yes
If you are relying on individuals' consent as a basis for using their personal data, have you developed a process for managing the withdrawal of consent?	Yes
If you are obtaining consent, you must ensure that the individual understands their rights and is capable of giving consent; this is assessed on a case-by-case basis. If you are processing personal data about younger individuals or those with reduced capacity, have you put a process in place to obtain consent from parents, guardians or legal representatives, if appropriate?	Not applicable

Security
Ensuring personal data are secure at all times is extremely important. Organisations can now be fined up to £500,000 for breaches of security involving personal data where those breaches are considered to have been due to negligence, recklessness or as a result of an issue which should reasonably have been foreseen. The DPA requires us to ensure that *appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data*. It is important that any personal data you collect or use during your activities remains secure until it is destroyed, which includes ensuring that only those who are authorised to access and use the data can do so. **For further guidance on information security, please see the Information Governance pages of the UCLan intranet and the LIS IT Security Policy, also on the intranet.**

If you are intending to publish information which could identify individuals, have you made those individuals aware that this will happen via your privacy notice and obtained their consent, if appropriate?	Not applicable
Will papers, files, audio visual recordings, CDs, USB (memory) sticks, microfiche or other media which contain personal data be kept in locked cabinets, cupboards, drawers etc. when the offices are vacated?	Yes
Do all individuals who will have access to or be using the personal data understand that it must not be provided to any unauthorised person (which includes disclosing information to family members or other representatives of data subjects, unless the data subject has given consent for us to do this)?	Yes
Do all individuals who will have access to or be using the personal data understand their responsibilities under the DPA and have they received data protection training? An e-learning course is available to staff – see the Information Governance intranet pages for information about enrolling.	Yes
Do you have appropriate procedures in place to ensure the security of the personal data if it is removed from UCLan offices for any reason? Electronic data must only be removed if it is stored on encrypted devices or media e.g. an encrypted disc or USB stick, an encrypted laptop etc. Alternatively it can be accessed remotely via a secure connection. If an unencrypted device containing personal data is lost or stolen, it is likely to lead to a substantial fine for a breach of the DPA. Non-electronic records must be rigorously safeguarded at all times and not left unattended or in view of unauthorised people. Laptops, USB sticks and other devices, papers or any other form of personal data must not be left in cars.	Yes
Will the personal data be stored on the UCLan network in a secure location with restricted access, to prevent unauthorised parties who have no right or need accessing the data?	Yes
Are all individuals who will have access to or use the personal data aware that personal information should not be stored off the UCLan network and should only be stored on equipment owned or leased by UCLan, unless exceptional circumstances apply? Storage under such exceptional circumstances must include the use of appropriate security measures. No personal information should be stored on any removable media e.g. USB sticks, CDs or devices e.g. laptops, smartphones unless they are encrypted.	Yes
Are all individuals who will have access to or use the personal data aware that any	Yes

information accessed via remote working methods such as Outlook Web Access, UCLan Global or similar must be treated securely in line with relevant legislation and all University guidelines? UCLan business information, including personal data, should not be stored on personal, non-UCLan equipment or devices unless exceptional circumstances apply.	
Are all individuals who will have access to or use the personal data aware that email is not a secure method of communication and can easily be sent to the wrong recipient and do they know how to encrypt documents so that they can be attached to an email and sent securely? N.B. Encryption passwords must be provided separately and never included in the same email as the encrypted attachment. Guidance is available on the Information Governance intranet pages.	Yes
Are all individuals who will have access to or use the personal data aware that all non-electronic material which contains personal data and has been authorised for disposal must be disposed of via the University's confidential waste service (including handwritten notes, computer print-outs etc.)?	Yes
Are all individuals who will have access to or use the personal data aware that any paper documents, electronic media or hardware which has been designated for disposal must be kept in a secure location until it has been appropriately destroyed and any information it contains is no longer accessible or recoverable? Electronic media and hardware should be disposed of in line with LIS guidelines and procedures.	Yes
Can you confirm that if personal data will be transferred overseas (outside the EEA), you have taken advice from the Information Governance Officer to ensure the transfer can legally take place? This includes via email and by virtue of using 'cloud' providers which store your data on their servers based overseas.	Not applicable

Third parties acting on behalf of UCLan

Under some circumstances, it will be necessary or desirable to work with organisations external to UCLan, such as charities, research organisations, private companies, other public sector organisations, contractors, service providers or any other types of third parties. If a third party is acting on our behalf e.g. providing a service for us or on our behalf and that activity involves the third party accessing, collecting or otherwise processing personal data, they are a *data processor* under the DPA. A well-recognised example of a data processor relationship is a UK bank using an overseas company to provide its call centre. The overseas company has access to the UK bank's customer information in order to provide the call centre service, but it can only use that data for the purposes of providing the call centre service because this is the service they are providing under contract on behalf of the UK bank.

The DPA contains specific requirements we must adhere to when we use a data processor:

- we must choose a data processor which provides sufficient guarantees about its security measures to protect the personal data it will process for us;
- we must take reasonable steps to check that those security measures are being put into practice; and
- there must be a written contract setting out what the data processor is allowed to do with the personal data. The contract must also require the data processor to take the same security measures we would have to take if we were processing the data ourselves.

Further information about using data processors is available on the Information Governance

intranet pages or from the Information Governance Officer.

If you are using a data processor or you need help deciding if the proposed arrangement does involve a data processor, have you taken advice from the Information Governance Officer?	Not applicable
If you are using a data processor, have you taken advice on information security from the Information Governance Officer and the Information Security Officer?	Not applicable
If you are using a data processor, have you taken advice from the Contracts Team in Legal Services or from Purchasing (as appropriate) to ensure you have sufficient contractual arrangements in place to cover the use of a data processor?	Not applicable
If you are using a data processor, can you confirm that a contract will be signed by all parties which meets all the requirements of the DPA as set out above?	Not applicable
Can you confirm that we have been provided with sufficient guarantees about the security measures the data processor has in place and that you have a process in place to confirm that these are being followed?	Not applicable

Once this form has been completed, it should be attached to your ethics checklist and submitted as directed. If your activity does not require further ethical approval, this form should be retained with your project documentation as a record of your considerations and data protection compliance. If you require any further advice or guidance to help you complete this checklist, please contact the Information Governance Officer: DPFOIA@uclan.ac.uk. Members of staff can also find a variety of guidance documents and FAQs on the Information Governance intranet pages.

APPENDIX 7-TRAVEL/FIELDWORK RISK ASSESSMENT FOR THE NGT

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RISK ASSESSMENT FORM

Risk Assessment For	Assessment Undertaken By	Assessment Reviewed
Service / School: [redacted]	Name: Zoe Cartwright	Name: Peter Hill – SHE Section
Location of Activity: UK Only	Date: 05/08/16	Date: 10/08/2016
Activity: Generic staff travel within the UK by car, train, coach etc for lower risk activities such as conferences, exam boards, visiting students on placement, etc. This risk assessment must be read in association with FM SHE 042 Procedural Guidance for the Management of Health & Safety During UK Travel	Signed by Dean of School / Director of Service or equivalent: Mr Zoe Cartwright	*This section to be used when the assessment is reviewed in academic year*
REF:	Date: 12th August 2016	

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Private Car *Vehicle accident*	Staff	Trip not to commence if staff have concerns about vehicle safety;		Low-Med

		Any safety equipment provided by staff at premise must be used as directed Attendees to familiarise themselves with the location of fire escape routes particularly in overnight accommodation; University accident reporting procedures.	the trip begun, must be assessed prior to them starting.	
Personal safety (general) *Physical and/or verbal assault, leisure time activities*	Staff	Research area to be visited if unfamiliar including areas/locations you should avoid., identify safest travel form, routes, location of stations, car parks, etc.; Carry a mobile phone to raise the alarm if necessary; Carry a personal alarm (available from Harrington Security Lodge).	**Out of Hours:** Security (24-hour security lodge) holds a cascade list of senior staff within the University: 01772 892068.	Low
Slips trips and falls	Staff	Wear footwear suitable for the conditions; Particular care should be used when crossing unfamiliar / dimly lit areas, car parks, etc.		Low
Environmental conditions (weather)	Staff	Consult daily weather forecast for the area before setting out; Wear clothing suitable for the expected weather conditions, be prepared for sudden changes		Low
Additional specific issues related to planned travel or proposed work activity				

APPENDIX 8-POSTER ADVERT FOR NGT

Date: August 2016
Version number: 1

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You are invited to come along to a group discussion study on:

Understanding mental health staff views on improving burnout and mental toughness

Date: ……October 2016

Time: 2.00pm

Location: Meeting room at……

Please contact Zoe Cartwright (PhD student) for more information or to register your interest via email at ZCartwright@uclan.ac.uk

APPENDIX 9-FOLLOW UP LETTER OF INVITATION FOR NGT

Date: August 2016
Version number: 1

University of Central Lancashire

Follow up Letter

Understanding mental health staff views on improving burnout and mental toughness.

Researcher: Zoe Cartwright (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

Hopefully you will have recently received information regarding the above study inviting you to take part.

I am writing again to remind you of this invitation as we have not heard back from you regarding whether you would like to participate. I have enclosed the information again for your convenience.
I would like to remind you that it is completely up to you whether you take part or not. It will not affect any future relations with the University of Central Lancashire or your current job role.

