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Abstract

Background

Limited research explored the professional wellbeing of mental health practitioners until COVID-19, and community mental health practitioners caring for children and young people have received little attention.

Aim

To develop an understanding of workplace wellbeing in a community setting to inform workforce wellbeing and retention strategies.

Method

This is the first mixed methods study of workforce wellbeing with a children's community-based mental health team operating within a new integrated mental health Hub, combining quantitative analysis of Professional Quality of Life data with a content analysis of survey and interview data.

Findings

Findings emphasise the importance of attachment-focused safe-base support for creative coping. Emotionally engaged leadership enhanced team resilience, and multi-level skills modelling nurtured team spirit and professional growth.

Conclusion

Safe-base emotionally supportive leadership that promotes skills development, operational support, team spirit and peer-led sharing of skills helped the team remain cohesive and resilient throughout very challenging working conditions during a UK winter lockdown.

Keywords: workplace wellbeing, compassion satisfaction, healthcare, burnout, secondary traumatic stress

Practitioners' Wellbeing within a Novel Community Mental Health Hub for Young People

The importance of workplace wellbeing has been amplified throughout the COVID-19 pandemic, particularly for frontline workers (Wong et al. 2020; Parry et al. 2021). For a workforce to experience workplace wellbeing, they need safe and supportive environments in which they can flourish and experience fulfilling satisfying work (Schulte et al. 2015). The integral role of nurses in mental health has been highlighted during the COVID-19 pandemic, with attention to wellbeing starting from the beginning of training, as it is recognised the wellbeing of trainee nurses will impact their academic and practice success (Juanamasta, et al., 2022). However, overvalued metrics and administrative burden are cited as barriers to therapeutic engagement and contributing factors to work-related stress (Bifarin, et al., 2022).

In general, mental health workers report lower levels of job satisfaction and higher levels of work-related stress and burnout compared to other professions (Walsh & Walsh 2001; Lloyd et al. 2002; Dollard et al. 2012;). These professional risk factors can influence their global quality of life and patient outcomes (Priebe et al. 2004; Grandey et al. 2012; Coates and Howe 2015;;). For example, emotional exhaustion amongst mental health practitioners working with young people has been found to reduce productivity and increase fatigue-related mistakes (Coates & Howe 2015). These findings are mirrored across the health sector as a culture of putting others first and long working hours have been directly associated with poorer decision-making, and increased risk to healthcare professionals and patients alike (Greig & Snow 2017).

The community mental health workforce usually provide face-to-face support, employing active empathetic listening, ensuring care continuity and the timely provision of

support. They frequently lead on critical decision-making, risk assessment and management within environments that often present structural and procedural uncertainties (Sancassiani et al. 2015). Although therapeutic interactions can be characterised by satisfaction and joy, they can also involve feelings of frustration and disappointment, often due to resources not being equitable to needs, which means practitioners are not always able to provide the optimum service they strive for (Priebe & Reininghaus 2011; Sancassiani et al. 2015). Over time, exposure to stress and distress can lead to depersonalisation, staff burnout and reduced workplace wellbeing (Wykes et al. 1997; Brotheridge & Grandey 2002; Carpenter et al. 2003; Mann 2004; Evans et al. 2006; Lasalvia et al. 2009;). Without suitable support for staff, the sustainability of care models reliant on workforce selflessness and emotional labour is jeopardised, resulting in preventable human and financial costs (Wykes et al. 1997; Parry, 2017).

Risk factors for mental health practitioners include role ambiguity, complex bureaucratic processes, and a lack of consistency between the personal values of practitioners and employing organisations associated with burnout (Leiter & Maslach 2000; Lewandowski, 2003; Veage et al. 2014; Coates and Howe 2015). In contrast, effective team working, group cohesion, freedom for emotional expression between colleagues, and valuing one's work can act as protective factors (Onyett et al. 1995; Reid et al. 1999; Lasalvia et al. 2009; Grandey et al. 2012; ;; Sancassiani, 2015).

Additional pressures have been placed on healthcare services resulting from the COVID-19 pandemic (Hennein & Lowe 2020), which is why it is imperative to acquire insight into the experiences of multidisciplinary community mental health staff who have been under-researched thus far but will play a vital role in post-COVID recovery and the increasing

demand for mental health services (McGorry et al., 2022). It is now widely accepted that collaboration across children and young people's services will be required to establish alliances of support to promote and preserve young people's mental health as we emerge from the pandemic and its true mental health impact upon young people is revealed (Hoagwood et al. 2021). Brief early interventions delivered to young people in the community will be an essential part of the recovery jigsaw (Galea et al. 2020) and will most likely be delivered by the community mental health workforce.

