Processing People!

The Purpose and Pitfalls of Case Management Supervision Provided for Psychological Wellbeing Practitioners,

Working Within Improving Access to Psychological Therapies (IAPT) Services:

A Thematic Analysis

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Abstract

The spread of Improving Access to Psychological Therapies (IAPT) services in the National Health Service (NHS) in England required a new role called a Psychological Wellbeing Practitioner (PWP). The PWP role was envisioned as a frontline position requiring substantially less training than practitioner psychologists, to deliver brief evidence based therapy techniques. PWPs partake in what is called case management supervision (CMS), designed in order to support their unique role. The aim of this qualitative study is to ascertain PWPs understanding and experiences of the case management supervision they partake in. Data was collected by conducting semi-structured interviews with eight PWPs. Interviews were recorded, transcribed and investigated using Thematic Analysis (Braun & Clarke, 2006), which was used to identify recurring patterns of meaning, or themes, in the data. Three main themes were identified by the researcher including: *'Part of the IAPT Machine'*, *'Pitfalls of CMS'*, and *'Serving a Purpose'.* These themes illustrate expectations of, struggles with and implicit realisations about the role that CMS has within the broader remit of IAPT services. The findings of this study are discussed in relation to existing literature, current developments and personal observations about the PWP role, whilst also corresponding, more broadly, to the social and political positioning of IAPT services.

List of Abbreviations

BABCP - British Association for Behavioural and Cognitive Psychotherapies

BACP - British Association for Counselling and Psychotherapy

BPD – Borderline Personality Disorder

BPS – British Psychological Society

CBT – Cognitive Behavioural Therapy

CMS – Case Management Supervision

CoP – Counselling Psychology

DBT – Dialectical Behavioural Therapy

DOH – Department of Health

GMHW - Graduate Mental Health Worker

GP - General Practitioner

HI – High Intensity

IAPT -Improving Access to Psychological Therapies

NHS – National Health Service

NICE - National Institute for Health and Clinical Excellence

PCMHW - Primary Care Mental Health Worker

PWP – Psychological Wellbeing Practitioner

TA – Thematic Analysis

UCL - University College of London

Literature Review

Development of IAPT

In 2006, the Layard et al. (2006) report was published and the Labour government at the time responded by introducing Improving Access to Psychological Therapies (IAPT) programmes (Clark, 2011). Initiation of these services was predominantly in response to an economic case (Rizq, 2012a). IAPT services were also designed to make psychological therapies more widely available as an alternative or supplement to medication, to facilitate the treatment of common mental health problems such as anxiety and depression (DoH, 2012).

The introduction of IAPT was the result of two 'demonstration sites', which were pilot services during 2006/7. In one of these sites (Doncaster), psychological therapies were delivered using a stepped care organisational protocol (Richards & Suckling, 2008). Based on National Institute for Health and Care Excellence Guidelines (NICE, 2011b), people who access IAPT depression and anxiety services are offered treatment using a stepped-care approach. 'Stepped-care' refers to a model by which people receive the least intensive intervention for their needs (NICE, 2011b). Richards et al. (2010) state there are two reasons for stepped care: Firstly, it ensures the 'least burdensome treatment' for both patient and service. Secondly, it also makes sure that treatments of varying intensity are offered according to patients' needs.

Delgadillo, Gellatly, & Stephenson-Bellwood (2015) describe stepped care as a 'feasible and effective model'. Although, the notion of offering patients the 'least burdensome treatment' when they engage with services (Richards et al., 2010) may be viewed as a cost saving exercise for IAPT, rather than a practice motivated by prioritising the needs of patients.

IAPT services have now been established in 95% of primary care trusts across England (Clark, 2011). Following the economic case put forward by Layard et al. (2006), a reported £170m of government funding was given for IAPT programmes, in order to help treat people suffering with anxiety and depression (Samuels & Veale, 2009). The evolution of IAPT services in the National Health Service (NHS) in England pioneered new therapeutic roles, specifically in the modality of Cognitive Behavioural Therapy (CBT). Between 2008–2011, a reported 3600 new psychological therapists (60% high-intensity CBT therapists, 40% PWPs)

were trained to provide 900,000 people access to psychological therapies, that otherwise would not have had access to a service (Clark, 2011). It was estimated that by 2011, 25,000 people would no longer be claiming sick pay and benefits as a direct result of accessing IAPT services (Richards & Borglin, 2011). A further 2,400 new psychological therapists were forecast to be trained between 2011 and 2014 (Clark, 2011).

The current IAPT workforce consists of step 2 and step 3 workers within the stepped care approach. Step 2 psychological wellbeing practitioners (PWPs) or low intensity workers (LI) provide low intensity CBT treatment and assessments at a high volume, for mild to moderate depression and anxiety (Richards & Whyte, 2009). PWP work centres around guided self-help, or brief face-to-face psychological interventions (up to seven sessions) as recommended by the National Institute for Health and Care Excellence (NICE, 2011a).

The term ‘step 3 worker’ refers to a high intensity (HI) CBT therapist who offers therapy to people who have more severe depression or anxiety, or for people whom low intensity treatment has not been sufficient (Green et al., 2014). HI workers can provide up to 20 therapy sessions, normally on a face-to-face basis. Glover, Webb & Evison (2010) identified that some IAPT services offer step 3 high intensity counselling; others, due to a lack of resources, may only offer CBT as HI treatment. The introduction of IAPT services has provoked many varied reactions in the therapeutic field, specifically in counselling psychology there has been arguments for the introduction of IAPT diluting the role of psychologists (Rizq, 2011).

The Role of PWP

The role of PWP has evolved from the graduate mental health worker (GMHW) or primary care mental health worker (PCMHW) these roles were initially established to work with brief evidence-based therapy techniques, to assist general practitioner’s (GP’s) in managing common mental health problems (Schafer & Wrycraft. 2007). Richardson & Richards (2010) suggest that PWPs do more guided self-help than GMHWs did previously, advocating a greater emphasis on patient self-management compared to other therapeutic interventions. There is also more of a focus on medication management and signposting to other agencies (Richards, Farrand & Chellingsworth, 2011). The PWP role, although initially established in England, is now being adopted by foreign healthcare systems - for example, in Australia and

New Zealand. It appears that the IAPT model is to be utilised as a cheaper 'early intervention service' in mental health services working with anxiety and depression (Koivu et al., 2016).

Like the GMHW or PCMHW, the role of PWP is a non-professionally orientated role; trainee and qualified PWPs are predominantly graduates in Psychology. It has been noted that PWPs can be 'without prior formal qualifications in health' (Bennett-Levy at al., 2010b). PWPs undertake a 45 day training programme that requires over a year to complete. Supported by 'intensive supervision' PWPs can offer 'evidence-based interventions' to a large number of patients' (Thwaites et al., 2015).

There are differences in occupational background for HIs and PWPs (Turpin, Richards, Hope & Duffy, 2008). The majority of qualified HI's were previously counsellors, nurses and clinical psychologists. Conversely, the highest number of PWPs came from healthcare assistant backgrounds. It is important to highlight that this data was collected in the first year of IAPT, meaning that the figures may not be as relevant 10 years on. Nonetheless, this provides a working guideline to the differing professional backgrounds for HI workers and PWPs.

Initially PWPs were known as 'high volume, low intensity CBT workers'; this was later shortened to 'low Intensity' workers (Bennett-Levy et al 2010a). Low intensity (LI) means that the intervention is regarded as a 'lower dose' of therapy (Richards & Whyte, 2011). This refers to an emphasis on self-help interventions that require less support from the mental health worker. It has been observed that the term 'low intensity' was being misunderstood as implying the therapy was of a lower value when compared to 'high intensity' practitioners (Richardson & Richards, 2010). The term 'low intensity' refers mainly to the method of delivering CBT, rather than patients' experiences (Bennett-Levy at al., 2010a). Due to this confusion, the dominant term has is now psychological wellbeing practitioner or PWP.

The PWP role has been compared to that of a 'coach' (Richards et al., 2010); this would imply that a PWP is to mental health, what a personal trainer is to physical health. The coach helps to develop a plan of action with their client, whilst acknowledging that the 'real work' is done by the service user. PWPs work at a high volume; this can mean up to 45 active cases at any one time (Richards et al., 2011). The Department of Health (DoH, 2008) implementation plan for IAPT identifies that

PWP's will, on average, work with 175–250 patients per year, thus becoming highly skilled in their trained interventions.

Step 2 PWP interventions include psychoeducation (Clark, 2011), which refers to education about the CBT model and teaching of the tools that can be applied to assist with anxiety and low mood, targeting behaviours and thoughts. This can be delivered either in a group or one-to-one; it may include, guided self-help or brief face-to-face psychological interventions. These brief interventions refer to behavioural activation (BA), exposure, cognitive restructuring (CR), panic management, problem solving, sleep hygiene, as well as supporting CBT written self-help materials (Richards et al., 2011). Along with step 2 interventions, PWPs also undertake assessments and are usually the frontline staff encountered by the public - on accessing an IAPT service. PWPs are rigorously trained in conducting structured assessments. This includes eliciting information about patients' main difficulties, triggers, thoughts, feelings and behaviours, collecting information regarding the impact on clients' lives, a detailed risk assessment relating to risk to self and others, past mental health history, medication, drug and alcohol consumption, and patients' expectations and goals for treatment. The aim for PWPs is to limit these assessments to 35 minutes in length (Richards & Whyte, 2009). Depending on services, full time PWPs are expected to conduct between 8-12 assessments a week, in addition to guided self-help treatment sessions.

Counselling psychologist Rizq et al., (2010) has drawn similarities between primary care mental health workers (PCMHWs) and the PWP role. She conducted a study into the experiences of a group of newly qualified PCMHW's and captured their reflections on their new role. Each participant subjectively recorded their experiences in a reflective professional paper which subsequently was analysed using Thematic Analysis. Rizq et al. (2010) findings suggested that workers see more complex patients than the mild to moderate depression and anxiety outlined by the original IAPT model. Other themes identified included managing risk, role confusion and a lack of career progression.

Within the counselling psychology field James Binnie (2015) asserted that in IAPT, 'the reality is that often inexperienced members of staff without sufficient training or psychological knowledge are left trying to assess complex clients' (p. 80). In addition to this, in today's economy there is a growing lack of charities and services providing long term or specialised therapeutic interventions. For example,

there have been cuts to drug & alcohol, bereavement, domestic violence and sexual abuse services due to lack of funding. Cairns (2014) studied re-referrals in IAPT, noting a broad range of presentations; 18 of these difficulties were seen as 'separate issues' from the IAPT identified anxiety, stress or depression. The most common additional issues complicating the referral were physical abuse, bereavement, challenging relationships and alcohol use. Any patient engaging with an IAPT service and disclosing these issues would not meet the IAPT criteria for treatment. A big part of a PWPs role is signposting, but other services are diminishing in today's economic climate, as a result, distressed individuals are not getting the support they need. Consequently, this is having to be managed in assessments by PWPs (Rizq, 2014a).

Another reason for PWPs seeing more complex clients could be due to nationwide cuts in the NHS; community mental health teams do not have the capacity to take on patients unless they are at immediate and serious harm to themselves or others. The result of this is that, there seems to be an ever-growing void concerning these more complex people who do not fall neatly into the depression and anxiety category, but do not present a tangible risk. There is a real sense that GPs are referring more complex people to IAPT services as they do not know where else to send them. Subsequently, inappropriate referrals are being assessed by PWPs, this saves GPs time, as regardless of whether the patient meets IAPT service criteria, the GPs receive a copy of an in-depth assessment and signposting information that they can use for future referrals. Additionally, patients with more nuanced needs may be inaccurately deemed as eligible for IAPT; as services are concerned with their key performance indicators (KPI's), and need to reach a target of a certain amount of assessments a month. These assessments make up the numbers, which in turn secures future funding. From an organisational perspective, counselling psychology is able to bring a broader understanding of the implications of this system and investigate the impact of this on staff members as well as clients.

There is a high turnover of PWPs linked to burnout in the role (Steel et al., 2015). The high turnover may also be due to the fact there is limited career progression for a PWP; the role can sometimes be used as a stepping stone to undertaking further training such as HI training and clinical or counselling psychology doctorates. Furthermore, the high volume of work, lack of professional identity (Rizq,

2014b) and growing complexity of clients may contribute to a lack of job satisfaction and frequent staff departures.

What is Supervision?

The word supervision is used commonly across health and social services; it can be used to describe widely differing activities and has varying meanings worldwide. It is utilised in areas including management, personal development or clinical supervision. It can be informally or formally undertaken and occur individually or in groups. The focus of supervision can also vary; there may be a focus on outcomes or on the process itself; be this therapeutic process, clients process or a mixture of the two (Turpin & Wheeler, 2011).

Within the counselling psychology field supervision is highly valued both whilst training and as part of continuing professional development. Michael Carroll (2007), a counselling psychologist who specialises in employee wellbeing, identifies that supervision can encompass many things. Morrissey & Tribe (2001) characterise supervision as 'multifaceted' but primarily suggest it is used to help supervisees support their clients. Lane & Corrie (2006) are both counselling psychologists who specify that in therapy, supervision relates to a space to be reflective, enhance skill sets and foster both personal and professional development. There are many models of supervision; the process of supervision is usually based on similar theoretical principles to the therapy undertaken by the supervisee. Different approaches to supervision include Counselling (Leddick & Bernard, 1980) Humanistic (Farrington, 1995), Solution-focused (Rita, 1998) Psychodynamic (Rodenhauser, 1995), and CBT (Pretorius, 2006).

Wheeler (2003) provides a therapeutic definition of supervision as 'a formal relationship in which there is a contractual agreement that the therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The supervisor is understood to be accountable to the professional body to which the supervisee has allegiance' (p.8).

A specific counselling description of supervision is proffered by Inskipp and Proctor (2001): Supervision is 'a working alliance between the supervisor and counsellor in which the counsellor can offer an account or recording of her work; reflect on it; receive feedback and where appropriate, guidance. The objective of this

alliance is to enable the counsellor to gain in ethical competence, confidence, compassion and creativity in order to give her best possible service to the client.' (p.1).

In conclusion, Carroll (2007) maintains that 'Supervision is a forum where supervisees review and reflect on their work in order to do it better' (p. 36). Supervision refers to whatever impacts upon practice; this could be the therapist, client or the organisation involved (Lane & Corrie, 2006).