If you would like to take part please email me at ZCartwright@uclan.ac.uk

If you would like to discuss this further you can contact either myself on the above email or alternatively my supervisors Jessica Janssen via
Tel: 01772 89 4560 or Email: JJanssen@uclan.ac.uk
And Hazel Roddam via
Tel: 01772 89 5484 or E-mail: HRoddam@uclan.a.c.uk

Thank you for your time,

Yours Sincerely

Zoe Cartwright
PhD Student
University of Central Lancashire

APPENDIX 10-ARTICLE PUBLISHED IN THE JOURNAL OF MENTAL HEALTH TRAINING, EDUCATION AND PRACTICE

Mental health staff views on improving burnout and mental toughness

Zoe Posner, Jessie Janssen and Hazel Roddam

Abstract

Purpose – *Burnout in mental health staff is acknowledged as a major problem. The purpose of this paper is to gain an understanding of mental health staff views on improving burnout and mental toughness in mental health staff.*

Design/methodology/approach – *Ten participants from two mental health rehabilitation units across the north-west of England took part in a Nominal Group Technique. Participants consisted of mental health workers from varied roles in order to capture views from a multidisciplinary team. The main question posed to the staff was "What strategies and techniques do you think could help improve burnout and mental toughness in mental health staff".*

Findings – *The study revealed that the top three ideas to take forward to help improve burnout and mental toughness in mental health staff were improving the culture/organisation, improving staff wellbeing and education. Additionally, staff were highly motivated and enthusiastic about engaging in discussion about what could be done to improve their wellbeing and the importance of taking this forward.*

Originality/value – *This study is unique in involving mental health staff in discussing their ways of improving their mental health. It is also unique as it has found the nine strategies to do this and these could be used in targeted training for mental health staff.*

Keywords *Mental health, Training, Burnout, Intellectual disability, Mental toughness, Staff wellbeing*

Paper type *Research paper*

Zoe Posner and Jessie Janssen are both based at the School of Health Sciences, University of Central Lancashire, Preston, UK.

Hazel Roddam is a Reader in Allied Health Practice at the School of Health Sciences, University of Central Lancashire, Preston, UK.

Introduction

Mental health services have recently seen an increase in demand for their services (Lasalvia *et al.*, 2009). High-volume work demands and targets in these services make it a pressurised environment to work in (Dowthwaite, 2016). Working in mental health is complex, there are pathways for different stages of the individual's condition and there is a wide range of mental health conditions and different roles within the mental health services (National Health service, 2016).

Mental health staff face challenges working in these settings, partly due to the complex nature of the conditions they are working with, including at times challenging behaviour from service-users, which can be stressful for the staff (Jenkins and Elliott, 2004). In addition, they also face organisational pressures such as low staffing levels, long shifts and more demands, with low levels of support (Lasalvia *et al.*, 2009). A combination of these factors can be linked to mental health staff experiencing burnout (Lasalvia *et al.*, 2009).

Burnout in mental health staff

Burnout in mental health staff is acknowledged as a major problem, with as much as 67 per cent of mental health workers experiencing high levels of burnout (Morse *et al.*, 2012). Staff working in mental health and intellectual disability services are particularly vulnerable to burnout due to factors such as low staffing levels, client pressures and lack of support (Jenkins and Elliott, 2004). The definition of burnout has been described in different ways (Cherniss, 1980; Burke and Richardsen, 1993). However, the most favoured and accepted definition is

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one that has multiple dimensions of emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach *et al.*, 1996). A reduced sense of personal accomplishment refers to a negative self-evaluation of work and how well an individual feels they are fulfilling their job role. Emotional exhaustion refers to feeling depleted and fatigued. Depersonalisation includes negative attitudes towards work and clients. Burnout has shown to have a negative impact on the wellbeing of staff (Toppinen-Tanner *et al.*, 2005). Burnout can also undermine the quality of services provided between staff and service-users (Carney *et al.*, 1993). It may also lead to staff being less able to be empathetic, collaborative and attentive to service-users (Corrigan, 1990). Staff with burnout have been linked to having negative attitudes towards service-users, in terms of being distant and rejecting towards them, which in turn has been linked to poorer outcomes in service-users with severe mental health (Holmqvist and Jeanneau, 2006). Therefore, the ways of improving levels of burnout in mental health staff is vitally important.

Mental toughness

Mental toughness describes the capacity of an individual to deal effectively with stressors, pressures and challenges, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough *et al.*, 2002). It is suggested that those who can use energy positively during times of crises and pressure and during challenging and demanding situations are able to have positive attitudes and this reflects high mental toughness (Loehr, 1982). Strycharczyk and Clough (2015) have found that mental toughness can be taught and enhanced to individuals from a wide variety of backgrounds. They created the 4Cs model, which suggests that overall mental toughness is a product of four key factors. This includes seeing challenge as an opportunity, having high levels of self-belief and confidence, being committed to and being able to stick to tasks and believing that you control your own destiny. They have found that mental toughness can be developed through the learning of mental toughness training and techniques (Strycharczyk and Clough, 2015). Mental toughness coaching strategies may include positive thinking, visualisation, goal setting, attentional control, relaxation and anxiety control (Strycharczyk and Clough, 2015). Crust and Clough (2011) suggests that mental toughness can be enhanced in individuals by providing a challenging yet supportive environment, providing an effective social support mechanism and encouraging individual reflection. Therefore, if an individual can deal with pressure and stress more effectively due to being mentally tough, this may improve the levels of burnout in that individual (Gerber *et al.*, 2015). However, this has never been investigated in mental health staff. Previous interventions with mental health have included clinical supervision (Hyrkas, 2005; Edwards *et al.*, 2006), psychosocial interventions (PSI) (Ewers *et al.*, 2002; Doyle *et al.*, 2007; Redhead *et al.*, 2011) and social support (Jenkins and Elliott, 2004). However, although these interventions showed improvements in some of the dimensions of burnout, these interventions were not informed by staff opinions. It is more beneficial to allow staff to actively be in involved in developing training to improve staff wellbeing and training should be informed by staff opinions and consultation (Coates and Howe, 2015).

It is important that mental health staff wellbeing is taken seriously and that new interventions are developed to help staff to keep themselves well. Interventions that improve an individual's perceived burnout and mental toughness could be hugely beneficial for staff wellbeing as well as having an impact on the care and interactions provided to service-users.

This study was part of a PhD project with the aim to develop a targeted mental health training package for mental health staff. The staff involved in the study were informed that their ideas would be taken forward to help develop this, which they would be invited too if they were interested. It was explained that the training aimed to improve staff wellbeing by improving self-reported burnout and mental toughness in mental health staff.

Aim of the present study

This study aimed to gain an understanding of mental health staff views on improving burnout and mental toughness in mental health staff.

Method

Recruitment

Participants were identified from two mental health rehabilitation services in the north-west of England. Each service had approximately 20 members of staff. The services supported service-users with psychosis as well as other conditions such as depression, anxiety and intellectual disabilities. In the first instance, the manager of the services agreed for a poster advertising the study to be put up. All staff from these services were then sent a letter of invitation, information sheet and consent form in one envelope in their pigeon hole. The manager had requested this as the best way to recruit across these services, due to varying shift patterns and to avoid feeling coerced. The staff then contacted the researcher to express their interest in participating. Ethical approval for this study was granted from the University of Central Lancashire Ethics Committee on 26 September 2016. No ethical concerns were identified.

Participants

Participants were sampled via maximum variation purposive sampling to capture a wide range of perspectives relating to burnout and mental toughness. The sample allowed greater insights to be gained by looking at mental toughness and burnout from different angles, from mental health workers of different age, gender, profession and time working in the service. Inclusion criteria included any individual that had been working in any role in the mental health sector for at least three months.

Conduct of the Nominal Group Technique (NGT)

The group discussion lasted approximately two hours in total. The session included a clear introduction, why the NGT was being used, as well as that a new wellbeing training package for mental health staff is proposed. The researcher gave definitions for burnout (Maslach *et al.*, 1996) and for mental toughness (Clough *et al.*, 2002) in order to clarify that all participants agreed with the definitions. The NGT question was then presented to the group:

> What strategies and techniques do you think could help improve burnout and mental toughness in mental health staff?

The process consisted of five stages. Stage 1: participants were asked to write ideas in brief phrases and to work silently and independently. Stage 2: each individual engaged in a round-robin feedback session to concisely record each idea (without debate from the group). The researcher recorded all ideas from the group on a flip chart that the whole group could see. Stage 3: each recorded answer was discussed for clarity and importance. Ideas that were similar were discussed and grouped together under one heading, which the staff called themes. Stage 4: individuals voted privately to prioritise the ideas and ranked these themes from their most favoured action to least favoured action. Stage 5: individuals reported their priority list back to the group. Votes were tallied and calculated to identify the themes that were rated highest by the group as a whole. The ideas that were most highly rated by the group were most favoured group actions or ideas in response to the question posed at the start.

Results

A total of ten participants took part in the NGT, this included a mix of staff from the two services that were initially approached. Participants included staff from varying roles and included one clinical lead, two art psychotherapists, one project worker, one occupational therapist/therapy lead, two support workers, two mental health nurses and one assistant psychologist. Of the ten participants, seven (70 per cent) were female and three (30 per cent) were male. The median age of the female staff was 35 years (range 23-57 years). The median age of the male staff was 51 years (range 50-53 years). The median length of time of the participants working in their present post was two years one month (range 3 months-24 years) indicating a wide range of experience from different mental health workers in the group.

Definitions of burnout and mental toughness

The participants were asked if they were happy with the definitions of burnout and mental toughness that were given or wished to offer alternative definitions. The staff not only agreed with these definitions, they also displayed motivation and enthusiasm to discuss these topic areas as the definitions appeared to immediately resonate with the staff.

These definitions developed some interesting discussion. One staff member noted that they:

> [...] would like to learn strategies to become mentally tough, so they could use these skills when they needed them, such as in times of stress and pressure (P6).

Another staff member from another profession also added:

> [...] from the definition given I can see areas of mental toughness I would like to improve on straight away (P3).

It was interesting to note that during the discussion of these definitions, staff thought that there may be a link between mental toughness and burnout and one individual commented that:

> [...] improving one of these areas might improve the other (P2).

The NGT

The staff had numerous ideas (41 items were recorded) on what strategies and techniques they thought could help improve burnout and mental toughness in mental health staff (Table I). Ideas that were similar were discussed and grouped together under one heading. The group chose nine headings for the ideas to be grouped together under; the staff called these headings themes. These consisted of culture/organisation, staff wellbeing, education, teambuilding, positive thinking/feedback, support, relaxation, communication and the environment. Table I shows how each specific idea was placed under each theme, the order of themes voted and the definition for the themes.

The most favoured action identified in the NGT was improvements in the culture and organisation. The least favoured action to take forward was the environment. Although the group came up with nine themes, the importance of each of the 41 individual ideas was acknowledged.

Many important comments were made relating to the NGT question. In particular, throughout the discussion the staff commented on their perception that very little is done to look after or improve staff wellbeing in mental health services.