The current article provides a unique and timely insight into the workings and wellbeing of such a workforce during the second UK lockdown in the winter of 2020-2021. Over a four-month period, eleven members of staff working in a community mental health service were surveyed. The Hub was designed to trial a collaborative community approach to brief early intervention for children and young people aged 8-18-years experiencing mental health difficulties.

Aim

The aim of the study was to explore factors affecting practitioner wellbeing within the Hub environment, with the objective of developing recommendations as to how a Hub model could provide novel learnings for the mental health workforce through a mixed methods approach.

Methods

Design

Following consultations with the leadership team of the Hub and an initial literature review of integrated community health hubs, demographic and open-ended questions were developed. As workplace well-being is a distinct phenomenon from general well-being and should therefore be measured by a suitably sensitive instrument (Summers et al. 2021), we asked the staff team to complete the self-report Professional Quality of Life Scale (ProQOL; Stamm, 2016). The ProQOL assesses burnout, secondary traumatic stress, and compassion satisfaction.

Participants and Procedure

All eleven members of the staff team took part (8=British, 1=Bangladeshi, 1=Bengali; F=10, M=1, NB=1) and the mean age of participants was 31 years old (SD=11.594, range=22-61). All participants had a university degree, three participants had also completed a postgraduate degree. The majority of participants lived with other people (n=9). All of the participants who reported living with other people lived with an adult or adults (aged 19-74 years), three participants also lived with an adolescent or adolescents (aged 12-18 years) and one participant lived with children (aged 3-12 years). No participants lived with infants (aged 0-2 years), older adults (aged 75 years or over) or an individual with a registered/diagnosed disability.

All staff members were invited to complete the survey and an interview. All 11 staff completed the survey and three members of the team also volunteered to take part in an

individual semi-structured interview through secure teleconference software (Microsoft Teams). The same open-ended questions were asked in the survey and individual interviews to acquire additional insights. Individual members of the team were invited to approach the research team to preserve their confidentiality and anonymity as much as possible. Participants were also invited to provide a pseudonym so that they could identify their quotes in a service evaluation report. Those pseudonyms have been numericized in this article to further protect their anonymity.

Ethical Considerations

The research was approved by the Health Research Authority and an academic Research Ethics Committee.

Analysis

Statistical Analysis

Descriptive statistics were sought for each of the three subscales of the ProQOL. Histograms were examined to investigate whether scores on the compassion satisfaction, burnout and secondary traumatic stress (STSS) subscales were normally distributed. as histograms can be unreliable with small sample sizes, normality tests assessed whether ProQOL subscale scores were normally distributed.

Content Analysis

Content analysis is most often employed to analyse written qualitative data, which is why it was selected as the analytic tool for the open-ended survey data. As only three interviews were undertaken, the interview data were also coded within the content analysis matrix, developed from evaluative categories and emerging analytical categories. Within the survey itself, there were six concept categories, which are researcher-led predefined categories developed from the initial review of the literature and consultations with the staff team. In parallel to the deductive analysis for predefined categories, analytical categories were identified from an inductive analysis from participants' survey and interview data, which were further developed throughout the analytical process by two members of the research team.

A thematic matrix was developed to synthesise the concept and analytical classifications and categories. To prepare the data, classifications and categories were tabulated in the matrix, with coding led by characteristics of theoretical interest. Text passages were then written, which included direct quotes to remain close to the data, to inductively explore emerging themes. Finally, an analysis of the categories within the emerging themes formed the final synthesis (adapted from Kuckartz 2019).

Results

ProQOL Subscale Summary

The staff team overall demonstrated high levels of compassion satisfaction and low levels of compassion fatigue (Table 1).

<INSERT TABLE 1>

Inferential statistics

Shapiro-Wilk tests were non-significant ($p>0.05$) suggesting that scores on all three subscales were normally distributed (Table 2).