The Importance of Supervision

Rizq (2012b) highlights that 'we are living through a period of upheaval in the field of the psychological therapies' (p. 9). The field of counselling psychology places great importance on supervision and there may be an increased need for clinical supervision as a result of mental health services in the UK rapidly changing (Nellaney, Sloan & Turnbull, 2013). With such a push to meet targets in services, the importance of supervision may be increasingly overlooked. Roth & Pilling (2008) note that there is a risk of IAPT services 'rendering supervision invisible'. Clinical Psychologists' Morrissey & Tribe (2001), propose that the primary importance of supervision is for clients, as it helps therapists to deliver a better service by providing a space for continual personal and professional learning.

Supervision has been closely linked to having a professional identity (Holloway & Neufeldt, 1995) and many benefits of supervision have been outlined specifically in relation to counselling psychology (Lane & Corrie, 2006) advantages include: reviewing cases, reflection for practitioners and professional development. Additional benefits of supervision include: identifying personal reactions to work and monitoring the impact of this on practitioners' lives; providing a third person perspective; promoting continuing professional development, and ensuring the best service for clients (Holloway & Neufeldt, 1995).

Supervision is connected to better client outcomes in a range of health worker professions (Holloway & Neufeldt, 1995.; Roth & Pilling, 2007.; Freitas, 2002). In relation to clinical psychologists, occupational therapists, social workers and speech therapists; Clinical supervision is linked to improved outcomes for clients, regardless of job role (Spence et al., 2001). Reviews of supervision efficiency such as Holloway & Neufeldt, (1995) draw links with therapist performance; there is a suggestion that more importance is placed on therapists utilising supervision, rather than their

academic understanding. This would insinuate that the use of supervision is of more value than an intimate knowledge of theory or academic qualifications. For example, one can read all the books on a therapeutic modality, however, through the process of client work and utilisation of supervision, deeper experiential learning may take place that is hard to capture in literature or formal educational settings. It is easier to look at the process of supervision, than to examine the link between supervision and client outcomes (Roth & Pilling, 2007). Nonetheless, the possible benefits for clients is a vital consideration when thinking about the importance of supervision.

Many professional bodies advocate supervision; for example, the British Psychological Society (BPS, 2010) states that supervision is needed to help with the wide range of personal issues that can be raised by clinical work. Additionally, according to the Ethical Framework of the British Association for Counselling and Psychotherapy (BACP, 2013), counsellors and psychotherapists are encouraged to access regular supervision to enhance the quality of their work and uphold continuing professional development. Thirdly, the British Association for Behavioural and Cognitive Psychotherapies (BABCP, 2017), the organisation for CBT therapists, highlights that regular clinical supervision is a requirement for accreditation. Clinical supervision is recommended and encouraged by professional bodies; however, none of this applies to PWPs as there is no current professional body for PWPs. Although, it has been highlighted that due to the rapid introduction of IAPT services, there was little time for a thorough review of supervision literature when considering the supervision provided for PWPs (Turpin & Wheeler, 2011).

Supervision in IAPT

Supervision differs between modalities in IAPT services due to stepped care working (Richards et al., 2010). Counsellors receive counselling supervision from a trained supervisor in accordance with the BACP guidelines. High intensity therapists receive supervision in accordance with the BABCP recommendations. Perris (1993) identifies that CBT supervision tends to be quite didactic, focusing mostly on theoretical and technical aspects. Greenwald & Young (1998) identify that depending on the needs of the supervisee, working on understanding the therapeutic relationship is included in the supervision provided to HI therapists.

LI and HI workers in IAPT services are trained to ensure that they can carry out the requirements set out by NICE (2011a); both PWP and HI trainees are taught the

importance of establishing a therapeutic relationship. For example, in the PWP training manual (Richards & Whyte, 2009) PWPs are encouraged to 'quickly establish the expectation that you and the patient can work together in a trusting and warm relationship' (p. 9.). The manual also lists the 'common factors skills' such as a non-judgemental attitude, empathy and factually accurate and realistic reassurance. Such common factor skills are evidently very similar to Rogers (1957) core conditions, which include empathy and unconditional positive regard with 'realistic reassurance' closely identifying with 'congruence'.

HI workers are required to have prior training preferably in a core profession such as mental health nursing (Robinson et al., 2012) before undertaking the training. In their trainee manual, HI's are also reminded of the 'general competencies to carry out any type of psychological intervention', qualities such as empathy, being non-judgemental, building a trusting therapeutic relationship, these qualities are once again very similar to those outlined by Rogers (1957). A similarity in the roles of HI and PWP seems to be the emphasis on developing a therapeutic relationship with clients, the difference being that HI workers receive supervision to allow this to be explored in more detail, whereas PWPs do not.

Supervision for PWPs

The supervision PWPs currently receive is 'case management supervision' (CMS), which differs to clinical supervision, in that the immediate focus is on adhering to the CBT evidence base, (Richards et al., 2010). This leaves little room for personal or professional growth. CMS has been modelled differently to clinical supervision, which focuses on client progress, therapeutic technique, and model fidelity, alongside the wellbeing of the therapist.

CMS is defined as **'**the regular review of the caseloads of practitioners, providing low intensity interventions, within IAPT stepped care services' (Turpin & Wheeler, 2011). CMS supervisors are usually former PWPs who have undertaken the formal CMS training. The IAPT specified supervision training lasts 5-6 days (Roth & Pilling, 2008). CMS supervisors can also be HI workers or psychologists depending on different service resources, it is possible that counselling psychologists may find themselves providing supervision for PWPs.

Samuels & Veale (2009) cite Professor David Richards, who has had an active involvement with IAPT from its introduction, and has 'repeatedly spoken of the

importance of supervision and developing a safe, supportive relationship' (p. 44) for low intensity workers. CMS has been identified as 'central to the effectiveness of LI CBT within the IAPT model.' (Bennett-Levy et al., 2010a). Five purposes of supervision with relation to LI work have been suggested including: fidelity to evidence base, case management, clinical governance ensuring safety, skills development and worker support (Turpin & Wheeler, 2011). These purposes seem similar to clinical supervision purposes outlined by Carroll (2007) highlighting that there may be confusion with regards to the purpose of CMS and its differences to clinical supervision within IAPT.

PWP supervision is used for 'focusing on the safe and effective management of high volumes of patients' (Benett-Levy et al., 2010b) and PWPs should have one hour per week of CMS (Turpin & Wheeler, 2011). A high case load of clinical work can be demanding, and supervision is as important for adhering to the evidence base as clinical work (Roth & Pilling, 2007). Without CMS, managing a high volume of work may not be as effective (Pullen & Loudon, 2006), although it has been identified that different IAPT services may place different values on supervision for PWPs (Elkin,1999).

Although it may be confused with clinical supervision, CMS leaves little room for discussion about the wellbeing of the PWP; this is something that needs to be addressed separately from CMS (Richards et al., 2010). Turpin & Wheeler (2011) suggest that PWP trainees should receive both individual and group supervision aimed at case discussion and skills development; this should consist of 1 hour per fortnight. However, services differ in their approach (Elkin, 1999), and this is suggested only for PWPs in training. Clinical skills groups designed to aid professional development and continuing learning are recommended (Richard & Whyte, 2009), but there is no mandatory, formal wellbeing or reflective space provided to PWPs. In the field of counselling psychology, Rizq et al., (2010) suggests that reflective spaces are needed for PWPs as their training doesn't address the reality or complexity of referrals. Additionally, Steel et al., (2015) advises that IAPT managers and supervisors should be aware of the depersonalisation of clients that can occur within staff who are emotionally exhausted by their practice. Addressing the impact this has on client outcomes is clearly necessary for IAPT services.

Hoggett (2010) draws attention to the growing emphasis on 'performance' within IAPT services, asserting that 'inexperienced' PWPs are highly scrutinised

during CMS, to ensure that they are reaching their clinical outcome targets. This may well add to PWPs stress levels; if they perceive their work is being scrutinised. It is likely that PWPs are attracted to the role as they may feel that they want to help people and may possibly identify with being a 'wounded healer' (Hadjiosif, 2015); this may not balance with the clinical outcome targets monitored in CMS, which may trigger performance anxiety. PWPs are left to deal with the anxiety of a difficult dichotomy; wanting to help patients but confined by limits in their role, the high-volume case load, and service targets. It is highly likely that managing this polarity may lead to an increase in their stress levels.

Clinical Psychologists' Steel et al., (2015) completed a quantitative study into IAPT therapists and burnout; the study found that IAPT therapists were vulnerable to emotional exhaustion defined as an indicator of burnout as put forward by Maslach et al., (1996). This was regardless of their sex, age, experience, training, or their clients' distress levels. The study also looked at levels of depersonalisation and personal accomplishment for IAPT workers, and found that stressful emotional involvement was a predictor for the depersonalisation of clients. They also suggest that supervision would help to understand this further, ease emotional exhaustion and increase personal accomplishment. It is important to note that this study was not a national study of all IAPT services.

Further research has elucidated the links between the demands of being a PWP and wellbeing for example: Lim et al., (2010) findings' suggest that two predictors of emotional exhaustion are high work demands and lack of autonomy, which Steel et al., (2015) argue are characteristics of current IAPT services. Rizq's (2012b) case study similarly suggests that factors such as exhaustion, stress and the feeling of a lack in skills were reasons for PWPs leaving their roles. Houghton (2007) interviewed IAPT workers and conducted an Interpretative Phenomenological Analysis *(*IPA*)* to look at how they viewed their training experience. The findings were similar to Rizq (2012b) with the additional insight into trainees identifying that they felt they were seeing more complex clients, than the training equipped them for. This was published in 2007, nevertheless, this issue seems to still be prevalent in IAPT services today.

The key difference between CMS and clinical supervision, seems to be the lack of reflective space for personal and professional development. Due to the high-volume case load PWPs are expected to deal with, they are very limited in the time

they have to talk about each case in their supervision. For example, in the PWP training supervision competency, PWPs are required to talk about up to 14 cases in 35 minutes, leaving roughly 2 and a half minutes to talk about each patient. This is arguably not enough time for PWPs to experience all five purposes of supervision outlined by Turpin & Wheeler (2011), potentially leaving PWPs feeling unsupported.

Supervision and IAPT from a Counselling Psychology Perspective

The introduction of IAPT has provoked many varied professional reactions in the therapeutic field. Elder (2009), a GP and former president of the Balint Society (a movement set up addressing the therapeutic relationship with patients in GP practices) suggests that 'the IAPT programme is based on a rationalist 'treatment-based' medical model approach. Such a way of thinking seeks to isolate 'disorders' called 'anxiety' and 'depression' from the daily flow of people with life problems that come in and out of a doctor's surgery' (p. 313).

David Veale, a Psychiatrist and CBT Practitioner suggests that IAPT is successfully improving access to evidence-based psychological therapies for the population, 30 years ago they would not have been able to access such a service (Samuels & Veale, 2009). This is echoed by Bennett-Levy et al., (2010a), who identified that before the introduction of IAPT, patients were offered 'medication or nothing.' Although this has not been disputed, counselling psychologists such as Rizq (Rizq et al., 2010; Rizq, 2011; Rizq, 2012a; Rizq, 2012b; Rizq, 2014a; Rizq, 2014b) have provided psychological consideration of IAPT services from a range of angles. Instances include; gauging attitudes to new IAPT services from the perspectives of the staff (Rizq at al., 2010), staff wellbeing (Rizq, 2011), impacts of IAPT on staff and client's (Rizq, 2012a) and looking at IAPT politically (Rizq, 2014b). To expand upon Rizq's (2011) Psychoanalytic view of IAPT considering transference and counter-transference effects on PWPs, one could predict that strong feelings are being evoked in PWPs with high caseloads of depressed and anxious clients. Rizq et al., (2010) suggests that reflective spaces are needed for PWPs, as their training doesn't engage with the reality or complexity of referrals. It is important to conduct a review of the supervision PWPs receive; this will ensure the wellbeing of PWPs, which has a knock-on effect on client experience and outcomes (Rizq, 2014a; Rizq, 2014b).

It could be argued that ‘weak research designs’ in many studies of therapeutic alliance lead to an overestimation in the importance of the therapeutic relationship (Fonagy & Clark, 2015). Despite this claim the current PWP training still puts emphasis on establishing a therapeutic relationship (Richards & Whyte, 2009). To quote Elder (2009); ‘it is generally agreed that transference is found within all relationships and is a ubiquitous aspect of relating to others and to institutions’ (p 317). Transference, counter-transference and other strong emotions may occur with PWP interactions; especially in the face of depressed and anxious clients, even more so with inappropriate or more complex referrals.

Carroll (2007) maintains that help in understanding the therapeutic relationship with clients can be facilitated by looking at the Psychoanalytic notion of parallel process. Parallel process originates from the concepts of transference and countertransference where the supervisee and supervisor relationship can sometimes be experienced as parallel to the relationship of the client and therapist (Mcneill & Worthen,1989). It has been indicated that supervisors’ theoretical orientation impacts upon the supervision given (Morrissey & Tribe, 2001); studies have shown that therapists are likely to take on their supervisor’s theoretical orientation (Freitas, 2002). Parallel process can be difficult to comprehend, especially in CBT approaches. Nonetheless, it would be useful to have an awareness of its potential impact, regardless of orientation, in order to inform supervision and client work (Morrissey & Tribe, 2001).

Due to the very nature of the work, many front line mental health staff are at ‘risk of being flooded by intense and unmanageable anxiety’ (Bowden, Smith, Parker, & Boxall, 2015 p. 490). This theory stems from the early works by Bion (Bion, 1967), Kohut (Kohut,1977), and Winnicott (Winnicott, 1960) and relates to caregivers providing ‘holding environments’ to patients (Kahn, 2006). Three types of behaviour can facilitate the holding environment: containment, empathic acknowledgement and an enabling perspective (Kahn, 2006). These are necessary factors to consider with regards to supervision provision for frontline mental health staff.

John Lees (2016), a Psychotherapist, describes IAPT as ‘managed care’ which is ‘top down’, in which policies are introduced from the highest level and the system is based on rational principles of problem solving, as opposed to a ‘bottom up’ approach which deploys the wisdom gleaned from practitioner experience. Lees (2016) presents a systemic view that IAPT’s ‘top down’ approach is contributing to

pathologising individuals and disregarding the wider social and political systems that individuals are exposed to. Further exploration in this area has been advised (Mackinnon & Murphy, 2016). Simpson (1997), cited by Lees (2016), suggested that a better way to approach therapy services is by using a 'bottom up' approach where 'staff and patient relational dynamics can manage anxiety using our human capacity for containment' (p. 170) This is reminiscent of Bion's notion of containing and being contained, (Bion,1985), it is possible that therapists become 'containers' for their clients (Ogden, 2004). With regards to PWP work there is a sense that PWPs are containing the mental health anxieties of society (Rizq, 2011) but one wonders, who 'contains the container?' In other words what is happening to the PWPs whilst they are holding this anxiety? Emotionally charged work comes with a risk of burnout and vicarious traumatisation. When considering the theory of parallel process, it is possible that PWPs may be susceptible to feeling depressed or anxious themselves. Recent research into the mental wellbeing of staff in the NHS confirms this as a possibility (Cotton, 2016).