One staff member commented on why they thought the existing support in place is not always useful:

> Is it a cultural thing? Supervision is in place but sometimes I don't get chance, we don't complain, just dig in and crack on, when really we should go and get supervision. I've felt quite stressed at times if I have not been able to get supervision because my supervisor off sick or something, I don't go and complain, I just crack on, but really is that the right thing to do? (P10).

Much of the discussion focussed on why they thought the ideas they had come up with would be beneficial. Some of the quotes from the group discussing the benefits can be seen in Figure 1.

When the votes were tallied and calculated from the group, most actions received similar scores apart from the theme of environment. Therefore, although culture/organisation was the most favoured action, the other themes of staff wellbeing, education, team building, positive feedback, support, relaxation and communication were rated fairly equally by the staff as important actions to take forward.

Discussion

Improving burnout and mental toughness

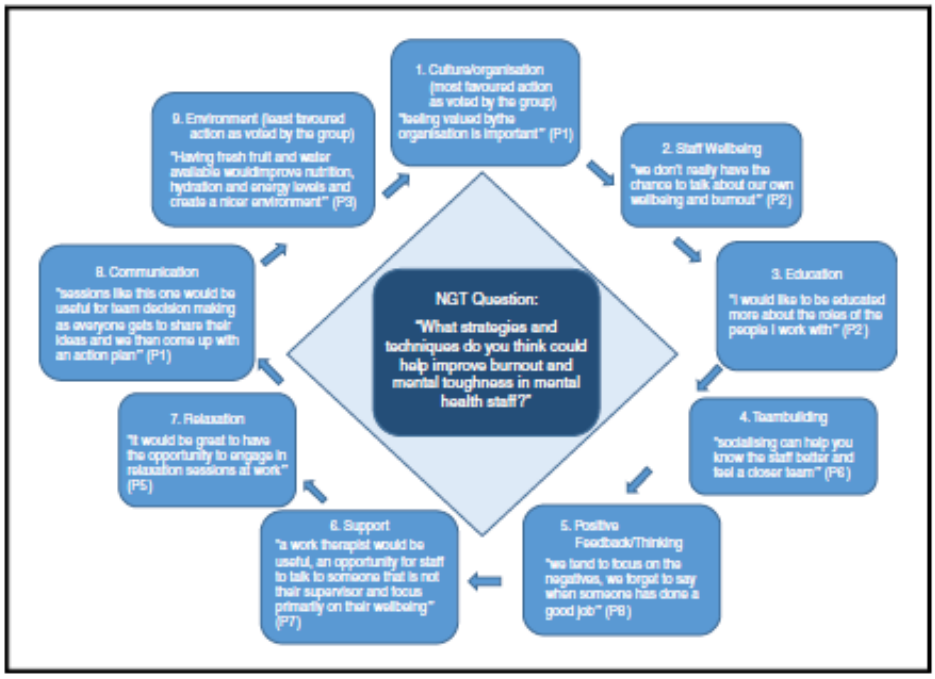
This study shows that staff working in a mental health setting are motivated and enthusiastic to discuss issues around improving their mental health. The top three important themes

Table I Individual ideas from the group, the themes, order voted and definitions

Individual strategy	*Theme*	*Order voted*	*Definition of theme*
Involving the team in decision making Staff incentives for good work Organisation to understand staff wellbeing needs better Create a positive culture throughout the organisation Start/end the day with something positive, e.g. 5 minutes to reflect on what did well	Culture/ Organisation	1	Related to anything that involved higher management, the organisation and the way in which they worked
Recognise burnout Learn anxiety control/ stress reduction Mental toughness coaching strategies Visualisation Learn a good work-life balance Learn coping strategies to use daily Mental health wellbeing days for staff Opportunities to refresh the coping skills Learn confidence and self-esteem skills Burnout and mental toughness assessments	Staff wellbeing	2	Involved anything relating to keeping well, including burnout, mental toughness, stress and anxiety. It included any specific strategy that could help with wellbeing
Training for staff for their role Training for staff to help them develop new skills Opportunities to learn from other professionals Education about what is burnout and what is mental toughness See progression from training in day-to-day activities by goal setting	Education	3	Included ideas that would increase knowledge and understanding. It included training, development and anything with an educational aspect
Away days, time away from work to bond with staff team Staff groups, e.g. breakfast club Socialising outside of work, e.g. nights out, afternoon tea Support each other, even if task outside of job role, e.g. random acts of kindness	Teambuilding	4	Included anything that involved the staff socialising, improving staff relationships and time together in and outside of work
Positive feedback more often to colleagues Engage in peer appraisal and positive recognition Learn to engage in positive thinking rather than negative thinking	Positive thinking/ Feedback	5	Involved improving positive attitudes, thoughts and behaviours
Personal supervision – opportunity to discuss personal issues. Clinical supervision – discuss difficulties with the team Work therapist/councillor for staff Peer supervision for burnout – discuss wellbeing with their peers Set manageable and clear goals throughout the team, and support each other to achieve these	Support	6	Included any support for staff either internally or externally. Included any supervision, any support groups and any therapy/counselling
Use relaxation techniques at work, e.g. breathing techniques Exercise, e.g. yoga, tai-chi, walking groups available to staff Time and space at work to relax, e.g. mindfulness sessions. Massage.	Relaxation	7	Included anything that would help the staff to relax, keep calm and reduce stress and anxiety. It included using relaxation at work and having time and space to relax and unwind at work
Clearly understand roles by open and clear communicationHandovers and de-briefing	Communication	8	Included anything that involved staff improving how they respond and communicate to each other
Environment set up so that everyone can do their job effectively, e.g. enough computers, chairs, stationary Provide a quiet space for staff to go to during work Fresh fruit and water always available to staff to improve nutrition, hydration and energy levels	Environment	9	Involved any practicalities that would help improve the working environment, such as rooms, furniture and equipment

were: culture/organisation, staff wellbeing and education. These findings were in line with previously published theoretical and empirical papers. The results have also added value and new knowledge, by generating additional insights to the participants' perspectives and priorities, as well as giving valuable practical pointers for implementation.

Figure 1 The themes as chosen by the staff, the order the group ranked these, along with quotes from the group



The top priority action to take forward from the NGT was improvements in the culture and organisation. This included ideas such as involving the team in decision making. Previous research identified that it is paramount that new training and initiatives, to improve staff wellbeing and burnout should be informed by mental health staff views and ideas (Coates and Howe, 2015). Therefore, carrying out the NGT was an important process of the development of this training. It is also essential that the staff will be able to see clearly that the training has been created based on their feedback and feel listened too (Coates and Howe, 2015). The staff wanted the organisation to understand staff wellbeing needs and have a better awareness of this issue, e.g. training for higher management on staff wellbeing. Previous authors suggested that it is beneficial for management to participate in wellbeing training. Scarnera *et al.* (2009) found that teaching managers leadership skills and involving them in wellbeing training such as positive thinking workshops is beneficial, as perceived support from managers can affect burnout levels. Therefore, the NGT findings reinforce earlier published work that all staff (including managers) should be involved in wellbeing training.

The second priority action related to staff wellbeing techniques. This included helping staff to recognise and prevent burnout by teaching specific techniques, e.g. anxiety control, stress reduction. In previous training 84 participants were encouraged to learn relapse prevention for burnout, which showed improved burnout rates (Salyers *et al.*, 2011). Therefore, the NGT findings concur with other studies that staff wellbeing training should allow staff to learn about burnout and ways of preventing this. Under this theme, staff reported that they would like training on specific techniques that may make them more mentally tough. Mental toughness coaching strategies may be able to improve areas such as performance, resilience and wellbeing (Strycharczyk and Clough, 2015). The development of mental toughness may be achievable through the coaching or training of specific techniques. These techniques include visualisation, positive thinking, attentional control, goal setting, anxiety control and relaxation (Strycharczyk and Clough, 2015).

The NGT participants emphasised that developing a good work-life balance by learning skills to help with time-management and goal setting would help improve mental toughness and burnout.

This supports previous findings that has displayed that goal setting may be useful, as interventions such as clinical supervision, which involves group goal setting can be beneficial in reducing burnout in these settings (Edwards *et al.*, 2006).

The mental toughness literature also supports that goal setting and learning to prioritise tasks is beneficial for improving mental toughness. Strycharczyk and Clough (2015) suggests that goal setting helps prioritise and motivate individuals in tasks.

Amongst the staff wellbeing techniques were confidence and self-esteem training. Positive changes in burnout have been found due to the implementation of self-esteem workshops (Carson *et al.*, 2001). Techniques such as visualisation which can help with confidence and self-esteem are also noted to improve mental toughness (Sheldon and Lyubomirsky, 2006). Therefore, self-esteem and confidence training is found to be effective in previous studies and viewed as important in the NGT.

The NGT group also suggested under the heading of staff wellbeing that there should be mental health wellbeing days for staff and regular opportunities to refresh the coping skills they have learned. Practicing wellbeing strategies is important for their effectiveness, with Sheldon and Lyubomirsky (2006) concluding that it may be important to encourage regular practice of such techniques in a training programme for mental health staff. In addition to this, the consideration of refresher or follow-up sessions, in order to maintain the effectiveness of the techniques, was considered beneficial (Sheldon and Lyubomirsky, 2006).

Staff in the NGT also thought that it would be worthwhile for burnout and mental toughness to be assessed by the workplace, so goals could be made on how to improve. The Mental Toughness Questionnaire 48 (Clough *et al.*, 2002) has been found to be useful in assessing which interventions are most useful in improving mental toughness and with different people (Strycharczyk and Clough, 2015). It also allows individuals to see their strengths and limitations and set goals to work on these (Strycharczyk and Clough, 2015). The Maslach Burnout Inventory (Maslach *et al.*, 1996) also allows staff to see how they score in each of the three dimensions of burnout.