<INSERT TABLE 2>

A one-sample t-test was conducted to investigate whether the average compassion satisfaction score in this sample is significantly different from 42, a score indicative of high professional satisfaction. Overall, participants in this sample displayed high levels of compassion satisfaction, low levels of burnout and particularly low levels of STSS. These results were further supported by the results of the one-sample Wilcoxon signed rank tests. No significant relationships were found between compassion satisfaction, burnout and STSS scores using Spearman's Rho correlation and Pearson's correlation.

Employing Spearman's Rho correlation, a significant negative relationship was found between age and burnout scores, suggesting that older participants displayed lower levels of burnout compared to younger participants. Participants aged 29 or under had significantly higher burnout.

Another new variable was created to split participants into two groups based on their annual income (less than £26,000 annual income; £26,000 or more annual income). Participants who had an annual income of £26,000 or above, which is close to the UK household average income (Office for National Statistics, 2020), were grouped together to examine whether their scores differed from those of participants with an annual income lower than the national average. Lower income participants had significantly different

ProQOL scores compared to participants with an annual income higher than the national average.

Participants were also split into two groups based on their employment type and participants who worked full-time had significantly higher burnout scores than participants who worked part-time (part time only or part-time and self-employed): $t(9)=2.555$, p=.031; $U=3.500$, p=.042. This significant difference suggests that those who work part-time (part time only or part-time and self-employed) display significantly lower burnout levels compared to those who work full-time, thus exposure to workplace stressors may be important to consider.

Content Analysis

Within the content analysis, there were 48 classifications that led to 12 categories: six conceptual categories and six data-driven categories. These categories were then synthesised to form seven emerging thematic categories and then three themes (Table 3).

<INSERT TABLE 3>

Theme 1: A dynamic, developing, imperfect Hub… with great potential

The Hub is a pilot service developing over time with few opportunities for comparison across the sector. Consequently, the staff team described uncertainty as to what the Hub is now and what it might become. However, they did not describe that this uncertainty affected their wellbeing. Rather, the unique offer of the Hub for the local community and optimism as to what it might be able to achieve appeared to support hopefulness. One of the aspects of the Hub that provided staff with satisfaction in their work was the 'feel' of the Hub; the

friendliness and relaxed nature, which may have been supporting, and being supported by, the wellbeing of the staff team.

Theme 2: Safe base, safe space, collaborative support

A key factor for the wellbeing of the Hub team was the support they provided for each other. Within the peer support system was a freedom to be emotionally vulnerable without prejudice and to receive empathic collegiate support. The line management system provided emotional support and guidance, as well as opportunities to seek formative advice and guidance to refine skills, which informed professional growth. Overall, participants described a safe space in which to work and a safe base from which to grow professionally to enhance the quality of the service.

Theme 3: Bridges for resilience and working within the walls of the service

Despite the relatively high level of qualifications already gained by participants, a consistent category that emerged throughout the accounts was that of wanting further training. There was a clear and apparent drive amongst participants to enhance and improve the quality of care provided to clients of the service. This drive for service quality ran in parallel with a struggle against the constraints of working in a brief intervention service and was exacerbated by the perception of increasingly complex referrals. In this sense, the nature of the service, demand for care and contentiousness of the staff team were working against each other. The outcome appeared to be that staff wanted to enhance their skills to meet the young people's needs within the time allocation the Hub model affords. In summary, training and skills development held the promise of building bridges between the current status quo and a hope of being increasingly able to support children with significant difficulties. This hopefulness for the future, optimism for service- and self-development helped participants

generate a helpful perspective about what they could and could not offer within a valued service. There is a noticeable absence in the literature about the staff experience of providing brief interventions, which seems to be an important area in need of research attention.

Discussion

A combination of a routinely used professional quality of life measure in addition to written and spoken qualitive data has provided important novel insights into an under-researched but vital workforce, who are likely to be integral to young people's mental health in the pandemic recovery. Overall, the ProQOL demonstrated the Hub staff team report high levels of compassion satisfaction and low levels of compassion fatigue. In terms of risk factors to wellbeing, younger members of the team appeared to be more at risk of burnout than their more senior colleagues. This contrasts with the nursing literature, where ProQOL scores have shown that those with a longer period of service as a psychiatric nurse experienced higher levels of secondary traumatic stress symptoms (Lauvrud et al. 2009). However, mental health nurses working in an adolescent psychiatric intensive care unit demonstrated similar results on the ProQOL as our sample, with a higher-than-expected compassion satisfaction score overall and lower than expected reported burnout and secondary traumatic stress (Foster, 2019). Further mixed methods and qualitative work would be helpful to understand why these discrepancies exist and how support mechanisms can be embedded into useful and relevant workplace wellbeing initiatives.