Clinical psychologist Gillian Bowden and colleagues (Bowden et al., 2015) outline the stresses and rewards for front line mental health staff. Drawing attention to the Foresight Report that argues for individual and corporate responsibility for change in looking after the wellbeing of mental health frontline staff, it states that 'companies have a strong incentive to adopt working practices that look after the mental health and wellbeing of their employees' (Foresight Report, 2008, p. 34). In conjunction with this, a recent study presented at the New Savoy Conference detailed, the Charter for Psychological Staff Wellbeing and Resilience (2016); which highlights that 50% of Psychologists in the NHS are suffering from depression and anxiety themselves. This is part of the research conducted by Dr Elizabeth Cotton, who is a writer and educator working in the field of mental health at work and is currently conducting the Surviving Work Survey (Cotton, 2016). It appears that attention on the wellbeing of frontline mental health staff is gaining momentum and has piqued interest from a wide range of professions. IAPT services and PWPs are not exempt from this.

In the BPS, (BPS, 2007) Guidelines for supervision from the Division of Counselling Psychology state that "Supervision is a cornerstone of Counselling Psychology training" (BPS, 2007, p. 3), this foregrounds the importance placed on supervision from a counselling psychology perspective. Many journals cited hitherto

originate from counselling psychologists; Rizq, Lane & Corrie and Carroll are amongst the authors references thus far. Supervision is an inordinately important part of both becoming and the continuing to practice as a counselling psychologist (Carroll, 2007). Additionally, counselling psychology is diversifying into many areas, counselling psychologists who choose to work in the NHS may end up working in IAPT Services whether in supervisory, management or organisational capacities.

Counselling psychologists show varying interests in the NHS and IAPT services. Although this section has mainly drawn from Psychodynamic thinking to illuminate the importance and function of supervision, it is important to also consider other modalities, given that the IAPT model of choice is primarily CBT. Hadjiosif (2013) puts forward a persuasive argument for the necessity of supervision with regards to adhering to modalities; in this case it was specifically for Dialectical Behavioural Therapy (DBT), which is a modified form of CBT, used when working with clients with Borderline Personality Disorder.

There are many current debates around the function and system of IAPT, like the discussion documented by Samuels & Veale (2009); these are ongoing in journals such as BPS's 'The Psychologist' and BACP's 'Therapy Today'. Another more recent dispute is over the emergence of Children and Young Persons' IAPT (CYP-IAPT) between Timimi, (Timimi, 2015a; Timimi, 2015b) and Fonagy & Clark (2015). Additionally, much of the IAPT research is financially supported by the Department of Health IAPT Programme, thus highlighting conflicts of interest. A pertinent example of this is disclosed by David Richards (Richards & Borglin, 2011). This suggests that IAPT research is becoming more insular and possibly biased due to financial implications and NHS structures and systems.

IAPT is continuing to evolve away from the sole focus on anxiety and depression, as indicated by the recent proposal of providing IAPT for children and young people (CYP-IAPT) (Fonagy & Clark,2015). An IAPT service for people with Severe Mental Illness (IAPT-SMI), specifically Psychosis (Jolley et al., 2015) has also been proposed. Furthermore, a journal has been created outlining a 4-year plan to integrate the treatment of long term health conditions into IAPT services (Wroe et al., 2015). It is clear that IAPT services are ever-evolving and rapidly changing within the NHS. No doubt the PWP role will be diversifying alongside these changes, which may possibly add to PWP demands and caseloads.

Irrespective of professional modality, regardless of what clinical work is being undertaken it is imperative for counselling psychologists to consider supervision, and its links to therapist wellbeing and client outcomes. This encompasses PWPs, and the experience of therapy that they are providing to the members of the public who access IAPT services.

Background to the Research and Researcher's Position

This research has originated as a result of my personal experience of training to be a counsellor and subsequently obtaining a role with an IAPT service as a trainee PWP. Following this, my training as a counselling psychologist helped me to deconstruct my experiences in IAPT from a critical perspective.

Prior to undertaking the counselling psychology doctorate, in an attempt to finance myself and gain more experience in the NHS, I chose to apply for a trainee PWP role in a local IAPT service. At the time, this was a great opportunity for me; getting paid to train to work in therapy services in the NHS. The idea for this research originated from my early experience as a trainee PWP. Having trained to be a counsellor prior to my PWP role, I was shocked at what I was being taught as a PWP. For example, gathering of information in an assessment was deemed to be more important than the well-being of the client in front of me. Additionally, I was perturbed by my interpretation of PWPs wellbeing not being considered a priority. On the first day of training, one of the trainees left unceremoniously. I realise in hindsight that she may have seen the nature of IAPT not fitting with her values as a caring and free-spirited human.

During my counselling training, I valued immensely the supervision space that I accessed and I missed this kind of supervision as a PWP. When I challenged the lack of supervision related to wellbeing in the PWP role in an assignment, I received it back as a fail from the training institution. It appeared evident to me that, as a PWP, I was expected to take the training onboard and not deviate from these rigid protocols or challenge the structure of the role. On reflection I feel that this was part of what drew me to training as a counselling psychologist; in my experience this criticality is encouraged in counselling psychology teaching contexts. As I embarked on the PWP role, my colleagues would find out I was the 'new PWP' and would meet me with comments such as 'oh good luck' or 'what do you want to do after the PWP role?', this implied that the position in the service was one that, in its short life span,

had developed quite a reputation as unfulfilling and short term. I was uneasy during my PWP training about only receiving CMS, particularly considering how many people I was expected to see and assess each week, and in comparison, to the case load and supervision I received as a counsellor. I also noticed my fellow PWP colleagues were often off sick or leaving, the ones left behind seemed flat and burnt out, often complaining about the role but seeming too occupied with admin and exhausted with the nature of the role to challenge its remit. This led me to research critiques of IAPT and to look further into PWP supervision. I found that there had been very little research conducted into PWPs experience of supervision, but a significant amount of burn out in the PWP role. I wondered about the relationship between the two but I also wanted to try to capture the rarely heard voice of the PWP in relation to the supervision that they receive. In hindsight, there seems to be confusion within the PWP training around the function of CMS. CMS has been outlined to provide worker support alongside managing caseloads (Turpin & Wheeler, 2011) however, the support in CMS could be confused with clinical supervision through lack of a formal supportive space outside of CMS for PWPs.

As a counselling psychologist I feel that it is important to consider an ethical stance with regards to PWPs who are providing psychological support to people and potentially receiving little of this support themselves. There also seems to be an added complicating factor of a possible expectation that they would receive support around their wellbeing. I was curious about other PWPs experiences of supervision; if they corresponded with my experiences or offered a different angle of insight.

Since beginning my training as a counselling psychologist my knowledge has widened with regards to the political context of therapy, specifically IAPT services and their history with regards to the political landscape. My hope is to give a voice to PWPs in order to try to explore their understanding and experiences of CMS.

Following a thorough literature review, I am unaware of any research that has explored the understanding and experiences of CMS for PWPs in IAPT Services. I feel that with recent studies showing high burnout (Steel et al., 2015), a lack of professional identity (Rizq et al., 2010), along with the fact that PWPs are seeing increasing numbers of complex cases (Houghton, 2007) and experiencing clients with ‘high intensity emotions’ (Bennett-Levy at al., 2010b); an exploration into the supervision for PWPs will hopefully inform future working.

I would describe my therapeutic style as integrative, however the critiques and theory I apply throughout this thesis are mainly psychodynamic and systemic; these theories seem the most relevant to understanding IAPT and CMS for PWPs.

I understand that the NHS is funded by the government and run in an economic way (Rizq, 2012b). Nevertheless, I anticipate that this research will outline themes relevant to portraying PWPs understanding and experiences of case management supervision. I hope this research can at least, be helpful to PWPs working in IAPT services, with the purpose of helping them think about the sufficiency of the supervision they receive, and to help them contemplate their own wellbeing, to assist them with the demands placed upon them in this seemingly demanding role.

Method

Introduction to Methodology

In this section, I will outline the aim of this study, the key features of my chosen analysis which is Thematic Analysis and I will also explain the rationale for why I have chosen this approach for this research. I will outline the epistemological position of this research, include some reflexive commentary to locate my subjectivity within the research process, to make salient how it might have impacted upon the design, and data analysis. I will also consider ethical issues related to the research and summarise each stage of Thematic Analysis.

Study Aim

The aim of this study is to explore the understanding and experiences of CMS for PWPs in IAPT Services. The research question is:

What are Psychological Wellbeing Practitioners' (PWPs) understanding and experiences of Case Management Supervision (CMS)?

This captures both: PWPs understanding of the role and function of CMS and also PWPs subjective experiences of CMS.

Research Design

A Qualitative design has been chosen to address the aim of this study. Qualitative research fits with the ethos of counselling psychology and its commitment to the scientist practitioner model (Woolfe, 2010).

Qualitative researchers are interested in what it is like to experience conditions, rather than reducing them to quantifiable variables or cause and effect (Willig, 2001). With regards to this study, a Qualitative method is preferred over a Quantitative method because the aim is exploring PWPs understanding and experiences of CMS.

Positivism implies that there is a clear-cut connection between the world (objects, events, phenomena) and our perception/understanding of it (Willig, 2001) however even positivists have recognised that our understanding of the world can

only ever be partial (Chalmers, 2013). Contemplating the polar opposites of naive realism and extreme relativism, I approached the research from a place in the middle known as critical realism; this has been described as marrying “the positivist’s search for evidence of a reality external to human consciousness, with the insistence that all meaning to be made of that reality is socially constructed” (Oliver, 2011. p. 2). At times during this research I used a more realist standpoint however my criticality evolved throughout the research process.

The goal of this piece of research is to produce useful and local, rather than objective and global knowledge, as I recognise the limitations of generalising claims based on a few interviews.

Silverman (1993) outlines the difference between ‘methodology’ which is “a general approach to studying research topics”, and ‘method’ which is about “a specific research technique”. It is important to note that epistemology is more significant to methodology and not all research methods are compatible with all methodologies (Willig, 2001).

The specific method of data analysis I selected to address this research was Thematic Analysis (TA), which has been used by a large body of research within qualitative psychology to identify, analyse and report patterns or themes in language-based data (Braun & Clarke, 2006). The procedure for TA outlined by Braun & Clark (2006) was used as a guideline to provide structure to the convoluted process of detecting recurring themes, or central organising concepts, in PWPs’ accounts outlined in transcribed semi-structured interview data. Critical Realism and TA are compatible, as TA is flexible and not tied to any particular epistemological viewpoint (Braun & Clarke, 2006).

With regards to the choice of method of data analysis an alternative research aim would warrant use of a different method: For example, an aim such as ‘Capturing PWPs personal experiences of case management supervision’ would lend itself to more of a phenomenological investigation, focusing more on PWPs individual subjective experiences of supervision. A research question like this would lend itself more to an Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009), this refers to how participants make sense of their lived experiences. I chose not to use IPA in this instance as my aim is not to interpret individual PWPs lived experiences of CMS. Although IPA recognises that research is a dynamic process (Smith, 1996) IPA lacks the theoretical flexibility of TA. IPA can

lack the substance of TA due to the twofold process of focusing on individual cases and themes across the cases (Braun & Clarke, 2013) and there is a risk with IPA that the social or cultural context can be overlooked. TA is better suited to this study as its primary aim is to identify recurring themes that occurred across interviews, rather than focusing on idiographic exploration of lived experiences. In addition, there is a need for PWP experiences of CMS to be situated in the wider context of IAPT services.

Data Generation

Kvale (2007) defines interviewing as a 'professional conversation'; the goal of which is for participants to talk about their own experiences, in their language and concepts, in this case with regards to CMS. A semi-structured interview refers to the researcher having prepared a set of questions, whilst allowing room for participants to add to data in ways the research questions do not address.

Semi -structured interviews have been chosen for this study over other methods of data generation, such as focus groups, as the research lends itself to probing individual understanding and experiences of CMS. Interview data has been described as 'richer' than focus group data (Braun & Clarke, 2013). As little research has been done into the understanding and experiences of CMS for PWPs, semi-structured interviews were more suited in this instance. Focus groups may also be harder to recruit to as PWPs have high caseloads (Richards et al., 2011), additionally, it may be difficult logistically to find a time where all participants would be free to attend the focus group.

Similar research exploring mental health workers' experiences such as the study conducted by Rizq et al. (2010) used TA on written journal data, however semi-structure interviews have been chosen in this instance in the hope that this will provide richer data than written data. Semi-structured interviews have been identified as compatible with TA (Braun & Clarke, 2013).

This research is concerned with interviewing PWPs, specifically wanting to know about their experiences and understanding of CMS. An interview schedule, (Appendix G) consisting of broad open-ended questions was devised to facilitate in depth discussion of the research topic during the interviews. Creating the interview schedule followed a process of using my own experience of CMS, along with discussion with PWP colleagues, brainstorming possible questions and discussing

these with my research supervisor. This procedure was followed to ensure that the semi-structured interview questions were directly applicable to CMS for PWPs, and that the questions fitted into addressing the study's aim. The intention was to avoid the potential risk of focusing too heavily on broader questions about the PWP role in general, rather than CMS. The initial semi-structured interview schedule was used in a pilot interview and edited to make sure the schedule was fit for purpose: for example, the questions flowed in a coherent order and made sense to potential participants.

The semi-structured interviews were approximately 1 hour long, however some interviews took longer than others. All Interviews were conducted face to face, at the PWPs place of work or in a professionally rented therapy room, this was to ensure safety of participants and the researcher. The semi-structured interviews were audio recorded and transcribed in preparation for TA.

Thematic Analysis

TA cannot be undertaken without a data set, as a result, transcription of the semi-structured interviews happened as soon as possible after the interviews had taken place as recommended by Braun & Clarke (2013). Throughout the transcription of the data, all identifiable information was removed from the transcripts, this included names of participants and any other names spoken during the interview, details of participant location or service, along with any other identifiable information. An example transcript including initial codes but with identifiable information removed can be found in Appendix H.