The third priority action was education. During the NGT, staff agreed that training and education are essential in improving burnout and mental toughness. The ideas they suggested included increasing knowledge to make them more confident and able to fulfil their responsibilities effectively. Some of the wellbeing training was placed under the heading of staff wellbeing rather than education, as selected by the staff. When mental health staff learn new ways of working with service-users, this can improve burnout, as they feel they have more skills to work effectively with those individuals (Ewers *et al.*, 2002). Others that have explored the use of training to reduce mental health staff burnout have often focussed on teaching staff PSI as a way of doing so (Ewers *et al.*, 2002; Doyle *et al.*, 2007; Redhead *et al.*, 2011). The skills taught often help staff become more empathetic towards service-users, by increasing their understanding of mental health and learning strategies to work through problems effectively that service-users may be experiencing (Ewers *et al.*, 2002). The findings are consistent in suggesting that education focussing on new ways of working is valuable.

Apart from the top three priority themes, the other six themes suggested by the staff were still rated as important and will be incorporated in the proposed training. Theme 4 – teambuilding – included ideas such as away days and time away from work to bond with the staff team. Group teambuilding has been found to be effective in reducing burnout, as well as improving morale and job satisfaction (Robinson-Kurpius and Keim, 1994). Theme 5 – positive feedback/thinking – suggested that learning to engage in positive thinking rather than negative thinking would be helpful. Training to manage negative emotions, thoughts and increase positive thinking may reduce burnout (Scarnera *et al.*, 2009). Theme 6 was support. There are positive outcomes in terms of reduced burnout levels in mental health staff with the use of clinical supervision, which provides support to staff (Edwards *et al.*, 2006). However, a recognised problem of using clinical supervision to improve burnout in mental health staff is that individuals do not always get the opportunity and time out of normal working duties to attend these sessions and they are not always regularly available (White and Roche, 2006). Although relaxation as a technique to improve burnout and mental toughness was prioritised as seventh, the staff were motivated when

discussions were held about the benefits of relaxation techniques in the workplace. Goodman and Schorling (2012) support that a mindfulness course can reduce burnout in healthcare providers. As well as training on formal mindfulness practices, the course focussed on how mindfulness could be applied in the workplace, an area that the NGT emphasised as important. Positive and constructive communication was seen as important during the NGT discussion in improving burnout and mental toughness, even though rated eighth in the themes. Communication is important for staff wellbeing, negative communication should be minimised and staff should be encouraged to have discussions that are helpful and constructive (Jenkins and Elliott, 2004). Although voted as the least favoured action to take forward by the group, the staff still selected environment as a theme. Staff require time and space to immerse themselves in the wellbeing techniques they are taught and being away from work in a different environment is beneficial (Razzaque and Wood, 2016).

As discussed the findings are in line with previously published theoretical and empirical papers. However, this study is unique in involving mental health staff in discussing their ways of improving their mental health. It is also unique as it has found nine strategies to do this and these could be used in targeted training for mental health staff.

Implications

The NGT primarily aimed to find out what strategies and techniques mental health staff thought could be helpful to improve burnout and mental toughness. The findings of this study will be used to develop a staff wellbeing training package for mental health staff. However, in addition to developing ideas for the training, the study had other possible implications.

Including staff in the development of training

An important factor throughout this process is that staff thought it was beneficial for them to be included in the decision-making process of what should be included in a wellbeing training package for mental health staff. The importance of making the staff feel their opinions and ideas were valued and that the training would be relevant to them was apparent. According to Coates and Howe (2015) it is important to include mental health staff in developing and designing wellbeing initiatives. The staff reported and agreed that if they were more involved in developing training for themselves, they would feel more committed and invested in the training. If training is seen as something that is compulsory or "a means to an end" then staff expressed that they are not fully immersed in the training. Evidence shows that initiatives adapted to the needs and preferences of individual clinical services and staff are more effective (Coffey *et al.*, 2004; McCray *et al.*, 2008). It was clear that from being involved in the development of this wellbeing training package that they were interested and enthusiastic about implementing this and taking it forward.

Using the NGT to start discussions on wellbeing

The NGT proved to be a beneficial method for aiding the group discussions. It also had additional benefits that were not known prior to the implementation of the NGT. This included the benefits of starting a discussion with the staff about their own wellbeing and what they thought could help improve this. Simply allowing the staff space and time to have the opportunity to discuss wellbeing as a topic was evidently important to the staff that attended. With staff finding that simply talking about the definitions of burnout and mental toughness sparked enough interest to get them starting to think about their own wellbeing and how to improve this. Discussing wellbeing and a burnout prevention plan with colleagues can be a beneficial tool and is recommended in burnout prevention training (Salyers *et al.*, 2011).

Limitations of the study

Despite the NGT been a successful method for data collection some limitations of this method are recognised. The NGT can be regimented in the way that it focusses on one question and has a single purpose in a one off meeting. Although during this group the staff engaged in discussion to share ideas and add clarity to points made, it is recognised that compared to other methods the

NGT can minimise discussion. Therefore, it is sometimes argued that this can limit the full development of ideas and be less stimulating for the individuals involved (Cantrill *et al.*, 1996). However, as this method allowed for effective data collection with the staff and positive feedback was received from individuals, this method was successful for this study.

Future recommendations

The findings from the NGT will be of great value in developing a wellbeing training package for staff burnout and mental toughness. It is recommended that the NGT is a beneficial method to capture mental health staff views on what could improve their wellbeing. Further recommendations would be to carry out the NGT with the same question at different services. This could include asking the same question to staff from other mental health rehabilitation services, including those from other organisations. This could include services and organisations from areas outside of the north-west, across the rest of the UK. It could also include carrying out the NGT with services other than mental health rehabilitation, such as with staff in hospital settings, on acute wards and those working in the community. This would allow for comparison of ideas from different mental health settings and different organisations. It would be interesting to discover if the opinions on strategies and techniques to improve burnout and mental toughness were universal or are specific to services or organisations. This would allow more generalisable wellbeing training packages to be developed. Alternatively, it may suggest that each service has different opinions and that it would be beneficial to always directly include the staff in the development of a wellbeing training package for each individual service.

Conclusion

Staff who engaged in the NGT discussion displayed a clear interest in the topic area of improving staff wellbeing. They offered many ideas and engaged in open discussion on the strategies and techniques that they thought could help improve self-reported burnout and mental toughness in mental health staff. They also valued being engaged in the decision-making process and development of the proposed training package. This study showed that mental health staff want to improve the organisational culture towards mental health and their wellbeing and want to be educated about this topic.

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APPENDIX 11- LETTER OF ETHICAL APPROVAL FOR THE WELLBEING TRAINING

22 September 2017

Jessie Janssen/Zoe Posner
School of Health Sciences
University of Central Lancashire

Dear Jessie and Zoe

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 706

The STEMH ethics committee has granted approval of your proposal application 'Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

William Goodwin

Will Goodwin
Deputy Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

APPENDIX 12- INFORMED CONSENT FORM FOR THE WELLBEING TRAINING

Date: July 2017
Version number: 1

University of Central Lancashire

Informed consent form

Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout

Researcher: Zoe Posner (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

After reading the participant information sheet please tick if you have read and understood the following and sign to give consent to participate in this study:

1. I confirm that I have read the information sheet dated July 2017 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason up to the end of the training. ☐

3. I am aware that all information is anonymous and will be kept confidential throughout ☐

4. I give consent to take part in the training, to be interviewed in the weeks following the training and to be included and interviewed in the 3 month follow up ☐

7. I give consent to be audio recorded during the interviews ☐

8. I understand that all data will be stored securely in line with the UCLan code of conduct for research and UCLan Data protection policy. ☐

9. I understand that I cannot retract data that has already been anonymised. Direct quotes may be used but will not be attributable to any participant. ☐

10. I agree to anonymised data being utilised within reports, publications, presentations, other research and teaching purposes. ☐

11. You may be interested in receiving your scores from the two questionnaires you complete, if you would like to receive these scores please tick to confirm this in the box. If you tick to receive your scores this will be given to you after you have engaged in the first interview. ☐

10. If you would like to receive feedback on the findings from this study please tick here and provide a correspondence address or email address that you would like these sent too. ☐

Correspondence Address:

_____
_____
_____
_____

Email Address: (please clearly state the email address you would like to be contacted on with regards to arranging a suitable date and time for the interviews)

_____

I agree to take part in the above study. ☐

Age: **Job Role:**

_____	_____	_____
Name of Participant	**Date**	**Signature of participant**

_____	_____	_____
Name (Person taking consent)	**Date**	**Signature (person taking consent)**

When completed 1 copy for participant and 1 copy for researcher

APPENDIX 13-LETTER OF INVITATION FOR THE WELLBEING TRAINING

Date: July 2017
Version number: 1

University of Central Lancashire

Letter of Invitation

Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout

Researcher: Zoe Posner (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

As you are a member of staff who has worked for a mental health service for 3 months or more, I am writing to invite you to take part in my study. I am a PhD student at the University of Central Lancashire carrying out research titled *'Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout'*.

Burnout in mental health staff is acknowledged as a major problem, with as much as ***67% of mental health workers experiencing high levels of burnout*** (Morse et al., 2012). Mental Toughness describes the capacity of an individual to ***deal effectively with stressors, pressures and challenges***, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough et al., 2002). It is believed that mental toughness can be developed by different coaching strategies in individuals from a wide variety of backgrounds. However, this has never been researched in the mental health staff population.

You are been invited to take part in a pilot of a wellbeing training package for mental health staff. The group involved in the training will consist of around 20-25 participants from your place of work and one other service from your organisation.
The training will consist of being ***taught mental toughness coaching strategies*** that have already been developed to ***improve mental toughness*** in other areas such as sport and education (Strycharczyk and Clough, 2015). This will include but is not conclusive of ***learning positive thinking, visualisation, anxiety control and goal setting***.

Before you decide whether to take part in the study I would like you to understand why the research is being done and what it would involve for you, therefore please take the time to read the participant information sheet and consent form.
It is completely up to you whether you choose to take part or not, it will not affect any future relations with the University of Central Lancashire or your current job role.

The group discussion is expected to take place on (insert dates). The group will take place in a training room at your organisations head office in Manchester.
If you have any questions or would like to take part please contact me the researcher at ZPosner@uclan.ac.uk
Yours Sincerely
Zoe Posner
PhD Student
University of Central Lancashire

Date: July 2017
Version number: 1

University of Central Lancashire

Information Sheet

Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout

Researcher: Zoe Posner (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

Why I am being asked to take part?
You have been invited to take part as you are a member of staff that works in a mental health service and has done so for 3 months or more. The study aims to include a variety of individuals and professionals who work in mental health, in order to pilot a wellbeing training package.