The uncertainty surrounding what the Hub would be in years to come and possible anxiety this could have caused appeared to be offset by the secure base support offered within the team. Wu and Parker discuss how "secure-base support" from leaders can facilitate

staff members' ability to explore options, new working environments and tolerate uncertainty (2014, p.4). This positive influence of secure-base support appeared relevant and apparent for the Hub staff, who were able to collaboratively harness the secure-base support to work flexibly and creatively around a system "that's designed to do something else but we bought into it and kind of are bending ourselves to meet it, than it working for us". In the same way that: "the treatment relationship also provides a secure base from which the client can make the necessary changes for a greatly expanded repertoire of self-capacities and relational skills" (Pearlman and Courtois 2005, p.457), the staff team were also able to use the secure-base support they felt they had from the leadership team to advance their own skills, which seemed to support their sense of professional growth and workplace satisfaction.

Strengths and Limitations

This small-scale study offers unique insights and recommendations for workforce wellbeing for community mental health workers, although of course also embodies a number of limitations. The sample was largely white British and female, which means findings should be interpreted with some caution. However, 80% of the UK's non-medical health workforce is female (NHS 2008) and 77.9% of NHS staff are White, which has led to calls to better support people of Black, Asian and Minority Ethnic groups to enter the healthcare professions (NHS 2020). Therefore, our sample shares similar characteristics with the current mental health workforce. Another recognised limitation of this small-scale study was the sample size, which is why multiple inferential statistical methods were employed

Finally, there are often risks in terms of data quality with self-report measures, although the research team had a designated contact point for any queries from staff in relation to the

survey, interviews and ProQOL so that participants could quickly and easily access support if required. The research team also held regular digital drop-ins so that staff could talk through the research process and raise any queries or concerns. A potential strength of this study is that the content analysis facilitated the development of both deductive and inductive themes, reflecting priorities for exploration set by service stakeholders, as well as eliciting experience-based perspectives from participants. This method could be helpful in future healthcare research to explore priorities of services and stakeholders, whilst attending to personal accounts of lived experience.

Conclusion

In summary, safe-base emotionally supportive leadership that promotes skills development, operational support, team spirit and peer-led sharing skills initiatives helped the team remain cohesive and resilient throughout very challenging working conditions. Tentatively, these features also appeared to enhance professional growth and contribute to the reported wellbeing of this workforce and could be adopted by mental health teams to nurture wellbeing at work.

Implications for practice

1. The staff team described a three-tier approach to supporting their own wellbeing. Operational support involved weekly team meetings to enable a shared point of contact and reference point, as well as a clinical support group with clinicians from the local health service who could provide reassurance and specialist guidance as needed.

2. There were also a number of team building initiatives which could be informal (e.g. shared cups of tea, adding humour to online chat spaces, helping each other with ad hoc administrative tasks) or formal (e.g. designated 30-minute lunches to ensure everyone could have a break and time together) and nurtured a sense of belonging and camaraderie.
3. Additional opportunities arose for implicit learning through time together and fortnightly skill sharing meetings, alongside explicit skills training through attendance at training events together.
4. Although the team wanted further training and perhaps recognition of their developing skill set, they were conscious of the platforms they had created for themselves to continue their professional development and growth, which further enhanced their job satisfaction and workplace wellbeing.
5. Based on our findings, key points for practitioner wellbeing in a mental health setting include:
    - Optimism for what the service might achieve for the population it serves appeared to compensate for uncertainty and facilitated hopefulness. Nurturing optimism, faith in service potential and hopefulness through transformational service development and leadership could support the wellbeing of frontline mental health practitioners.
    - Leadership promoted a culture through which continued learning was encouraged, which dispelled expectations of 'all knowing'. Consequently, curiosity and creativity could be maintained, promoting wellbeing and professional growth simultaneously.

- Access to professional training could not only develop professional sills in the short-term, but create a sense of hope for future achievements and positive outcomes, even when needs outstripped resources in the here and now.
- Mental health practitioners with lower household incomes may require further support for their wellbeing.
- Working part-time in a face-to-face role could pace the undertaking of therapeutic support, which may be a protective factor.

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