The epistemological position of the research comes from a critical realist stand point, and my aim for this research was to analyse the whole data set rather than focusing on one aspect. I attempted to analyse the data inductively rather than being theoretically driven. I focused on developing latent themes and further exploring the meanings conveyed through language. An example of this is the subtheme: *"Who is the head of the machine?".* It is important to note that my criticality evolved throughout the process of TA. At points I stuck closely to describing what participants communicated which could be interpreted as more realist, at other times I explored the social constructs surrounding what participants conveyed through their use of language.

Six phases of Thematic Analysis were followed for this study (Braun & Clarke, 2006). The phases are described as follows: Phase 1: Familiarising myself with the data. This was done through the process of transcribing the interviews (Riessman, 1993) along with re-reading and listening to the audio recordings of the interviews. I also made preliminary notes during this process. Phase 2: Generating initial codes. This was undertaken by taking the preliminary notes and organising these into collections of codes. The themes were mainly data driven rather than theory driven. The entire data set of transcripts were worked through to produce codes. I used coloured pens and spider diagrams to help track this process. Phase 3: Searching for themes; this included sorting the codes that I had identified into broader themes. Phase 4: Reviewing the themes: I did this by creating the first draft of the thematic map. The initial map was reconfigured numerous times to ensure the themes represented the data, but were also distinguishable and well defined. Evidence of the evolution of the thematic map can be found in Appendix I. The initial thematic map includes a broad outline of themes and subthemes, the second draft streamlines these themes and the thematic evolution is portrayed in these early thematic map drafts. An example of this evolution is; the amalgamation of the themes presented in the first map of *'Supervisory Relationship', 'More support is needed'* and *'The right decision'* into one theme named in the second draft *'Where CMS falls short'*. Phase 5: Defining and naming themes, was done alongside Phase 4 and creating the thematic map to ensure I could relate to the data in a clear way. This is evidenced in Appendix I and in the final thematic map in the Findings section (Table 3). Phase 6: Writing up the report. This was a crucial part of the TA as during the write up the themes were reviewed numerous times and renamed in some instances, to ensure a considerate and rigorous analysis of the data was undertaken.

It has been noted that TA develops over time and should not be rushed (Ely, 1997). I did not approach TA in a linear or rigid way but adopted a more flexible way of working over time. I kept engaged in relation to this analysis by using spider diagrams, colour coding and making reflexive notes throughout this process.

Participants

This study sought to capture understanding and experiences of CMS for PWPs in IAPT services. The criteria for selecting participants included the following: Participants held a current role as a PWP in an IAPT service, and had more than 1

year of experience in the role following the completion of their PWP training. This criterion ensured that participants had enough time to get a full picture of the job role and the CMS provided.

Participants were also eligible to take part if they had prior experience of the PWP role, and had worked as a PWP for at least 1 year post their PWP training. However, if previous PWPs reported being in another job for longer than 2 years they were excluded from the study, this was implemented to make sure participants experiences were not outdated due to the rapid changes in IAPT. These criteria enabled the researcher to recruit participants due to the high turnover of the role.

Recruitment for this study had a narrow sample to enlist participants from, with regards to the inclusion/exclusion criteria. Sampling was purposive, with the aim of generating 'insight and in-depth understanding' with regards to this topic (Patton, 2002). Recruitment for this study was unable to avoid the 'usual suspects' who are easier to recruit and can dominate research in psychology, these are educated, white, middle class, straight people (Braun & Clarke, 2013). I feel that this was inescapable; as to access PWP training courses require a psychology degree or equivalent, and the 'middle class' are more likely to complete a degree (Reay et al., 2001).

Snowball sampling was utilised for this study and enlisting participants to take part in this research included sending out an email (Appendix C) to potential PWPs that may be willing to take part, and asking them to cascade the email to their PWP colleagues. Two attachments were sent along with the initial email: Firstly, the participant information sheet (Appendix A) and secondly the study advert (Appendix B). I received ten replies in response to the recruitment email, three respondents were former PWPs, from three different IAPT services and five of the respondents were current PWPs, from three different IAPT services. One respondent had worked as a PWP for less than 1 year, and the other was still completing their PWP training. As these two respondents did not meet the inclusion criteria they were excluded from the study. In total, eight participants were eligible to participate in the study, and as a result eight research interviews were conducted. Interviews were all conducted face to face, in a place convenient for the participant, this was usually a confidential privately rented therapeutic room.

Participants were reminded of the participant information sheet (Appendix A), were required to sign the participant consent form (Appendix D) and complete the

background information form (Appendix E) prior to commencing interviews. Background data included: current job role (in the broadest terms to protect anonymity) and how long they have been or were a PWP for. Details of specific IAPT services that PWPs work or worked for was not collected to ensure confidentiality. Table 1 outlines participant information relevant to the study. Age of participants ranged from 26 years old to 59 years old (Mean 37; SD 11.3). Time spent as a PWP ranged from 1 year to 7 years (Mean 4; SD 1.9). All participants identified as White British ethnicity; this is following the outlined categories of ethnicity offered by the Office for National Statistics (2014). At the end of the interview participants were given the opportunity to ask any further questions with regards to the study and were subsequently given the debrief information sheet (Appendix F).

Table 1: Participant Details

Participants (Pseudonyms)	**Gender**	**Approximate Age**	**Approximate Time spent as a PWP**
Jasmine	Female	26	1 years
Beatrice	Female	59	3 years
Rebecca	Female	28	2 years
Howard	Male	30	4 years
Louisa	Female	38	7 years
Lola	Female	29	2 years
Karen	Female	35	5 years
Leanne	Female	52	6 years

Reflexivity

It is widely accepted that in qualitative research the researcher is an instrument in their own right (Marshall & Rossman, 2006). There are two types of reflexivity: personal and epistemological, both of which are integral to the research process (Willig, 2001). Personal reflexivity refers to how researcher values and beliefs affect the research; this can also touch on how the research may change the researcher. Epistemological reflexivity includes looking at the research itself and how

the design of the study impacts the findings. This helps researchers reflect on assumptions about the world and how knowledge is obtained.

With regards to personal reflexivity, it is important to acknowledge my insider status with regards to my participants. Before, and partly during, my training as a counselling psychologist, I undertook the role of a PWP in an IAPT service for a total of 2 years. I have worked in the NHS for 9 years, which affords me insider knowledge about its management systems, funding, and other policies and procedures. Inevitably, this knowledge featured in many aspects of my study, from the questions I asked in the interviews to the way I thematically organised the data.

It has been important for me to have an ongoing awareness of my subjective experiences and knowledge of the NHS and IAPT services; to ensure I don't unconsciously influence the data collection or analysis (Charmaz, 2006). Although at times this has been unavoidable. I nurtured my continuing awareness by taking the time to reflect on my own answers to the semi-structured interview questions. I kept a journal throughout the research and had regular contact with my supervisor to discuss my developing awareness, and my own perspectives, with regards to this research.

Ethical issues

All information with regards to this study was communicated to participants by emailing out the information sheet which includes details of how to withdraw (Appendix A), all participants had accessed this information before I met with them to conduct the interviews. The information sheet (Appendix A) and consent form (Appendix D) provided to participants both contained information on the participants' right to withdraw from the study and how to commence this process. The information sheet (Appendix A) was recapped and participants were given the opportunity to ask any questions before the interview commenced, this was in order to ensure participants were clear about the process. Participants' were also encouraged to contact the research team if they experienced any distress as a result of partaking in the interview; nobody used this safety measure, which was put in place to reduce the risk of the study.

Confidentiality has been upheld for participants by providing pseudonyms and changing/deleting any identifiable information.

My intention was to conduct this study aspiring to be as ethical as possible. Ethical approval was granted by UWE Faculty of Health and Applied Sciences Ethics Committee (Reference Number: HAS.15.10.025). The ethical guidelines of the university were followed along with the BPS's Code of Ethics and Conduct (BPS, 2009) and the Division of Counselling Psychology's Professional Practice Guidelines (BPS, 2006).

Findings

This section will include a presentation of the thematic categories generated by myself, as the researcher, during this Thematic Analysis. These categories are displayed in two formats (Table 2 & Table 3). Furthermore, they will be discussed in more detail and grounded in data extracts taken from across the data set.

The themes have been presented in an order that aims to build upon the sense and significance of the analytical narrative (Braun & Clarke, 2013), with regards to the aim of the research.

The intention was for individual themes to be able to stand alone, whilst also providing a partial angle of insight in terms of the research question. In some cases, the themes offer differing, sometimes contrasting, responses to the research question, this will hopefully provide in depth consideration of the data.

The research question guiding this analysis is:
What are Psychological Wellbeing Practitioners' (PWPs) understanding and experiences of Case Management Supervision (CMS)?

This analysis encompasses both the ontological question of what is CMS and a phenomenological dimension, which considers how CMS is experienced idiographically. In other words, themes presented here attempt to capture both what it is like to be a PWP having CMS and individual experiences of CMS.

Analysis of the data set generated three overall themes, an overview of these themes is shown in list form (Table 2) and a thematic map (Table 3). Theme 1 outlines participants experiences and use of language in referring to IAPT services like a machine, where the power is held in the machine and how CMS serves the purpose of helping the machine run smoothly. Theme 2 delineates where CMS falls short, drawing on participants experiences and opinions about areas in which CMS does not meet their needs. Theme 3 outlines all the positive aspects of CMS and all the areas in which it is helpful in supporting PWPs to undertake their high-volume work.

Table 2: Themes and Subthemes generated during Thematic Analysis

List of Themes with further Subthemes

1. Part of the IAPT Machine

i. Who is the head of the machine?
ii. Being a Robot

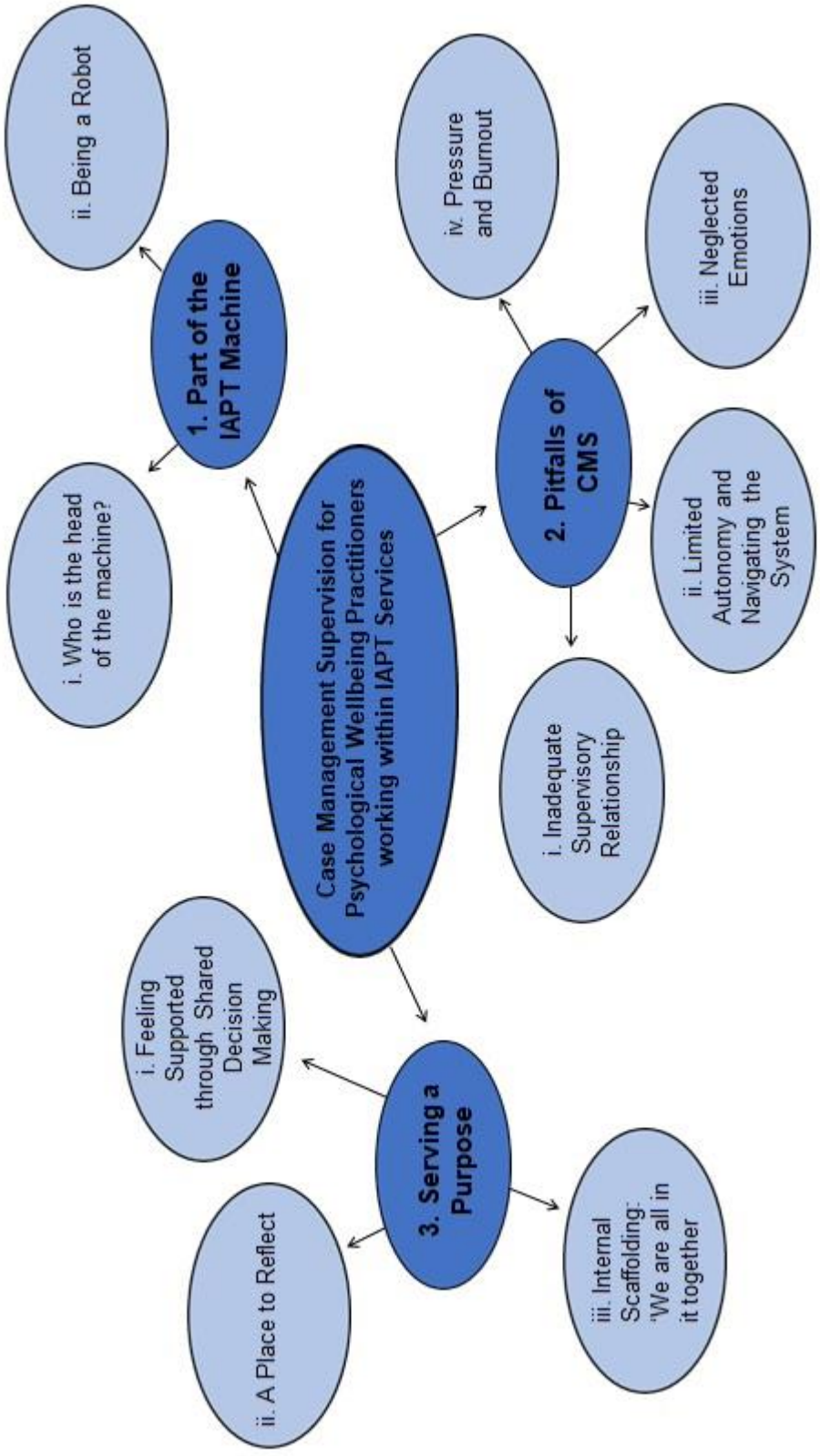
2. Pitfalls of CMS

i. Inadequate Supervisory Relationship
ii. Limited Autonomy and Navigating the System
iii. Neglected Emotions
iv. Pressure and Burnout

3. Serving a Purpose

i. Feeling Supported through Shared Decision Making
ii. A Place to Reflect
iii. Internal Scaffolding: ‘We are all in it together’

Table 3: Thematic Map



Part of the IAPT Machine

This theme focuses on meaning patterns within the data set that illustrate participants' understanding of CMS as being part of the IAPT service structure. The term machine refers to; 'an apparatus using mechanical power and having several parts, each with a definite function and together performing a particular task.' (Oxford Dictionary of English, 2017). IAPT services can be conceptualised as being part of a wider political machine. The idea of IAPT services specifically taking on the identity of a 'machine' is further outlined in literature such as Rizq (2012a). CMS seems to be an integral part of the IAPT machine; helping the service run smoothly to deliver what it is required to. Analysis of the data has identified a theme of the mechanical nature of the job role of a PWP, and how CMS helps to support this way of working in the broader machine of IAPT.