Why is the study taking place?
The aim of this study is to explore the experience of mental health staff in wellbeing training to improve their mental toughness and burnout. Burnout in mental health staff is acknowledged as a major problem, with as much as 67% of mental health workers experiencing high levels of burnout (Morse et al., 2012). Mental Toughness describes the capacity of an individual to deal effectively with stressors, pressures and challenges, and perform to the best of their ability, irrespective of the circumstances in which they find themselves (Clough et al., 2002). It is believed that mental toughness can be developed by different coaching strategies in individuals from a wide variety of backgrounds. However, this has never been researched in the mental health staff population.

What is involved in the study?
You have been invited to take part in a pilot of a wellbeing training package for mental health staff. The group involved in the training will consist of around 20-25 participants from your place of work and one other service from your organisation.
The training will consist of being taught mental toughness coaching strategies that have already been developed to improve mental toughness in other areas such as sport and education (Strycharczyk and Clough, 2015). This will include but is not conclusive of learning positive thinking, visualisation, anxiety control and goal setting. You will be asked to complete two questionnaires (The Maslach Burnout Inventory and Mental Toughness Questionnaire) on the first day of the training as part of the introduction and again at the end of last day of training. You will also be asked to take part in an interview during the week after the training has taken place. This interview will simply consist of answering a few questions regarding the training that you were on. The interview should last approximately 45 minutes. I will arrange a suitable time for

this interview to take place at your workplace with you. The training and interview will be audio recorded and used for my PhD research.
You will also be asked to be seen as part of a 3 months follow up after the training. This is expected to take place (insert date). This will involve completing the same two questionnaires you completed at the training (The Maslach Burnout Inventory and Mental Toughness Questionnaire) for a third and final time. You will also be interviewed again and simply asked questions again with regards to the training you were involved 3 months previous as part of this study. This follow up meeting should last no more than 1hr 15 minutes in total.

How much time will it take?
The training will run for approximately 6 hours each day over 4 days.

When and where is the research taking place?
The training is to take place on (insert dates) 9.30am-3.00pm in a training room at your organisations head office in Manchester.

What do I do next?
You have received a letter of invitation, participant information sheet and consent form. If you are interested in taking part please email ZPosner@uclan.ac.uk to let me know.

What will happen to the information?
All data collected will be kept confidential and anonymous and used for research purposes only. All data will be stored on a password protected computer. Your name or any identifying characteristics will not be available to anyone, at any point. The information will become part of a research thesis and may be presented at conferences and in research journal papers. During the group discussion, all participants will be asked to agree to maintain the confidentiality of any information provided by others during the discussion. The group will be audio recorded, after it has been transcribed, the recording will be destroyed in accordance with the University of Central Lancashire guidelines. Direct quotes will be used but they will be anonymised so that you cannot be identified.

What if I am interested in the results from the questionnaires I completed?
You may be interested in receiving your scores from the two questionnaires, if you would like to receive these scores please tick to confirm this on the consent form. If you tick to receive your scores this will be given to you after you have engaged in the first interview (around the week after the training has taken place). If you have any questions or require any further information regarding your scores you may contact the researcher on ZPosner@uclan.ac.uk. You are advised to seek local sources of support e.g. your line manager or GP if you feel distressed by your scores.

What if I am interested in the study results?
If you would like to receive written feedback on the results of this study, please tick that you would like this on the consent form and provide a correspondence address or email address in the space provided on the consent form.

Do I have to take part?
No, it is up to you to decide whether to take part or not, it will not affect your future relations with the University of Central Lancashire or your current job role if you do not take part. Please

take time to read all the information provided and feel free to ask questions regarding the study. Participation in this group is completely voluntary, and you are under no obligation to take part.

What will happen if I don't want to continue with study?
You can decide not to take part at any stage, even if you have signed the consent form. You don't have to tell us why you have changed your mind. Your decision to withdraw will not affect your current job role in any way. If you change your mind after the training, we will continue to use information that is anonymous and cannot be traced back to you. Withdrawal is essentially not possible after the training has occurred and data is aggregated, however you can withdraw from the group at any time before the end.

What are the potential risks and benefits of taking part?
Possible risks: We understand that due to the nature of the topic, sensitive issues may be discussed and that the opinions of some participants may differ to others of the group. All information that is shared during the training sessions will be treated as personal and sensitive and it is vital that all group members respect this and their confidentiality. I will try my best to make all participants as comfortable as possible in terms of discussion and all participants will be encouraged to talk to the researcher if they are worried or have concerns. In the unlikely event that an individual displays signs of emotional distress during any point of the project, data collection will be stopped. The participant will also be advised to seek local sources of support e.g. their line manager or GP.

Possible benefits: Although benefits cannot be guaranteed the training aims to explore the experience of mental health staff in wellbeing training to improve their mental toughness and burnout. Therefore, possible benefits in terms of an individual's mental toughness scores and/or burnout levels may be found. Studies that have used similar techniques to the ones in this training in other settings such as sport and education have found benefits in developing an individual's mental toughness which has led to improved wellbeing and performance (Strycharczyk and Clough, 2015).

What if I have a complaint?
If you have a complaint with regards to any part of the research being carried out please contact Dr Jessica Janssen or Dr Hazel Roddam on the below contacts and they will discuss the complaints procedure and next steps with you.

Who is doing the research?
The research is being carried out by myself (Zoe Posner) a PhD Student at the University of Central Lancashire.
If you have any questions you may contact me the researcher at ZPosner@uclan.ac.uk
Or my supervisors Dr Jessica Janssen via
Tel: 01772 89 4560 or Email: JJanssen@uclan.ac.uk
And Dr Hazel Roddam via
Tel: 01772 89 5484 or E-mail: HRoddam@uclan.a.c.uk

Thank you for taking the time to read this information sheet

APPENDIX 15-DATA PROTECTION CHECKLIST FOR THE WELLBEING TRAINING

University of Central Lancashire

Data protection checklist: Teaching, research, knowledge transfer, consultancy and related activities

All activities which involve personal data of any kind, in any way, must comply with the Data Protection Act 1998 (DPA). This checklist outlines the requirements of the DPA and the measures you must take when processing personal data; it also provides a mechanism for recording the steps you will take to ensure the personal data you are using are safeguarded and the reputation of the University is upheld.

Ensuring personal data are processed fairly and lawfully with due regard for individuals' privacy and ensuring that personal data remain secure are paramount. Demonstrating that we have considered the requirements of the DPA when conducting our activities will provide assurances to students, employees and business partners that their personal data is protected at UClan. Organisations can be fined up to £500,000 for breaches of the DPA which are considered to be as a result of negligence or recklessness; therefore it is important that we get it right from the outset. If it is possible to use anonymised data so that individuals cannot be identified from it and still achieve your aims, this is always the preferred method of operating. Truly anonymised data (which cannot be reconstructed or linked to any other data you hold or may hold in the future to enable you to identify individuals from it) does not constitute personal data because it cannot be used to identify individuals.

What is *personal data*?

Personal data are data relating to a living individual who can be identified from those data (or from those data and other information in our possession or likely to come into our possession). Personal data can be factual (such as name, address, date of birth) or can be an opinion (such as a professional opinion as to the causes of an individual's behavioural problems). Information can be personal data even if it does not include a person's name or other obvious identifiers; for example, a paragraph describing a specific event involving an individual or a set of characteristics relating to a particular individual may not include their name, but would clearly identify them from the set of circumstances or characteristics being described or represented. If you are unsure whether or not your activity involves personal data, please contact the Information Governance Officer to discuss on DPFOIA@uclan.ac.uk.

What is *processing*?

The DPA is concerned with the processing of personal data. Processing means obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data, including –

(a) organisation, adaptation or alteration of the information or data,
(b) retrieval, consultation or use of the information or data,
(c) disclosure of the information or data by transmission, dissemination or otherwise making available, or
(d) alignment, combination, blocking, erasure or destruction of the information or data.

If your proposed activity involves processing personal data, you must complete the following checklist. If you are unable to answer *Yes* to each applicable question, you must contact the Information Governance Officer for advice before proceeding. If you require any further information or guidance to enable you to answer *Yes* to each question, please contact the Information Governance Officer: DPFOIA@uclan.ac.uk.

Type of activity:	**Study consisting of training staff, questionnaires and interviews.**
Activity name/title:	**Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout**

Processing personal data fairly
The DPA requires us to process personal data fairly and lawfully. In practice, it means that you must: • have legitimate grounds for collecting and using the personal data; • not use the data in ways that have unjustified adverse effects on the individuals concerned; • be transparent about how you intend to use the data, and give individuals appropriate *privacy notices* when collecting their personal data; • handle people's personal data only in ways they would reasonably expect; and • make sure you do not do anything unlawful with the data.

Have you checked and confirmed that the intended uses of personal data in your activity have a legal basis?	Yes
If your activity involves *sensitive personal data*, have you checked and confirmed that you can satisfy a condition for processing this kind of personal data from the DPA? Sensitive personal data includes data about racial or ethnic origin; political opinions; religious or similar beliefs; trade union membership; physical or mental health or condition; sexual life; commission or alleged commission of any offences; or any proceedings for any offence committed or alleged to have been committed.	Not applicable
If the intended use of the personal data would or would be likely to have an adverse effect on one or more individuals, have you considered and documented why that adverse effect is justified?	Not applicable
Have you documented why you are collecting the specific items of information to demonstrate that you have legitimate grounds for doing so e.g. if you are carrying out research into how students' music preferences affect their degree classification and also collecting participants' shoe sizes, can you show you have a legitimate need for this information?	Yes
Have you written an appropriate privacy notice to provide to individuals at the point you collect their personal data? A privacy notice tells individuals how we will use their personal data once we have it. It should contain your or your organisation's identity, as appropriate; the purpose or purposes for which you intend to process the information; and any extra information you need to give individuals in the circumstances to enable you to process the information fairly, such as whether or not the information will be disclosed to a third party. If you need assistance drafting a privacy notice, the Information Commissioner's Office (ICO) has produced a Privacy Notices Code of Practice.	Yes

Consent
One of the conditions from the DPA which you can satisfy to enable you to process personal data is '[consent]'. Consent is defined by the European Data Protection Directive as '*…any freely given specific and informed indication of his wishes by which the data subject signifies his agreement to personal data relating to him being processed.*' The ICO maintains that the fact that an individual must 'signify' their agreement means that there must be some active communication between the parties. An individual may 'signify' agreement other than in writing, but organisations should not infer consent if an individual does not respond to a communication e.g. from a customer's failure to return a form or respond to a leaflet. Consent must also be appropriate to the age and capacity of the individual and to the particular circumstances of the case. For example, if you intend to continue to hold or use personal data after your relationship with the individual ends, then the consent should cover this. Even when consent has been given, it will not necessarily last forever. Although in most cases consent will last for as long as the processing to which it relates continues, you should recognise that the individual may withdraw consent, depending on the nature of the consent given and the circumstances in which you are collecting or using the information. Withdrawing consent does not affect the validity of anything already done on the understanding that consent had been given. You must realise that consent must be *informed* and be freely given; this means it can be withdrawn at any time and you must have a process in place to manage this. If you are doing something which you are required to do by law and the individual has no choice about it, do not ask for their consent; this is misleading because you must do it by law anyway, whether or not they consent to it. Consent can either be explicit or implied: • *Explicit consent* is where an individual actively opts in to an activity e.g. Tick this box and sign here if you consent to us using your information in this way, then return this form. • *Implied consent* is where you tell an individual what will happen to their information unless they tell you they object e.g. Please sign and return this form. We will use your information for the additional purposes outlined in our privacy notice unless you tell us not to by ticking this box. **If you are processing *sensitive personal data* and relying on consent as your basis for doing so, you must obtain explicit informed consent from individuals.**

If you are planning to obtain consent from individuals before using their personal data, have you checked and confirmed that consent is necessary and is the most appropriate basis for your processing?	Yes
If you are processing sensitive personal data, have you planned to obtain individuals' explicit consent?	Not applicable
If you are relying on individuals' consent as a basis for using their personal data, have you developed a process for managing the withdrawal of consent?	Yes
If you are obtaining consent, you must ensure that the individual understands their rights and is capable of giving consent; this is assessed on a case-by-case basis. If you are processing personal data about younger individuals or those with reduced capacity, have you put a process in place to obtain consent from parents, guardians or legal representatives, if appropriate?	Not applicable

Security
Ensuring personal data are secure at all times is extremely important. Organisations can now be fined up to £500,000 for breaches of security involving personal data where those breaches are considered to have been due to negligence, recklessness or as a result of an issue which should reasonably have been foreseen. The DPA requires us to ensure that *appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data*. It is important that any personal data you collect or use during your activities remains secure until it is destroyed, which includes ensuring that only those who are authorised to access and use the data can do so. **For further guidance on information security, please see the Information Governance pages of the UCLan intranet and the LIS IT Security Policy, also on the intranet.**

If you are intending to publish information which could identify individuals, have you made those individuals aware that this will happen via your privacy notice and obtained their consent, if appropriate?	Not applicable
Will papers, files, audio visual recordings, CDs, USB (memory) sticks, microfiche or other media which contain personal data be kept in locked cabinets, cupboards, drawers etc. when the offices are vacated?	Yes
Do all individuals who will have access to or be using the personal data understand that it must not be provided to any unauthorised person (which includes disclosing information to family members or other representatives of data subjects, unless the data subject has given consent for us to do this)?	Yes
Do all individuals who will have access to or be using the personal data understand their responsibilities under the DPA and have they received data protection training? An e-learning course is available to staff – see the Information Governance intranet pages for information about enrolling.	Yes
Do you have appropriate procedures in place to ensure the security of the personal data if it is removed from UCLan offices for any reason? Electronic data must only be removed if it is stored on encrypted devices or media e.g. an encrypted disc or USB stick, an encrypted laptop etc. Alternatively it can be accessed remotely via a secure connection. If an unencrypted device containing personal data is lost or stolen, it is likely to lead to a substantial fine for a breach of the DPA. Non-electronic records must be rigorously safeguarded at all times and not left unattended or in view of unauthorised people. Laptops, USB sticks and other devices, papers or any other form of personal data must not be left in cars.	Yes
Will the personal data be stored on the UCLan network in a secure location with restricted access, to prevent unauthorised parties who have no right or need accessing the data?	Yes
Are all individuals who will have access to or use the personal data aware that personal information should not be stored off the UCLan network and should only be stored on equipment owned or leased by UCLan, unless exceptional circumstances apply? Storage under such exceptional circumstances must include the use of appropriate security measures. No personal information should be stored on any removable media e.g. USB sticks, CDs or devices e.g. laptops, smartphones unless they are encrypted.	Yes
Are all individuals who will have access to or use the personal data aware that any	Yes

information accessed via remote working methods such as Outlook Web Access, UCLan Global or similar must be treated securely in line with relevant legislation and all University guidelines? UCLan business information, including personal data, should not be stored on personal, non-UCLan equipment or devices unless exceptional circumstances apply.	
Are all individuals who will have access to or use the personal data aware that email is not a secure method of communication and can easily be sent to the wrong recipient and do they know how to encrypt documents so that they can be attached to an email and sent securely? N.B. Encryption passwords must be provided separately and never included in the same email as the encrypted attachment. Guidance is available on the Information Governance intranet pages.	Yes
Are all individuals who will have access to or use the personal data aware that all non-electronic material which contains personal data and has been authorised for disposal must be disposed of via the University's confidential waste service (including handwritten notes, computer print-outs etc.)?	Yes
Are all individuals who will have access to or use the personal data aware that any paper documents, electronic media or hardware which has been designated for disposal must be kept in a secure location until it has been appropriately destroyed and any information it contains is no longer accessible or recoverable? Electronic media and hardware should be disposed of in line with LIS guidelines and procedures.	Yes
Can you confirm that if personal data will be transferred overseas (outside the EEA), you have taken advice from the Information Governance Officer to ensure the transfer can legally take place? This includes via email and by virtue of using 'cloud' providers which store your data on their servers based overseas.	Not applicable

Third parties acting on behalf of UCLan

Under some circumstances, it will be necessary or desirable to work with organisations external to UCLan, such as charities, research organisations, private companies, other public sector organisations, contractors, service providers or any other types of third parties. If a third party is acting on our behalf e.g. providing a service for us or on our behalf and that activity involves the third party accessing, collecting or otherwise processing personal data, they are a *data processor* under the DPA. A well-recognised example of a data processor relationship is a UK bank using an overseas company to provide its call centre. The overseas company has access to the UK bank's customer information in order to provide the call centre service, but it can only use that data for the purposes of providing the call centre service because this is the service they are providing under contract on behalf of the UK bank.

The DPA contains specific requirements we must adhere to when we use a data processor:

- we must choose a data processor which provides sufficient guarantees about its security measures to protect the personal data it will process for us;
- we must take reasonable steps to check that those security measures are being put into practice; and
- there must be a written contract setting out what the data processor is allowed to do with the personal data. The contract must also require the data processor to take the same security measures we would have to take if we were processing the data ourselves.

Further information about using data processors is available on the Information Governance

intranet pages or from the Information Governance Officer.

If you are using a data processor or you need help deciding if the proposed arrangement does involve a data processor, have you taken advice from the Information Governance Officer?	Not applicable
If you are using a data processor, have you taken advice on information security from the Information Governance Officer and the Information Security Officer?	Not applicable
If you are using a data processor, have you taken advice from the Contracts Team in Legal Services or from Purchasing (as appropriate) to ensure you have sufficient contractual arrangements in place to cover the use of a data processor?	Not applicable
If you are using a data processor, can you confirm that a contract will be signed by all parties which meets all the requirements of the DPA as set out above?	Not applicable
Can you confirm that we have been provided with sufficient guarantees about the security measures the data processor has in place and that you have a process in place to confirm that these are being followed?	Not applicable

Once this form has been completed, it should be attached to your ethics checklist and submitted as directed. If your activity does not require further ethical approval, this form should be retained with your project documentation as a record of your considerations and data protection compliance. If you require any further advice or guidance to help you complete this checklist, please contact the Information Governance Officer: DPFOIA@uclan.ac.uk. Members of staff can also find a variety of guidance documents and FAQs on the Information Governance intranet pages.

RISK ASSESSMENT FORM Version 2

uclan
University of Central Lancashire

Risk Assessment For	Assessment Undertaken By	Assessment Reviewed
Service / School: [redacted]	**Name:** Zoe Posner	**Name: Peter Hill – SHE Section**
Location of Activity: UK Only	**Date: 30/07/17**	**Date: 07/08/2017**
Activity: Generic staff travel within the UK by car, train, coach etc for lower risk activities such as reseach, conferences, exam boards, visiting students on placement, etc. This risk assessment must be read in association with FM SHE 042 Procedural Guidance for the Management of Health & Safety During UK Travel **REF:**	**Signed by Dean of School / Director of Service or equivalent:** Dr Hazel Roddam **Date: 14th Aug 2017**	*This section to be used when the assessment is reviewed in academic year*

List significant hazards here:	List groups of people	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Private Car *Vehicle accident*	Staff	Trip not to commence if staff have concerns about vehicle safety; Driver must have 'business use' coverage on their insurance policy; Vehicle Use Self Declaration Statement should be completed; Route will be planned in advance.		Low-Med
Vehicle general *Accident, incident Tiredness, poor road conditions, etc*	Staff	Consult weather forecast for the area before setting out in the winter; Trip not to commence if staff have concerns about vehicle safety; Mobile phones must not be used when driving even with a hands free kit. They may be used when parked in a safe place with the engine switched off; Driver will not pick up hitch-hikers; On arrival the vehicle will be parked in a well-lit area as close to the destination as possible; Driver will keep doors locked in stop/go traffic; Seat belts must be worn; A minimum break of at least 15 minutes after every two hours of driving is recommended and a 45-minute break taken after any continuous driving period of 4.5 hours (periods of less than 15 minutes do not count towards the 45 minutes break requirement); The driver should take a continuous rest period of at least 11 hours in any 24-hour period and only drive for a maximum of 9 hours in any 24-hour period subject to a 56-hour weekly maximum; Care should be exercised to ensure that alcohol consumed on the previous day does not affect driving performance;		Low-Med