The following quote outlines this further:

> *"Doing the role has really kind of stressed to me how much I don't want to be in that kind of machine of seeing that many people each week, because I just don't think it's healthy for anyone."* (Karen)

It appears that Karen has picked up on the machine analogy for herself and the potential pitfall of working as human in an area that requires such a high volume, and mechanistic way of working. Furthermore, other participants spoke about the concept of the machine. For example:

> *"Everything in IAPT is so high pressure, so high volume and so you know rat a tat tat in terms of let's get all this information out. It can feel a bit like a machine sometimes and maybe, maybe you feel like the person can sometimes get a bit lost in it all.*" (Beatrice)

This quote implies that Beatrice also identifies likening IAPT to working in a machine and highlights that the '*person'* can get *'lost'*, this seems to be a negligent oversight in a service that claims to work with human mental health difficulties, such as anxiety and depression.

The use of language such as '*care pathway'*, *'criteria'* and phrases such as *'low intensity CBT'*, *'high intensity CBT'* and *'stepped up'* are all typical examples of the discourse that is used by participants' when specifically referring to CMS and IAPT services. Use of this language has the effect of simplifying the process of

seeing clients within IAPT services, moving away from the complexity of therapy or connection to fellow human beings. This language further suggests the use of short cuts in discourse and serves to remove the human emotion or experience from the system of IAPT. This delineates IAPT services being run as a business and CMS being part of making sure everyone is adhering to the *'business model'*. The term *'business model'* seems to refer to the modus operandi of IAPT. IAPT services have evolved from economic arguments (Rizq, 2012a) and it would be understandable that this development may be reliant on a business way of thinking, arguably moving away from consideration of individual wellbeing in favour of reaching targets alongside a heavy focus on numbers and figures to prove IAPT's worth as a business. The notion of IAPT being run as a business seems evident in the transcripts of many of the participants interviewed. For example, one participant described CMS as the following:

> *"Case management is literally just going through the list of how many people you are seeing, what you are doing with them, is there any risk issues, where you are in treatment. So more of a business kind of management"* (Karen)

The use of the phrase *'business kind of management'* suggests that Karen identifies with IAPT being run as a business and CMS *'literally'* supporting this way of working. Other participants' identified aspects that relate to a business style of working explaining that:

> *"As a PWP you haven't got any magical powers but it's selling, selling the intervention to them and selling the idea that if you do this it could be helpful. I think that's the skill really of a PWP job."* (Howard)

The notion of *'selling'* aligns itself closely with images of a business, it is not a phrase one would necessarily expect when hearing a therapist talking about their client work in a therapeutic setting. Howard's identification of selling an idea to patients, suggests that, the business model is at the forefront of a PWP's role and CMS is used to help adhere to this.

The following quote provides a summary in relation to this theme:

> "*I know it's all about money and business but actually this is therapeutic work and there needs to be more time given, if PWPs are supposed to be in it a long time you know."* (Lola)

This quote from Lola suggests that there may be a culture in IAPT that emphasises money and business over the therapeutic work, there also seems to be an acceptance or resignation of this just being the way it is. There seems to be a conflict with regards to the values of the PWPs and the service; this appears to be the norm for PWPs. The analogy of being part of the IAPT machine may provide some comfort to PWPs, by way of providing an explanation for why their role is the way it is; including high turnover and emphasis on client scores and targets. Lola's use of language appears to convey that she is realistic about what working in IAPT entails but still expresses a desire for it to be different. In addition, Lola's quote infers further about the longevity of the PWP position; that aspects of the role would have to change to decrease the elevated levels of turnover of PWPs in IAPT services. Lola's experience of the high turnover seems to be reflecting Steel et al. (2015) and Rizq's (2014b) emphasis on the PWP role being transient.

This theme suggests that participants' experience of CMS contributes to obscuring the reality of the role; that humans are accessing the service in distress and PWPs are expected to support them in some way. The following subthemes explore this theme further.

Who is the head of the machine?

This subtheme problematizes power dynamics that appear to occur within CMS between the PWP and their supervisor, and additionally with both PWP and supervisor and the wider context of IAPT. The concept of an IAPT machine lends itself to the questions of: Who is running the machine? and Who holds the power in the machine? The notion of having a case management supervisor suggests that the power does not lie with the PWP. This subtheme further explores who or what holds the power in IAPT service structure, and how CMS supports or opposes this.

A lack of power experienced as a PWP in relation to the wider system of 'stepped care' was shared by several participants:

> *"I do wonder whether a flaw of the stepped care model is how people working on the lower levels are seen. There's a bit of a hierarchy, of*

> *course there is, but there's also a pecking order as well. I know when we were referred to as low intensity therapists as opposed to PWP… I think that choice of language can be quite damning in a way"* (Louisa)

Louisa seems to be explaining that the PWP role is at the bottom of the IAPT hierarchy; indicated by her verbalising being at the bottom of the *'pecking order'* as a *'low intensity therapist'*, thus holding little power to influence or honour their own process with the clients they assess and work with.

Similarly, further limitations of the role of PWP were expressed by other participants:

> *"I want to be able to do other things to help those people which is limited a little bit with what we do because it's low intensity, it's supposed to be single strand but you know I want to be able to do more"* (Rebecca)

Rebecca appears to highlight the struggle that she would like to be able to do more, but feels limited by the lack of influence given to the role of PWP. The phrase used here of '*single strand'* suggests that PWPs do not have any other skills than the *'low intensity'* skills they are trained in, Rebecca seems to be expressing a lack of fulfilment and a want to provide *'more'* for her clients.

This restricted way of working also appears evident in supervision:

> *"I think that can affect the relationship with clients sometimes. If they feel like they've been waiting a long time or they know you have to go talk to a supervisor, they almost don't trust your decision because you've had to go to a supervisor"* (Rebecca)

This extract implies that Rebecca may experience very little power or autonomy over her own work, this could have direct impact on clients, who may begin to question PWPs competence and decision-making skills.

It was recognised by one participant that the IAPT model may be used to guide patient treatment:

> *"I think it's the model isn't it. It's the model, there's adherence to the model. It's very short and has a quick turnover"* (Leanne).

It remains unclear what IAPT model Leanne was referring to but this could be; the high volume of people through the service in order to meet access targets, the model of treatment recommended by the NICE Guidelines or stepped care. The concept of the stepped care model seems to be supported by CMS as insinuated in the following extract:

> "*I think it helps me to keep quite boundaried. I don't go too off key into other kind of modalities of treatments and I do then stick to Step 2 PWP CBT interventions"* (Louisa)

CMS appears to be utilised to support the IAPT model by playing an important part of keeping PWPs conscious of their limits and boundaries of their skill set. The term *'stepped care'* has been used by most of participants interviewed and one function of CMS appears to ensure that '*stepped care'* is adhered to. It could be that the service model holds the power in the IAPT machine, but there seems to be a risk that this 'model' may be followed with no deviation in the face of human complexity.

The majority of PWPs interviewed indicated that CMS has supported them to manage their high caseloads, to ensure a plan is followed systematically for each client. The following excerpt focuses on this further:

> *"Well it kind of just helps you formulate a plan. Nothing more I don't think really, and come up with obviously the NICE guidelines treatment plan"* (Leanne).

Leanne seems to be identifying the point of CMS is to get a plan for clients and may not provide a space for anything alternative to be discussed. It appears that both supervisor and PWP do not have much influence in the IAPT system and are guided by a higher power, this could possibly be the NICE guidance. The higher power being NICE guidance could have the impact of practitioners or even case management supervisors not thinking for themselves, overlooking their autonomy or lived experience of the client in favour of categorising them and following the guidance without question. This is highlighted further by the following excerpt from Jasmine, who implies the following concerns about her experience in CMS:

> *"Have I really communicated this in as much detail as I'd like to and given a true representative of the patient and therefore, has the decision been made between us the right one. I think there is something to be*

> *said about your intuition of what it's like to be in the room with someone. Which if you're not given the time to explore and really communicate within supervision, to almost a bit of transference I suppose onto the supervisor, so they get a feel for what it was like or they at least ask you what your instincts are. Then sometimes they may make you feel a bit like oh do they really get the patient as an individual or is it a bit of a tick box of yes, they've got risks, so this is the procedure. Or they're suitable for the service because they fit these criteria. As opposed to really thinking about personalised care and what might be appropriate for that individual."* (Jasmine)

This extract suggests that Jasmine takes considerable pride and care in her work with clients and that she is very much in tune with her relational experiences with the people she encounters as a PWP. It appears that Jasmine feels her supervisor is not interested in *'getting the patient'* and instead focused on *'criteria'*. Jasmine speaks of transference which does not seem to be addressed in CMS. Instead CMS feels like a procedural exercise to satisfy the service targets and care pathways, rather than the *'personalised'* or '*appropriate'* care for individuals. Jasmine has highlighted transference as a possible oversight in CMS, transference can occur in all therapeutic settings (Elder, 2009), regardless of whether these services are run with a focus on targets or individual needs.

The CMS supervisors seem to be similarly caught up in the system as PWPs are, if anything they may be more exposed to the services pressure around targets and care pathways. The following passage elaborates this possibility:

> "*Senior PWPs in that role they've got their own agenda as they've got their own pressures and management"* (Louisa).

It is apparent that the CMS supervisors might not have the same agenda as PWPs, and this may sometimes be perceived as working against the PWPs they are supervising. This begs the question of: Whose agenda are PWPs and their supervisors working to uphold if not their own? The following extract may shed further light on answering this question:

> *"I know they say being a PWP isn't about relationship or anything like that, is it? but still. Well there's all kinds of different reasons aren't there really like the stress element; there's a high burn out, isn't there, amongst PWPs and obviously it's going to affect how we interact with people and so they're not going to get the best. I don't think they're*

> *going to get the best outcomes, if somebody is deeply affected by what they're saying"* (Leanne)

This passage from Leanne's interview highlights a few important aspects to consider. She seems to be implying that a relational dimension is overlooked as a factor in the PWP role. Leanne appears to be directly linking stress levels and burnout with the lack of recognition of the relational aspects of the role. It could be surmised that CMS does not provide a space for exploration if a PWP is *'deeply affected'*, as there is an expectation that this would not be the case. Additionally, Leanne links this lack of recognition of the *'relationship'* to poorer outcomes for the service, she also seemed unsure whether she was allowed to talk in these terms by use of the phrase; *'is it?'* which created a sense of insecurity about sharing her opinions. Although not made explicit, Leanne's use of the word *'they'* in this statement suggests that there is a wider context, predictably governmental policies or commissioners. It is possible that who Leanne refers to as *'they'*, could be holding the power over the IAPT agenda and overlooking the importance of the relationship in the PWP role. The term *'they'* suggests that there is a higher power, a person, group or body that is calling the shots with regards to IAPT. Specifically, who *'they'* are is implied and eluded to rather than spoken about explicitly. This leaves an air of mystery or assumption in the culture of IAPT, the suggestion of an invisible and hard to pinpoint higher power potentially makes the system harder to challenge.

Being a Robot

This subtheme portrays to the subjective experiences identified in the data of participants relating to feeling like robots who are part of a wider machine, who may feel pressure to put individual complexity and needs (the clients as well as the practitioner's) aside. Even the term 'PWP' suggests a move away from the humans who are carrying out the role. With an agenda pushed from a higher power and being part of the IAPT machine, people who undertake the PWP role need to learn to survive in this system in some way. CMS seems to serve the function to ensure the duties of PWPs are carried out. Many PWPs interviewed noted a systematic way of working and pressure to function as part of the wider IAPT machine. Being a 'robot' appears to be one of the ways PWPs try to survive this challenging role and CMS seems to support this robotic way of working.

> *"I get why it is the way it is. It does serve a purpose. I think it's just you don't get to explore anything yourself. I think that's important but then like I said it's hard to do that when you're not actually sure what's going on and you're a bit like a robot going from one person to the next."* (Lola)

This extract highlights that Lola may understand the nature of IAPT and the need for CMS to support this work, alternatively she also seems to be expressing some of the difficulties of not being able to *'explore'* her own feelings or experiences within IAPT. A lack of space to explore this seems to add to her confusion in the role, exacerbating the need to act like a robot. Other participants also appeared to reflect on the details of CMS, and what this was like to experience:

> *"It was going through, almost like a checklist but I guess that was the thing that I didn't like about it, on the sort of negative side now was that it did feel quite procedural and quite rushed, but then that was the nature of the job. You know that was the nature of how I had to be, probably, with clients as well. So, I wonder if the supervision kind of mirrors how you have to be in sessions because of the time limits of the role and the heavy reliance on procedure and manualised treatments."* (Jasmine)

Jasmine shares an important insight here in terms of her experience about how the robotic nature of the CMS may echo how she is expected to work with clients. She appears to accept that this formulaic way of working is a given attribute of the PWP role and the CMS received.

The impact of experiencing this type of supervision in comparison to other versions has been highlighted by other participants interviewed:

> *"It doesn't prepare you that much for that different kind of supervision… it's so almost robotic and you don't have time to think. You know it doesn't get you used to actually taking that step back, thinking about the process and how can I improve and all of that kind of thing. Ok I've been asked to do this technique, we need to focus on doing the technique and that's it sometimes."* (Karen)

It seems that Karen is articulating that CMS is an unusual form of supervision in a therapeutic service. In a way, CMS is almost an opposing experience to other supervisions where practitioners are encouraged to think

and reflect on the process both personally and with the client. It seems that CMS actively encourages PWPs not to think for themselves, favouring this robotic way of working which serves to oversimplify the therapeutic process. Some participants reflected on this, and shared potential challenges about working in this way with clients:

> *"So, if the plan has been to do one particular treatment but actually in session that's not always appropriate or it needs to be changed slightly that can be a bit awkward. Kind of forcing down one route and then obviously taking it back to supervision"* (Rebecca)

Rebecca notes the possible difficulties of agreeing a plan with her supervisor but not having the autonomy to change with the needs of the client in sessions. One of the assumptions of CMS and possibly the wider PWP role seems to be that once a plan is decided then this is always the best way forward; this is quite a robotic way of thinking and does not account for human flexibility or change. Rebecca's excerpt also highlights that there is little choice for the client but to be *'forced'* down a route they may not have control over. The use of the adjective here brings to mind phantasmagorias of machines pushing relentlessly without any human intervention or qualities of intuition, perspective or considering individual needs. This brings up questions around the ethical duties of such a service that promotes this way of working. However, it is important to note that not all participants reflected on experiences that showed such a lack of sovereignty:

> *"I think for a lot of PWPs in other services they're forced to apply interventions to somebody who is really not suitable because they're trying to push numbers through or they've got to meet a certain prevalence target. I'm fine I'm not in that position. I hope that we don't get there anytime soon."* (Howard)

Howard indicates that he has knowledge of how other services work in such a procedural way and he sheds some light on why this may be due to '*prevalence targets'* and *'pushing numbers',* this seems to be favoured over individually considering each human in distress. Howard seems to have made his peace with how these other services run, but also his use of the term being *'fine'* not working in that way suggests he would not appreciate working in this way himself.