		University accident reporting procedures.		
General safety issues at locations being visited	Staff	Premise / site / activity safety procedures / instructions to be followed at all times; Any safety equipment provided by staff at premise must be used as directed Attendees to familiarise themselves with the location of fire escape routes particularly in overnight accommodation; University accident reporting procedures.	Any activities that are undertaken as an addition to those outlined before the trip begun, must be assessed prior to them starting.	Low
Personal safety (general) *Physical and/or verbal assault, leisure time activities*	Staff	Research area to be visited if unfamiliar including areas/locations you should avoid., identify safest travel form, routes, location of stations, car parks, etc.; Carry a mobile phone to raise the alarm if necessary; Carry a personal alarm (available from Harrington Security Lodge).	**Out of Hours:** Security (24-hour security lodge) holds a cascade list of senior staff within the University: 01772 892068.	Low
Slips trips and falls	Staff	Wear footwear suitable for the conditions; Particular care should be used when crossing unfamiliar / dimly lit areas, car parks, etc.		Low
Environmental conditions (weather)	Staff	Consult daily weather forecast for the area before setting out; Wear clothing suitable for the expected weather conditions, be prepared for sudden changes		Low
Transporting data from offsite locations	Staff	Data and consent forms should not be left unattended at any time. They should be kept out of sight and when not in transportation locked in a secure filing cabinet. Any data and the consent forms should be transferred to a secure filing cabinet at the university as soon as possible. Any electronic data should be encrypted.		Low
Lone Working	staff	•Leave details of the field site, work schedule and contact detail with supervisors and/or school office prior to any trip. •Specify dates and times of departure and return; •Where possible carry a mobile phone; • Carry a personal alarm when on site at the services if manager of services reports this is required.		Low

APPENDIX 17-POSTER ADVERT FOR THE WELLBEING TRAINING

Date: July 2017
Version number: 1

uclan
University of Central Lancashire

You are invited to come along to a 2 day staff wellbeing training programme as part of the study:

Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout

Date: TBC

Time: TBC

Location: Training room at …….

Please contact Zoe Posner (PhD student) for more information or to register your interest via email at ZPosner@uclan.ac.uk

APPENDIX 18-FOLLOW UP LETTER OF INVITATION FOR THE WELLBEING TRAINING

Date: July 2017
Version number: 1

University of Central Lancashire

Follow up Letter

Exploring the experience of mental health staff in wellbeing training to improve their mental toughness and burnout

Researcher: Zoe Posner (PhD Student)
Academic Supervisors: Dr Jessie Janssen and Dr Hazel Roddam

Hopefully you will have recently received information regarding the above study inviting you to take part.

I am writing again to remind you of this invitation as we have not heard back from you regarding whether you would like to participate. I have enclosed the information again for your convenience.
I would like to remind you that it is completely up to you whether you take part or not. It will not affect any future relations with the University of Central Lancashire or your current job role.

If you would like to take part please email me at ZPosner@uclan.ac.uk

If you would like to discuss this further you can contact either myself on the above email or alternatively my supervisors Jessica Janssen via
Tel: 01772 89 4560 or Email: JJanssen@uclan.ac.uk
And Hazel Roddam via
Tel: 01772 89 5484 or E-mail: HRoddam@uclan.a.c.uk

Thank you for your time,

Yours Sincerely

Zoe Cartwright
PhD Student
University of Central Lancashire

APPENDIX 19-INTERVIEW QUESTIONS (DIRECTLY AFTER THE TRAINING)

Zoe Posner Attachment 3

Semi-structured interview questions

Interviews one week following the training:

1) Can you tell me a little bit about your job? (what do you do?, what sort of patients do you work with?)

2) Can you tell me why you wanted to attend the training?

3) Which aspects do you find difficult/challenging in your work?

4) What effects did the training have on the aspects you find difficult at work?

5) Can you think of something that has happened in the last month, that may have been challenging (you don't need to tell me this, just think of this as an example) can you describe anything you may do differently now because of the training if this happened again?

6) Can you describe the experience of being involved in training to improve your own wellbeing?

7)) Which aspects of the training were most helpful to you? Describe what made this helpful/important and what you got out of it?

8) Can you describe any other impacts the training has had on you or your service?

9) How would you describe the training to someone else?

10) Is there anything else you would like to tell me regarding this topic?

11) Your comments and answers have been useful and will be anonymised and used in my research, are you happy to include everything that we have talked about today?

APPENDIX 20-INTERVIEW QUESTIONS (AT THE 3 MONTH FOLLOW UP)

Semi-structured interview questions

3 month follow up:

1) Last time you told me about your job, has anything changed in the last 3 months?
2) Can you tell me why you wanted to attend the training 3 months ago?
3) Can you describe any aspects of your work you still find difficult or challenging?
4) What effects did the training you attended 3 months ago have on the aspects you find difficult/challenging at work?
5) Can you think of an example of something that has happened in the past 3 months, that may have been challenging (you don't need to tell me this, just think of this as an example) can you describe anything you did differently because of the training?
6) Can you describe the experience of being involved in training to improve your own wellbeing?
7) Which aspects of the training are most helpful to you now? Describe what made this helpful/important and what you got out of it?
8) Can you describe any other impacts the training has had on you or your service over the past 3 months?
9) How would you describe the training to someone else?
10) Is there anything else you would like to tell me regarding this topic?
11) Your comments and answers have been useful and will be anonymised and used in my research, are you happy to include everything that we have talked about today?

Code Book for interviews

Interviews directly after the training

	Core codes	Sub-codes
A	Motivation- to make positive changes in life to better their wellbeing	**MOT1:** Motivation to make staff wellbeing a priority **MOT2:** Motivation to talk about wellbeing **MOT3** Motivation for change at work **MOT4:** Motivation to use the coping strategies
B	Wider applicability- of the training and the techniques	**WA1:** Wider applicability of training for service-users **WA2:** Wider applicability of training at work **WA3:** Wider applicability of training outside of work
C	Most Helpful Technique- the techniques that were reported as most helpful	**MHT1**: Most helpful technique was relaxation **MHT2**: Most helpful technique was goal-setting **MHT3**: Most helpful technique was positive thinking
D	Challenges at work- the difficulties and challenges the staff reported at work and in their job	**CHA1:** Challenging not to be affected by service-user feelings and problems. **CHA2:** Challenging to keep up with large amount of paper work. **CHA3:** Challenging work load demands and pressure. **CHA4:** Challenging to switch off and relax after work **CHA5**: Challenging to deal with service-user behaviours **CHA6:** Challenging to deal with stress at work **CHA7:** Challenging to be restricted to job role
E	Relaxation/relaxed	**REL1:** Relaxation techniques were most helpful technique **REL2:** The training environment was relaxing **REL3:** The delivery of the training was relaxed **REL4:** Relaxation helps think better/sharper
F	Benefits- the different people the staff reported the training could benefit	**BEN1:** Benefits to the staff **BEN3:** Benefits to the service-users **BEN4:** Benefits to the organisation
G	Mental toughness and burnout- how mental toughness and burnout affect staff wellbeing	**MTB:** The link between mental toughness and burnout **MTB:** Becoming mentally tougher **MTB:** Preventing burnout

H	Experience- of being involved in the training	**EXP1:** Feelings from the experience of the training (e.g, feeling valued by organisation, like their wellbeing was important) **EXP2:** Description of their experience in the training (e.g. relaxing experience)
I	Reminders- being reminded of the training is useful	**REM1:** Reminders of the training through using techniques daily at work **REM2:** Reminders of training through regular wellbeing training **REM3:** Reminders of training through refresher sessions **REM4:** Reminders of the training through writing it down and using wellbeing file
J	Delivery- of the training by PhD student	**DEL1:** Delivery informal **DEL2:** Delivery practical **DEL3:** Delivery relaxed **DEL4:** Delivery structured
K	Change thinking patterns- think more positively	**CTP1:** Turn negative thoughts into positive thoughts **CTP2:** Think positively/self-belief
L	Link between STAFF wellbeing and SERVICE-USER wellbeing	**SSU1:** Staff stress levels effects how work with service-users (work in a more negative way) **SSU2:** Staff wellbeing effects relationships with service-users. **SSU3:** Staff wellbeing effects work productivity with service-users (stress causes reduced productivity)
M	Comparison of other training	**COM1:** Compared to other training this was informal **COM2:** Compared to other training this had purpose **COM3:** Compared to other training this was relaxed **COM4:** Compared to other training this was suitable for different levels
N	Mind and body- connection between mind and body/physical feelings	**MB1:** Connection between physical body and feelings (e.g. stretching and stress) **MB2:** Visualisation and physical movement (e.g. visualise stress and physically shake away from body) **MB3:** Body, mind and biology (hormones) connection. (e.g. Power poses reduce cortisol and make feel better)
O	Team benefits	**TEAM1:** Team benefited as provided opportunity to discuss work **TEAM2:** Team benefited as provided team bonding/building opportunity **TEAM3:** Team benefited as provided opportunity to think and talk about each other's wellbeing
P	Confidence	**CONF1:** Confidence in abilities **CONF2:** Interpersonal confidence

Code Book for interviews at the 3 month follow up

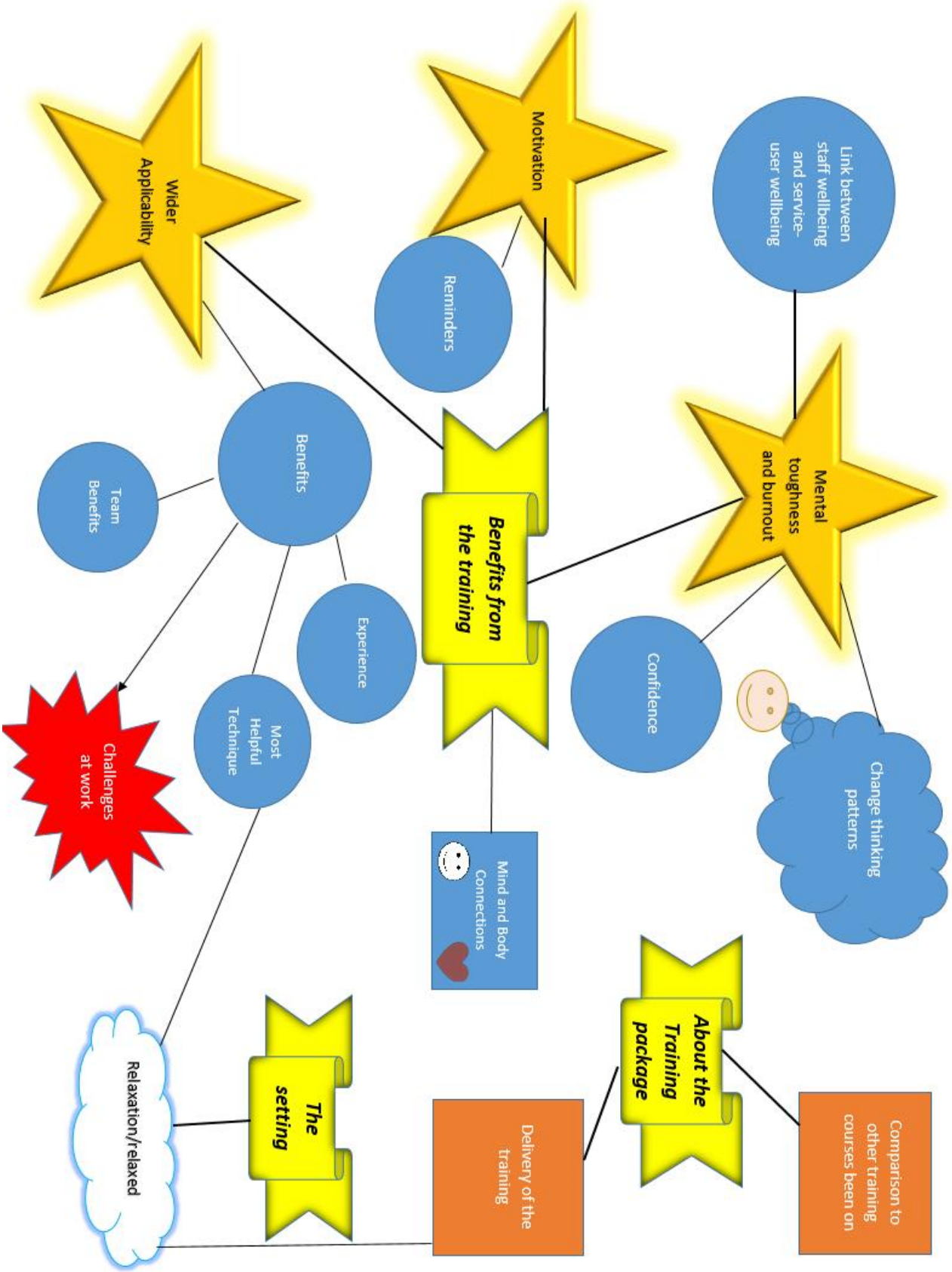
	Core codes	Sub-codes	Comments
A	Taking a step back-from stressful situations at work	**STEP1:** Stepping back from stressful situations helps reflect/make better decisions **STEP2:** Stepping back gives time to problem-solve better **STEP3:** Stepping back reduces stress and anxiety **STEP4:** Stepping back allows communication/be open with others that can help **STEP5:** Stepping back from stress is not a negative or weak action **STEP6:** Others might think you are avoiding situations if step back	
B	Practical techniques and wellbeing conversations/reflections-equally important	**EQUAL1:** practical side of the training (learning the techniques) was equally as important as having the time to talk and think about wellbeing **EQUAL2:** Talking about wellbeing might not be enough to improve wellbeing long term. **EQUAL3:** Practical techniques on their own might not be enough to improve wellbeing	
C	Time and space away from work	**TIME1:** Training allowed time away from usually work routine **TIME2:** Training might not as effective if had it at work place.	Overlaps with setting of the training
D	Mental Toughness	**MT1:** Mental toughness working in mental health is beneficial **MT2:** Knowing how to be mentally tough is useful **MT3:** Didn't know what mental toughness was **MT4:** Mental toughness might prevent burnout **MT5:** Descriptions of mental toughness	This core code came up in interviews immediately following training and follow up.
E	Burnout	**Burn1:** Burnout more quickly if don't take time for self **Burn2:** Burnout in mental health services as minimal focus on staff wellbeing **Burn3:** Burnout due to long shifts **Burn4:** Burnout due to stress and pressure at work **Burn5:** How burnout can make you feel	This core code came up in interviews immediately following training and follow up.

F	Relaxation	**REL1:** Used relaxation at home **REL2:** Used relaxation at work **REL3:** Used relaxation with service-users **REL4:** Easier to remember relaxation than other techniques **REL5:** Easier to use relaxation techniques even when busy	This core code came up in interviews immediately following training and follow up
G	Self-aware: of own wellbeing	**Self1:** Self-aware of how feeling/stress **Self2:** Self-aware of own signs/triggers/causes of stress	
H	Remembering difficult- remembering the techniques and remembering to use these	**REM1:** Remembering the techniques can be difficult **REM2:** Forget to use the techniques when might have helped **REM3**: Need ways of remembering- e.g acronyms **REM4:**Reminders useful	
I	Wider applications of training outside of work	**WA1:** Use techniques at home **WA2:** Use techniques on journey travelling to and from work **WA3**: Able to communicate better about stress to family **WA4**: Better work-life balance **WA5**: Not always enough time after work to apply techniques	This core code came up in interviews immediately following training and follow up.
J	Wider applications of training with service-users	**SU1:** Use wellbeing/teach techniques with service-users **SU2:** Use techniques to cope better with service-user's behaviours **SU3:** Use techniques to not be negatively affected by service-users feeling/problems. **SU4:** Staff wellbeing linked with service-user wellbeing	This core code came up in interviews immediately following training and follow up.
K	Change thinking patterns- think more positively	**CTP1:** Turn negative thoughts into positive thoughts **CTP2:** Think positively/self-belief	This core code came up in interviews immediately following training and follow up.

N	Changes/implementation to the service/culture-following the training	**CHANGE1:** Talked about staff wellbeing in meetings **CHANGE2:** Yoga sessions for staff **CHANGE3:** Yoga sessions for service-users **CHANGE4:** Perceptions of staff wellbeing changed (less taboo)	
O	Control-feel more in control of stress and pressure at work	**CON1:** Feel in control of work **CON2:** Feel in control of keeping well **CON3**: Feel in control of emotions	
P	Confidence	**CONF1:** Confidence in abilities **CONF2:** Interpersonal confidence	This core code came up in interviews immediately following training and follow up.
Q	Wider service/team	**TEAM1:** Relationships made with staff from other services/made friends **TEAM2:** Wider support network outside of own service **TEAM3**: on a different page to other services that didn't go, might be difficult when only certain services have had this training	This core code came up in interviews immediately following training and follow up.
R	Delivery of the training	**DEL1:** Delivery inclusive **DEL2**: Delivery practical **DEL3:** Delivery relaxed **DEL4:** Delivery-easy to understand	This core code came up in interviews immediately following training and follow up.
s	Setting of the training	**SET1:** Environment allowed for no distractions **SET2:** Setting was comfortable **SET3:** Setting was calm **SET4:** Nice environment made feel valued by organisation	This core code came up in interviews immediately following training and follow up.

APPENDIX 23-MENTAL REPRESENTATION OF CODES

(stage in the analysis process, not final version of thematic analysis)



Benefits from the training

'Motivation' (to make positive changes in life to better their wellbeing) is a main code as this was the most talked about and recurrent topic during the interviews. 'Reminders' (being reminded of the training is useful) is linked to motivation as the staff reported that reminders would help them to maintain high levels of motivation to take care of and prioritise their wellbeing.

'Wider applicability' is a main code as each participant talked about how they could and would use the training and techniques. Linked to this code is 'benefits' as this refers to the different people the staff reported the training could benefit. The code 'benefits' could incorporate the codes 'team benefits', 'experience' and 'most helpful techniques' as these contain sub codes that overlap. 'Challenges at work' links to 'benefits' as a benefit of the training is that it helps with the challenges at work the participants described.

'Mental toughness and Burnout' is a main code, although not talked about by every participant, those who did talk about it talked in detail. 'The link between staff wellbeing and service-users wellbeing' code could be categorised under this main code as participants talked about a mental toughness, burnout and wellbeing in staff linked to service-users. The code 'confidence' and 'change thinking patterns' could also be linked to this main code as confidence is a main component of mental toughness and positive thinking if one of the tools and techniques that can help improve mental toughness.

'Mind and Body connections' is a code that does not appear to fit into or link with the other main codes as the sub codes are all different.

About the Training Package

'Delivery of the training' has not been put in a star as it does not seem to share the same significance as the other main codes. It was not talked about as much by the participants. This code does link to 'relaxation/relaxed' as the delivery on a few occasions was described as 'relaxed'.

'Comparison to other training courses been on' differs to 'delivery of the training' as it specifically identifies clear differences between this training and other training courses. The 'delivery of the training' is specific to and only describes this training.

The setting

'Relaxation/relaxed' was talked about by participants and was mainly referring to the actual training environment being relaxing. It also refers to the delivery of the training being relaxing and the relaxation techniques being helpful. Therefore, the code 'relaxation/relaxed' also links to 'delivery of the training' and 'most helpful technique'.

APPENDIX 24 - Supervisory meeting extracts (for the development of themes)

Supervisory meeting extract: Wednesday 28th February 2018 10.00am-11.30am

"The main part of the meeting we spent on comparing codes from Zoe's and Jessie's coded RB transcript and found that there was a great overlap. Zoe will now continue to transcribe the last two interviews and then start coding the remaining transcripts. She will first do this on paper and keep a log book and afterwards she will put these into NVivo for further analysis. She is well on her way. For the next meeting Zoe will provide us some of the main codes and will give some examples of the quotes associated with this as another way of validating her findings."

Supervisory meeting extract: Monday 30th April 2018 10.00am-11.00am

"I discussed the development of themes from the interviews in detail during this supervision meeting. How the themes differed to one another and if there was any overlap was discussed together. We discussed the organising themes today and agreed that self, inside the service and outside the service were appropriate and that the global theme staff perceptions from the training would also be appropriate."