CMS seems to support the notion of being a PWP robot. Beatrice spoke about utilising CMS to go *'through my case load systematically'* as *'sometimes you miss something'* and that she uses it to *'check decision making.*' This implies that Beatrice's decision might not be the *'right'* one and she needs a supervisor to check she is not malfunctioning as a PWP robot. This links with the previous subtheme of *'Who is the head of the machine?'*, PWP robots seem to be programmed by a higher power. Several participants that had worked in the service for a longer time, were able to reflect on the systems of IAPT and experiencing the real-life functioning of the service. A lack of space for this to be addressed in CMS was insinuated:

> *"When you're discussing cases in supervision it meant that it would be them kind of taking it on… I don't want to know them they're just too complex, I don't really want to be the one having to see them. So, there'd be almost this kind of pressure on you to be seeing them but even though they're saying that they wouldn't be able to do work with them, they're kind of telling you to try and do something at the same time…. you'd get that heart sink moment of I just don't even, what's the point of talking to you about this person because you're just going to say no to stepping them up anyway when that's actually what I'm supposed to be doing*." (Karen)

The above extract emphasises the potential tensions of working in such an apparently inflexible team environment; noting the difficulties between the teams in IAPT in the face of complex clients. It is evident that PWPs may receive mixed message of don't deviate from *'protocol'* but do *'something'* with the clients, doing something seeming a preferable way of working than not offering anything at all, but this responsibility falling to the PWP rather than other more senior members of the team. At least a robot is programmed to do its specific task and not expected to do extras to accommodate other robots lack of support.

The PWPs experience of this way of working and how it relates to CMS is explored more in the following passage:

> *"Sometimes I get to supervision and I think, I start to talk about someone and I think I can't even remember who you were and that feels, to me that feels really sad that I can't, you know… it's just the volume of it all."* (Beatrice)

The reality of forgetting clients' due to the high-volume way of working seems to be an upsetting experience for Beatrice. CMS seems to be a place where PWPs

may realise they are not robots, even though there may be subtle pressure for them to act as though they are. This was also reflected by other participants:

> "*You see so many people every week and it's like remembering who you're seeing and their names and, it's so much. You need a structured case management supervision to physically get through everyone." (*Rebecca).

This infers that CMS, despite any problems or short comings, seems to be essential to ensure the efficiency of the work, and may be useful in reminding PWPs about the people that they have seen. This robotic way of working seems successful in so far as it is evaluated against the targets and wider remit of IAPT.

The robotic nature of CMS appears to be mirrored in the PWP way of working:

> *"It feels like you learn what you learn and then you just do it and you don't really develop past that point so it's quite robotic."* (Howard).

This quote outlines the possibility that the PWP role is quite confined to a certain group of specific tasks. Indeed, robots are designed to perform specific tasks and participants' accounts converge in laying out the nature of the rigid skill set that they are trained to deliver. For example:

> *"You're doing like 3 different treatments, with different people but you're basically doing 3 treatments over and over and over again".(*Rebecca)

The use of the phrases of: *'you just do it'* from Howard and: *'over and over again'* from Rebecca imply a way of working that is mechanical, repetitive and detached from the humans that are delivering it and receiving it. This sub-theme powerfully portrays many of the critiques that have been directed at the IAPT model, especially from the perspective of counselling psychology.

Pitfalls of CMS

This theme presents the areas in which CMS falls short and fails to acknowledge the PWP experiences and the wider context of working in IAPT. Many

participants referred to CMS as having a lack of space to explore the relational and emotional pressures of the PWP role. Within the data set there were mixed experiences with regards to this, with participants proffering differing levels of importance placed on having space to explore emotional responses to the job demands. This theme serves to bring together all the areas in which the PWPs interviewed indicated through their language that CMS does not fully support their needs, and furthermore, misses out on an opportunity to assist PWPs with their own emotional wellbeing and professional development. Participants who had previous experience of counselling or other therapeutic roles, used the interview to express exasperation with regards to a distinct lack of focus of their own wellbeing in CMS and in the PWP role.

> *"Sometimes in this role I don't think you feel very heard or you feel undervalued or underappreciated for the work that you do. I think that is possibly because of how fast paced it is, but actually case management could be a chance to feel more supported by your supervisor, and I'm not sure that really happens for me."* (Lola)

Lola outlines a potential oversight with regards to CMS, noticing that CMS could be a place for PWPs to experience additional support. Instead she reports a lack of appreciation for her work and a space to acknowledge these feelings seems to have been overlooked in her CMS. Lola also added that: *"I don't know if I've ever really experienced that support or that encouragement from my senior PWP unfortunately".* Here she seems to be referring to a missed opportunity for CMS to provide some sort of appreciation or acknowledgment of her hard work, directly linking this to her experience with her CMS supervisor. Elements related to this are explored further in the following subthemes.

Inadequate Supervisory Relationship

This subtheme identifies a possible oversight with regards to CMS which is the supervisory relationship. The arrangement in IAPT seems to be that PWPs have very little choice over who their case management supervisor is, as it does not seem to be considered as relevant, inferring that very little importance or recognition is given to the supervisory relationship. This echoes the lack of importance placed on the PWPs relationship with the people they assess. Instead of a supportive

relationship it seems that some participants had a more complex and challenging relationship with their supervisor, this has been described as a *'battle'* with the CMS supervisor about the needs of the patient vs service pressure:

> *"You don't know because they're saying as a senior PWP, you don't know if they're for that modality either… so it gets really difficult because you think well who's got the final say here? Does my voice actually even matter about what I think …there seems to always be a power battle. Who is having the final say here? Actually, if I don't agree with you then what happens and that gets quite confusing. It's horrible to carry that with you knowing that you've got this client who's waiting for you to tell them what's going on."* (Karen)

Karen identifies an internal dialogue of being at odds with her supervisor, that there is an undercurrent of *'who is getting the final say?'* underlying her experience in CMS. The use of the phrase *'power battles',* suggests that CMS can feel like an unsafe place where '*battles'* are engaged in. This could be a dissimilar experience to more traditional supervision; where the supervisory relationship is meant to be nurtured and the supervisors aim is to be alongside and supporting supervisees with their experience. Karen added:

> "*Things got very complicated in terms of well who is making the decisions anymore, because now my decision obviously isn't good enough"*. (Karen)

Karen who has worked in IAPT for longer than 5 years communicates not feeling *'good enough'* and possibly undermined in CMS by her supervisor, what remains unclear is if this battle comes from Karen or her supervisor. However, this poses a crucial factor to consider about the nature and quality of the relationship between supervisor and PWP, and how this impacts client work and survival within the IAPT organisation.

A similar experience was shared by another PWP who had worked in the role for longer than 5 years:

> *"I don't really feel like they're interested and I know it's hard because they've got their job to do. I am a supervisor myself and it's quite hard getting a balance but I don't feel there's any kind of empathy with your own stuff that it might be hitting upon."* (Leanne)

Leanne provides a unique angle of insight into CMS as she shared that she is beginning the role of CMS supervisor herself. Regardless of this, Leanne shares an experience of her supervisor not being *'interested'* in her own wellbeing, whilst also appearing to provide empathy to her supervisor's difficult position. Leanne's experience suggests one of providing empathy to others but not receiving it back, implications of this could be compassion fatigue or burnout as shown by research (Steel et al., 2015).

Another participant, that had spent longer in the role than the average PWP, also made reference to a supervisory relationship and the pitfalls with regards to this:

> *"Sometimes it was quite hard to get a mutually agreed decision because I guess they had their own interests and were protecting their waiting lists. But also I had to protect my own self as a PWP, to make sure that the work that I was doing was still within the PWP remit… The nature of the personality of my supervisor as well at times was quite forceful, very, very assertive and I think, for me, I wasn't as assertive as perhaps I could've been or would've liked to have been"* (Louisa)

Louisa's experience highlights why there may be potential conflicts within the supervisory relationship. There seems to be a conflict of agendas with regards to PWPs and their supervisors: the supervisor seems to be working in the interests of the service waiting list and as a result, Louisa feels the need to *'protect'* herself in supervision. This suggests she experiences an unsafe space for asserting herself in CMS, which warrants further consideration, especially if assertiveness is not a skill that comes easy for PWPs. In addition, Louisa has more experience and may be able to articulate this better than less experienced PWPs. Other participants picked up on a lack of authenticity from their supervisors:

> "*I feel like the relationship itself doesn't always feel genuine…. There is 'you're doing really well' just kind of slipped in there but it doesn't feel real."* (Lola)

This implies something about the nature of CMS not leaving room for a genuine *'real' connection* and the questioning of the authenticity of other members of the IAPT team, in this instance the case management supervisor.

The participants that had spent longer time in the role demonstrated a comprehensive understanding and insight into the systems at play in IAPT services. This can be used to understand why the supervisors might not be as forthcoming with sincere support for PWPs:

> "B*ecause of service targets and pressure on them, you know it's not coming from them personally but there is still that pressure and the pressure then gets put on to you. Because if you're really at logger heads about what treatment to do then that's really difficult because they haven't met the client or done the assessment or anything."*
> (Karen)

Karen articulates the possible reasons for CMS supervisors not being as attentive to PWPs needs. The concept of pressure seems to be commonplace within an IAPT service and Karen's quote seems to normalise this, it appears that differing roles within the service have independent pressures, this could leave the team fractured and serve to foster a culture of only looking after oneself by way of survival.

It is essential to note that not all participants shared experiences of an unsupportive supervisory relationship or a fractured relationship with supervisors because of service pressure:

> *"I've had quite a few different supervisors, some have been PWPs, some have been high intensity therapists… I've found sometimes it's been really, really frustrating because the person I was speaking to would just try to relate it to their own experience or was too directive. My current supervisor I really like because I've learnt an awful lot more about working with certain conditions, differential diagnosis and become more interested in CBT stuff than you'd normally get to do as a PWP."*
> (Howard)

Howard's quote emphasises the importance of individual supervisory relationships and the impact of these on the experience of CMS. He provides a potential explanation of how helpful different supervisors have been with regards to the supervisory relationship and the directive nature of the supervision. Howard's experience with a high intensity supervisor seems to provide him with an expansion of knowledge that he did not receive with a PWP supervisor. This once again highlights the significance of taking note of the unique supervisory relationship and how this, in turn, impacts the PWPs experience of CMS.

Not all participants reflected on difficult relationships with their supervisor:

> *"I think I've been very lucky because… I've had some really good supervisors… the two main case management supervisors I've had have been really supportive people so have kept an eye on my wellbeing as well as, you know, doing the business"* (Beatrice)

Beatrice communicates the importance of having a supervisor who checks in on her own wellbeing, her use of the word *'lucky'* suggests she feels fortunate for having this experience. Arguably this should be the way all PWPs are supported in CMS and should not be up to luck, after all one of the purposes of CMS outlined by Turpin & Wheeler (2011) is to support PWPs.

Similarly, other participants also shared supportive experiences with their supervisor:

> *"So sometimes my notes aren't the best but my supervisor… has really helped me with techniques and tips and things to help and that's made a big difference, so that's been really supportive. I'm glad I've had that. I feel lucky that I've had that."* (Rebecca)

In a comparable way to Beatrice, Rebecca appears to apportion her experience of having a supervisor that helped her practically with her notes as being *'lucky'*. There is an element of PWP showing gratitude for support that would be or should be without question in other supervisory contexts.

In conclusion, this subtheme summarises where CMS may be lacking in terms of the supervisory relationship in CMS. This was encapsulated by one participant in the following extract:

> *"I guess the case management supervision might look very different depending on who the supervisor is, what their values are, what background their training is, what modality they've come from".* (Jasmine).

This subtheme suggests that there is a wide range of experiences in the data with regards the supervisory relationship. For some participants, the common theme seems to be the loss of opportunity for CMS to create a meaningful and supportive supervisory relationship.

Limited Autonomy and Navigating the System

This subtheme refers to how PWPs autonomy, or lack of, effects how they have learnt to survive working in an IAPT service. The previous theme and subthemes explored a lack of autonomy for PWPs, this subtheme builds upon this and draws upon on how CMS may help PWPs navigate and cope with the IAPT system. It further explores a sense of how PWPs relate to their role within the service and how CMS may be able to support with this, but also where it seems to fail to provide the foundations that ensure a PWP feels a sense of fulfilment or identity towards the role. This is elaborated on in the following excerpt:

> *"There's always this tension between what am I supposed to be doing for my role in short-term therapy but is there also more that I could be doing as well. So, there's always that struggle of actually I don't really think this person is for me and just even psychologically if you've heard a really hard story or something like that, there's not time to talk about it, it's kind of like ok that's sad". (Karen)*

Karen articulates a likely difficulty between what she is expected to do and wanting to do *'more'*. She appears to insinuate that there is no space for these tensions to be addressed or acknowledged in CMS. The expression of feeling sad seems to highlight an emotion for Karen that is not being addressed in her CMS, she also talks about a *'tension'* relating to what she is meant to do and what she feels she should do, a tension between autonomy vs following the protocols or recommendations in CMS.

Karen was one of the participants that has worked as a PWP for over 5 years, a relatively long time in comparison to the average PWP work lifespan, which is an average of 2 years (Steel et al. 2015). Her perceptions seem to provide a unique insight into doing this role on a long-term basis:

> *"We joke as PWP's of it just feels like the role of disappointment… you could have a really good rapport and relationship with the client and do some really good work but that's it. Then its someone else's job to kind of takeover, you don't feel like you can see it from beginning to end all the time, or even talk about it in supervision and go wow you know this is going really well." (Karen)*

Karen's use of the phrase the *'role of disappointment'* and this being a '*joke'* warrants further exploration there could be something more ominous

underlying this comment and how it relates to CMS. What Karen could be highlighting, might indicate why the role of PWP is used as a stepping stone role, if it fails to provide expansion leading to disappointment in the role, then it is understandable that people would not want to stay in the role for the long-term. This passage also identifies that Karen's experience is of CMS failing to provide a space for any positive reflection about what has gone well with patients. This indicates a missed opportunity in which CMS stops short of recognising the PWPs arduous work and the limitations of the role, once again this mirrors the lack of genuineness and autonomy allowed in the role in general.

The lack of autonomy and the limitations of working in this way were recognised by other interviewees:

> *"You've been told you need to do BA or you need to do certain types of treatment with someone and it effects what you feel maybe you can do in the room, so if the plan has been to do one particular treatment but actually in session that's not always appropriate".* (Rebecca)

Rebecca's use of the phrase *'you've been told',* suggests her supervisor tells her what to do and how this directly effects how she feels in the room with her clients. The tension between knowing what was initially planned and this not feeling appropriate vs doing what she has been told to do. This frames a sense of doing things as a PWP that might not feel in line with the clients' needs, and may also bring up complex feelings including disappointment and frustration with the role and the service PWPs work in.

Most participants interviewed appeared to convey the tensions between what is expected of them, in contrast to the reality of the job role:

> *"We're going to be touched by some of these long conversations we have with people. I don't often think that people realise the impact that it can have when they're not in the role. No disrespect to anybody here, you know like managers, but just anybody who's not actually done the role won't really understand it."* (Leanne)

Leanne who also has a longer experience of working as a PWP, compared to the average PWP, identifies that the role seems to be misunderstood by '*people';* specifically identifying managers. This description outlines the potential isolation a

PWP may feel; not being in a recognised therapeutic role but still having to interact with distressed clients and contain the distress shared by patients, without this being acknowledged as part of the job.

Continuing with the theme of disappointment and autonomy, some participants reflected on developing certain skills to survive the role as PWP, but feeling *'deskilled'* in other areas:

> *"I do feel more confident… I feel deskilled in other ways but I do feel more confident in doing therapeutic work to some degree… I know that's a bit of a contradiction… I feel a bit more deskilled on explorative stuff with patients because that's not what I do it's very directive… there's not much time to even think about yourself or the patients much, after one session you're onto the next… it just makes me a bit more concerned that I've lost those kind of skills and I know how important personal awareness is for your therapeutic work if you're a counsellor."*
> (Lola)

Lola articulates her experience of the PWP role and her previous role as a counsellor, exploring how these roles are wildly different whilst still coming under the guise of '*therapy'*. Lola talks about not feeling like she has enough time to reflect on her own wellbeing; placing significant importance on her personal awareness, whilst also recognising that there is little space for this as a PWP. It is possible that due to previous counselling training that Lola may have expected her case management supervision to be more like her previous counselling supervision adding to her concerns of feeling 'deskilled'.

Other participants shared similar experiences to Lola, even though they came from different therapeutic backgrounds:

> *"I feel a little bit deskilled in the role, it is hard and then obviously you've got a mortgage to pay. I know it's not all about money but sometimes it's the constraints of life isn't it, and now I feel a bit trapped in the role but I do feel that I'm on a journey and I just have to carry on with it."*
> (Leanne)

Leanne appears resigned to having to carry on in the PWP role, using the word *'trapped'* suggests she feels no other option but to stay in the role, her acceptance may provide some form of control over what otherwise could be seen as

quite a demoralised position to be in. She also speaks of feeling *'deskilled'* in the role however it is less clear about what she feels deskilled in, in comparison to Lola.

The struggle between what is directed by a supervisor vs authentic exchanges with clients, was reflected by some participants:

> *"There'd always be sort of well just do this with them. Just find that one glimpse of technique that you might possibly be able to use in that situation. Rather than help you grow in your skills…oh try behavioural experiments…. actually, if you haven't been trained in it… that's not really part of my job."* (Karen)

This extract from Karen's interview suggests that there is a limit on skills for a PWP and it is implied that that she is encouraged to ignore her own limits by her supervisor. Karen seems to be boundaried and assertive in communicating *'that's not my job'*, this may be due to her being in the role for a longer time. It is evident that PWPs have had to develop skills in navigating the system of IAPT, using CMS to survive in the role, despite some participants feeling *'deskilled'* in other therapeutic areas.

One participant referred to general confusion surrounding use of the term supervision in IAPT:

> *"I get confused actually what they were called because different people called them different things. So, I had weekly supervision which I guess is called case management supervision, and that would just be the new assessments."* (Jasmine)

The uncertainty expressed by Jasmine about CMS refers to her differing experiences of supervision, she intimates that the word '*supervision'* holds differing meaning in differing contexts even within the system of IAPT. It appears the confusion is exacerbated by people using different terms for the same processes. There is a risk that there may be an unidentified assumption held by PWPs that CMS should provide support comparable to clinical supervision. This assumption could create further confusion and add to the systemic complexity of the IAPT services.

> *"It's just the service as a whole. Isn't it? No amount of supervision is going to be able to change that if you have somebody who really would*

> *like some counselling you know quite urgently, not because they're at risk but because they've got so many problems and lots going on. You have to put them on a long waiting list, that's frustrating but that's just the fault of the service, the structure of the service."* (Leanne)

Participants, such as Leanne, seem to express the opinion that attributes the difficulties experienced as a PWP and in CMS, to the *'fault'* of the service as a whole. The impact of having to place distressed clients on long waiting list does not seem to be addressed in the CMS provided for Leanne. Leanne delivers an insight into the possible attitude that PWPs adopt to survive working in a service that functions in this detached way.

The majority of participants interviewed spoke about reducing their hours as a way to cope with the demands of the PWP role; navigating the system by doing other roles alongside the role of PWP. For example, Beatrice revealed that she split her PWP role with another role in the service:

> *"If I didn't have variety I think I'd just wake up one day and thing I've got nothing left to give."* (Beatrice).

In this case it appears that Beatrice has learnt to survive in the service by not doing the PWP role full time.

CMS appears to provide a platform, for some PWPs, to remind them of their enforced limitations in the role and helping them learn skills to navigate and survive in the system of IAPT. From conducting the interviews, it seems evident that not many participants have had the chance to reflect on the disappointment and lack of fulfilment the PWP role supplies, as they used the interview as a space to consider this further. On the other hand, most participants seemed resigned to accepting that they have little autonomy within the system of IAPT. Instead they appear to utilise CMS for reviewing their caseloads whilst combining this with other creative ways such as reducing their hours, in order to function as part of the service.

Neglected Emotions

This subtheme presents participants experiences of CMS as not being a place where their personal feelings are routinely discussed. Additionally, participants mostly expressed that even if they wanted to reflect on their own wellbeing in CMS, this would not be responded to by their supervisor in a supportive way, providing little

recognition for the PWPs own processes. Participants disclosed that CMS felt an unsafe place to show such human vulnerability, in the face of such a structured and reductionist culture. Technically CMS does not seem to be designed to provide formal emotional support like clinical supervision. However, worker support is listed as one of the roles of CMS (Turpin & Wheler 2011) and it is understandable that PWPs may assume that CMS may be a place where emotions can be explored.

The inability for staff within IAPT services, including supervisors, to provide emotional support seems to leave a chasm in the recognition of the human experiences of PWPs undertaking the role:

> *"I don't think you get the emotional support, there's not really a place to have emotional support, it's more practical support on what you do with things and how you deal, what you're doing with patients."* (Rebecca)

Rebecca's use of language here is indicative of a lack of space to access emotional support as a PWP, this seems concerning as PWPs are expected on some level to provide emotional support for the high volume of people they see, without receiving this support themselves. Again, a difference in supervisors seems to impact the level of support received:

> *"I don't really feel like they're interested and I know it's hard because they've got their job to do… I don't feel there's any kind of empathy with your own stuff that it might be hitting upon. I've not been able to share how I'm feeling never, ever."* (Leanne)

A lack of empathy can be linked directly to the deterioration in the therapeutic relationship with clients. Likewise, it would be ignorant to not assume that a lack of empathy, experienced by Leanne in this case, could possibly lead to a deterioration in Leanne's own mental health. The phrasing of *'never, ever'* being able to share her feelings suggests that the space in Leanne's CMS has categorically not lent itself to exploration of her emotional experiences. Leanne had worked as a PWP for longer than the average time, as a result, she provides an important insight into the personal impact of not being able to share her feelings in CMS. Similarly, Rebecca communicates the dilemma of being trained to provide empathy to clients, but not receiving this empathy in her workplace, from her supervisor or the service as a whole:

> *"I've heard some horrendous stories and experiences people have been through, like really horrible, and I have to just sit with that. There isn't a space to talk to anyone about it and it's confidential. I can't talk about it, tell friends or someone at home… I'm stuck with that in my head… There's not really the space for how things have affected you personally or emotionally."* (Rebecca)

In other therapeutic settings, Rebecca's experience as portrayed in this extract could be viewed as extremely unethical, and potentially dangerous professional practice for both PWP and the clients they work with. The concept of the emotional burdens being *'stuck'* in Rebecca's head, begs the question of: How much can one human take of this way of working before they are unable to function effectively?

Unfortunately, Rebecca was not the only participant to imply this situation and it is insinuated that this is directly linked to the pitfalls in CMS:

> "*We don't talk about the therapeutic work, how you feel in the session and the impact it has on you as a practitioner. I think that's upsetting… You don't even stop and think about it when you're in the day to day of it. So yeah it doesn't encompass that, which in this role is really difficult. You need that emotional support as well and although its offered out, its offered out in a very management style. I suppose your needs and your own personal reflections and development are not supported as much as the patient; I know the patient is the main thing but actually that affects the patient too."* (Lola)

It appears that Lola was using the time in the interview to reflect on feelings that she feels she is not able to express in her CMS. Lola also reflects on how this may have a detrimental impact on the patients she works with. It is unclear what is meant by emotional support being offered out in a *'management style'* but this insinuates that there is something disingenuous about how PWPs are supported in CMS, this would arguably differ to the support received in clinical supervision if this were provided.

> "*I know we all have suffering, we all suffer don't we in different ways…. sorry I don't want to get emotional…. you begin to doubt yourself and you think my goodness I'm just some kind of robot or some kind of unfeeling person. It does make you think like that in the end."* (Leanne)

Leanne addresses a possible oversight of large corporate services such as IAPT, that we all experience suffering. Her use of language in this quote demonstrates the importance of validating a persons' experience regardless of whether people are accessing IAPT services or working within them. This extract could be seen as an example of a participant utilising the interview space to share previously unexpressed emotions with regards to the PWP role and CMS. A conflict is delineated in terms of PWPs experiences of questioning their own integrity about being a *'feeling person'* as demonstrated by Leanne. The following excerpt further elaborates on Leanne's experience:

> *"When I first came to the role I just thought it was really, really, really bizarre that there wasn't that space to reflect. You were bringing all these people and you were soaking up the emotions of everybody and you know listening to their difficulties day in day out… I think I've just got used to it now. I've become acclimatised to it, not that I've become hardened to listening to stories because it still does have an impact on you sometimes doesn't it."* (Leanne)

Leanne articulates her experience of joining her IAPT service, expressing her astonishment about the lack of emotional support in the role of PWP. Leanne, having worked in the service longer than 5 years, describes *'becoming acclimatised'* to the potential that there is *'no space'* to reflect on the emotional demands of the job. The notion that PWPs gradually just learn to accept the lack of a place to reflect on their own reactions and processes within the role is concerning. Particularly in relation to the literature that favours the importance of therapist wellbeing relating to having a space to explore personal processes, this has also been linked to client outcomes (Freitas, 2002).

As the PWPs interviewed came from a wide range of backgrounds, one insight compared the experiences of the PWP role with regards to a previous role in secondary care:

> *"I think if anything I'm more likely to have more emotional responses with the current client group that I work with right now."* (Louisa).

The scarcity of not having a space to explore the emotional side of being a PWP, creates further concern following the notion that the emotional responses PWPs have in their job, may be more intense than working in secondary care.

Additional areas of support outside of CMS were identified by way of trying to provide much needed emotional support for PWPs:

> *"Reflective practice was a little bit of an add on that felt like: oh somebody is recognising that we are real people in this, who have to do this job day after day, and we're not machines you know."* (Beatrice)

Beatrice reviews the reflective practice some PWPs have access to, although, there is not a requirement to provide this to all PWPs. The way Beatrice describes reflective practice does not intimate that this space is highly thought of as helpful for her. She also suggests that reflective practice spaces, provided for Beatrice approximately every 6 weeks, do not meet the needs of reflection and exploring emotional responses of PWPs either. However, it is important to consider that some participants did not place as much importance on sharing their emotional responses to the role, alternatively they prioritised experiential learning:

> *"I think that what I would have got from that supervisor that I wouldn't get from the current PWP supervision is: more learning around problems, presentations, more about the background of the person… so much, much more in depth, much richer and so beyond just the presentation and diagnosis, more about the person them self."* (Howard)

Howard outlines his experiences from a previous supervisor, although he explained he had not done a therapeutic role before becoming a PWP, it appears that he is sharing that other supervision has provided a space to think about his clients in more detail. Howard did not draw attention to his own emotional wellbeing in the role. Nevertheless, Howard did become emotional during the interview when discussing the experience of being able to help clients; this suggests that if he was given the space he may benefit from further exploration of his emotional processes, regardless of whether CMS is the correct place for this exploration.

Overall, the majority of participants interviewed seemed to convey similar experiences of CMS, identifying that their emotional needs were not

sufficiently addressed or supported. Exploration of other avenues of support, such as reflective practice, also seem to fall short in terms of aiding PWPs with their own emotional wellbeing.

Pressure and Burnout

This final subtheme outlines the tensions that PWPs may experience within the role, it is important to note that this pressure seems to be mirrored in CMS and in the wider IAPT services. Consideration of this subtheme is sympathetic to the reality of the strains generated by undertaking the PWP role and serves to further understand the experience of PWPs in CMS. This subtheme explores how factors interrelate within the role, incorporating consequences of the pressure experienced, for example, service tensions, leading to a lack of time, linking with instances of burnout.

> "*Sometimes you wish you had a bit more time like everything in IAPT, everything in IAPT is so high pressure."* (Beatrice)

Beatrice briefly elaborates on the pressure in IAPT, whilst also appearing to normalise and accept it as it is just the way everything in IAPT is. The term high pressure usually suggests that, at some point, something has to give in order to relieve the pressure. This pressure was also identified by another interviewee and comparisons were drawn in relation to other supervision experienced:

> *"It's a lot more rigid… it's very time pressured….no matter how many patients you've got, you've got an hour. Can't spend too long talking about each one."* (Rebecca)

Rebecca highights the lack of time experienced in CMS implying a rigid, time bound space, that is not flexible should the PWP need more time to discuss a patient. Although CMS is time pressured, Rebecca also shared the following reflection when talking about what she is required to bring to supervision:

> *"I've always had time to fit it in … I'd generally just bring in my new assessments and any risk or anyone I'm reviewing or needing help with."* (Rebecca)

Despite the time pressure Rebecca's use of language indicates she is able to fit in with this way of working. The real-life logistics and timings of CMS were conveyed further by Howard:

> "*It works out 2 to 3 minutes per person' with the main focus of case management supervision being "do they have any risk", "what's the main problem", "what's the intervention you're going to use"… some people then might not be discussed for more than 20 seconds or so, 20, 30 seconds."* (Howard)

Howard's breakdown of timings, further outline the high-pressure nature of CMS. The time frame of 20 to 30 seconds seems awfully short considering the nature of depression and anxiety, taking into account the variety of patients that PWPs might be assessing. It is inevitable that concerns may develop around how effective the CMS may be, if such little time is dedicated to each patient.

In addition, Lola reflected on her feelings relating to this subtheme:

> "*I don't feel I've enough time to explore, and often I'm concerned about my treatment decision at the end of it, and I kind of go away thinking I'm not sure about that."* (Lola)

This suggests that a familiar feeling in CMS is, the pressure of not having enough time; which leaves PWPs feeling concerned and unsure about their decision making. This is something that has been identified by other PWPs interviewed:

> *"It does sometimes feel like you're doing people a disservice, because it just seems so rushed*." (Leanne).

Leanne shares a key factor relating to the people she is discussing in CMS; that it feels that people are not getting the best service due to the time pressures.

Fears around the impact of this pressured working on clients were shared by others:

> *"I think that because of the pressure to do something with people they might not get a true sense of what therapy is like, so their first experience is of this very didactic, kind of, pure self-help method of working and I think there is the potential there to put them off what actual CBT is like, because it is very different to the way that we do it."* (Karen)

Karen identifies another potential tension within CMS; as well as the time pressure there is the pressure to *'do something'* with people. If this is so it is a big responsibility for a role that is described as '*low intensity'* and *'guided self-help'*. Furthermore, it is unclear about how this *'something'* sits with patients' choice and wellbeing. Interviewees also picked up on the unrealistic pressure of expecting PWPs not to foster therapeutic relationships with their clients:

> *"Perhaps there's a premise that we're not actually going to be listening to lots of stuff but I mean people don't know, you've got to actually put it in context. You've got to listen to some of the stuff that's gone on before, haven't you?" (*Leanne*)*

To take what Leanne has communicated at face value she seems to be sharing that patients who access IAPT service don't know, or understand, the limits of the PWPs role, this in turn can lead to a misunderstanding that PWPs are formal therapists. As a result, service users may attempt to begin the therapeutic work within the first contact with a PWP. It is important to consider the potential impact on clients of being cut off by PWPs, if they did begin telling their *'story'*. Leanne provides a realistic view of this; whilst also being sensitive to the impact on the client. This specific pressure of the role has been linked with burnout and is reflected in recent literature (Steel et al., 2015).

An explicit link between seeing people at such a high volume and burnout was suggested by the following participant:

> *"I love what I do and I don't want to burn out from it and just start not caring anymore, which is a real danger when you see people, that many people each week."* (Karen)

Karen is also able to articulate that she holds great affection for the role of PWP but also sees the potential pitfalls of working in such a way.

It is possible that individuals undertaking the PWP role are, most probably, as diverse as the client group that access IAPT services. With this in mind it is hard to say categorically that the high-pressured nature of the role is always detrimental to the wellbeing of PWPs.

On the other hand, the majority of participants used language that conveyed a negative appraisal of the stress and pressure of the PWP role, this is specifically highlighted in the following experience:

> "*I've experienced that on a Friday afternoon, when you've been seeing people all week and somebody comes in for an assessment. They're telling you the story and you're just inside thinking 'oh I'm exhausted now, I don't even want to listen to this' and you have to really pull yourself back."* (Beatrice)

The words used here by Beatrice portrays a tangible example of what it is like to be a PWP on a Friday afternoon, the fatigue that accompanies this and the effort it entails to continue to assess and provide people with the same due care and attention. It appears that CMS and the wider service, fail to recognise the compromising position PWPs are put in, being saturated with listening to peoples' distress.

In conclusion, the subthemes explored here all converge in the direction of the broad theme of *'Pitfalls of CMS'*. Throughout the data participants have articulated their experiences CMS not providing an optimum space to assist in their role as a PWP, with specific oversights around the emotional experiences of PWPs, having to work at such high volume and links between this pressure and wellbeing. The assumption that PWPs should receive further emotional support warrants further exploration.

Serving a Purpose

The primary meaning of this theme is centred upon the functionality of CMS, this theme contains a space where positive experiences of the PWP job can converge and be appreciated. This theme also encompasses the positive aspects of the PWP role and the wider support that is utilised by PWPs in IAPT services. There are many critiques of IAPT and it would be easy to get lost in only focusing on these throughout the data set. However, it is important to try to balance this with a more optimistic appraisal of both CMS and the PWP role, and the data collected provides a range of fertile insights which help to support this wider theme. This is presented further in the following subthemes.

Feeling Supported through Shared Decision Making

This subtheme relates to the use of CMS to provide support and assistance to PWPs with regards to the decisions they make, in terms of the care and treatment of the people they assess. Many participants interviewed shared a least one positive observation pertaining to the support they receive, or received, in CMS, specifically from their supervisor. This subtheme considers an opposing view to the previous subtheme of *'Neglected Emotions'* by explicitly outlining experiences that indicate a supportive element to CMS.

Appreciation of having CMS whilst training to be a PWP was identified by several participants:

> *"I think one of my real issues when I first started training was taking on people that were too complex and supervision was a good time to explore this, it was a bit of an eye-opener about reminding me about what I should be taking on and what I shouldn't… when you're in a room with someone you can feel like you want to rescue them… especially when you're new to training because you're not confident in your abilities, you take on too much because you don't know where that line is, what's good enough and what you should be doing."* (Jasmine)

CMS outlines the boundaries of the PWP role and keeps the PWP considering their limitations, whilst training this appears to be invaluable for PWPs with little experience about how the role is undertaken. This has also been echoed by another interviewee:

> *"I've found it quite helpful coming in as a trainee... It's been really valuable for me because you're very alone with patients quite often, definitely when you're training. You're learning, and being able to check your decisions, that you've done it right, even when they don't need to give you advice, just to know, helps build confidence in your ability as a practitioner."* (Rebecca)

CMS appears to provide a space for trainees to build their confidence and check their decisions, in a way this supports the shaping of PWPs into practitioners that are in line with the IAPT models. In this sense CMS could be a means to an end, with regards to making sure new PWPs adhere to the IAPT way of working. It appears that especially when training; the space provided by CMS is appreciated and utilised by trainee PWPs to help build confidence whilst learning in vivo.

A substantial proportion of participants interviewed, commented on the reassurance elicited through sharing their case load with another person:

> *"I feel that perhaps it helps, being backed up by another person maybe, agreeing the plan. Makes sure they have the right treatment; shared decision making can help the client rather than it just being one person"* (Leanne)

Leanne describes the importance of the feeling of shared responsibility, and implies that this is supportive for both her and the service users. The feeling of being supported by the CMS space was also picked up on by Lola:

> *"It makes sure you've covered certain things which is fine and really helpful in many ways. So, I'm kind of supported in the sense of risk to some degree. So, I know how to look after a patient and what to do if I'm not sure… you're not working on your own…that's very good because it can be quite solo at times."* (Lola)

Lola's use of language depicts that CMS helps her feel supported specifically with risk, or if she feels unsure about clients. She also stresses the importance of having such a person to share her work with as the PWP role can be quite an isolating one, in this sense CMS seems to be invaluable to the PWP role to keep the connection with the wider service of IAPT. The notion that CMS provides reassurance and safety with regards to clients that pose a risk, was also outlined by Howard:

> *"With the numbers that PWPs have to deal with. I think it does help to identify potential areas of risk that you might not have considered. Particularly for safeguarding stuff that maybe you know if the person or an extra pair of eyes can prompt you, to ask you questions about… you have to review your case load every week and I think that's really, really helpful and keeps you more on the ball."* (Howard)

It is evident that due to seeing such a large number of clients; PWPs use CMS to patrol risk issues that may otherwise be missed. Howard uses the term: *'extra pair of eyes'* when referring to CMS, which seems to be supportive to him with regards to managing patient risk.

The structure of CMS has been identified as a strength; this seems to be established by some case management supervisors who:

> *"Had a very clear idea about how supervision should be and what they needed to bring. It was very structured and very safe because it was structured…. I was ploughing on with some treatment and then my supervisor said oh but… are we missing anything here."* (Beatrice)

It seems to be an advantage in CMS if the supervisor and PWP are both clear about the structure, Beatrice notices that this structure helps provide a safe space that facilitates reflection on her work. This way of working appears to provide a supportive and secure base from which Beatrice can reflect on factors such as client information being overlooked. It is evident that although this experience was not shared by all PWPs; some PWPs like Beatrice could be experiencing a safe and nurturing environment in CMS, that assists them in reflecting on their client work. It would be all too easy to overlook the positive aspects of CMS due to the way PWPs have such mechanistic way of functioning within IAPT services, it is refreshing to pinpoint aspects such as the structure of CMS as working to create a safer environment for some PWPs.

A Place to Reflect

This subtheme refers to PWPs utilising the space provided by CMS, and more notably the time in the research interview, to reflect upon the optimistic aspects of being a PWP. There is little evidence in the literature presenting positive aspects of the PWP role. This subtheme encapsulates the encouraging aspects of the role and CMS shared by the participants in the interviews. The PWPs interviewed all used language to convey that they genuinely wanted to help and provide support to people in distress:

> *"The positive part of it is that I love working with patients...you're responsible for helping them, if you weren't there that's one less person to help. I can think of all these people I've helped and I want to be a part of that."* (Rebecca)

Despite being relatively new to the role of PWP, Rebecca refers to wanting to be part of a service that helps people, she draws attention to the level of

responsibility given to PWPs to help people in some way. Rebecca also seems to use the PWP role to provide her life with some meaning, she seems to relate to the care giving role and expresses a wish to identify with a wider community of people who also want to help others.

Reinforcement in terms of providing a meaningful service was also identified by PWPs who had been in the role for a longer amount of time:

> "*When you are working with more mild to moderate people… actually in 4 to 6 sessions you can do a lot of good."* (Karen).

Karen gives the impression that she is boundaried about when the PWP role can do *'good',* she explains that when the people who access IAPT fit the model it was designed for: '*mild to moderate anxiety and depression'* PWPs can assist clients with these specific difficulties. Despite recognition of the limitations of the role, participants could identify affirming aspects of the role:

> *"I do find it rewarding from time to time even though there are quite unrealistic targets. I think it does help, I think sometimes it can be quite helpful for people even if they don't finish treatment. I think just having a conversation with somebody about mental health can be helpful, kind of, normalising it a bit."* (Leanne)

Leanne appears very honest about pressures of the idealistic targets of IAPT, but she is also able to identify that talking openly about mental health can be helpful in itself; this may provide some positive reinforcement for her in the role. This experience was mirrored by other interviewees:

> *"The people who I see get better. You know on a certain level that kind of low intensity CBT can really work. I've seen people come out of depression, come out of anxiety, using those techniques so that's probably what keeps me going with it. I think for me I stay in it because I've got a mix as well, I also do some counselling." (*Beatrice)

On reflecting about what keeps her in the role of PWP Beatrice shared the above statement, she notices that the CBT techniques are effective in helping those showing symptoms of depression and anxiety. The witnessing of people getting 'better' seems to provide enough to keep her doing the role of PWP. It is important to note that Beatrice also has another role within the

service which appears to help her manage her PWP work. Alternatively, not all participants interviewed conveyed the same experience of the PWP role:

> *"I don't feel like I'm gaining anything extra by being a PWP now, so for me I'm at the point where I'm moving on… I went into therapy to meet new people, to hear their stories and to offer them some sort of support… I feel like I've got what I wanted to get and that was building up my confidence."* (Lola)

Lola outlines a possible reason for undertaking the PWP role; to build her confidence. Lola indicates that offering support to others is an aspect of the job she values. On the other hand, she also sheds light on to what may happen to PWPs with regards to the high turnover; identifying that she is not '*gaining*' anything more from being a PWP, this could relate to the lack of professional development and progression in the role, leading her to want to *'move on'*.

CMS can sometimes provide a space to recognise the rewarding aspects of the role of a PWP. The use of the interview space to reflect on this further seems to suggest that PWPs might appreciate more of this reflective space to share their phenomenological experiences of the role:

> *"I think it's quite nice sometimes to look at recovery rates… quite nice seeing your piece of work and having that positive feedback from your supervisor. I think that can feel very, very, very supporting. I think sometimes if you are working at quite a high-volume pace lots of your good work might get overlooked…sometimes through the supervision process you are recognising yourself what work you are doing and also it's quite nice having that recognition for the hard work from other people."* (Louisa)

A very important aspect of CMS seems to be the recognition Louisa receives for her work as a PWP, she was one of the participants that spent a longer time in the role and this recognition might have helped her survive in the role for a longer than average PWP. She identifies that she receives *'positive feedback'* from her supervisor and appreciates CMS providing a space for this. Not all participants shared this positive experience of CMS, but some were able to remark upon the novelty of being able to reflect on their role within the interview:

> *"It's been quite nice to reflect on it all really and to think about where I've come from in terms of case management. It's quite good, yeah thank you."* (Beatrice)

It appears that CMS can sometimes provide a space to recognise the rewarding aspects of the role of a PWP. The use of the interview space to reflect on this further seems to suggest that PWPs might appreciate more of this reflective space to share their phenomenological experiences of the role.

Internal Scaffolding: 'We are all in it together'

This final subtheme serves to create a place where easily overlooked aspects can converge in terms of the support accessed by PWPs. From analysis of the data, it felt important to create a theme to capture the strength and resilience evidenced by the PWPs interviewed, as they appeared to utilise their initiative in settings outside of CMS, to seek out creative sources of support to meet their needs. From exploration of the previous themes and subthemes it is evident that CMS serves a function within the IAPT service structure: an internal scaffolding if you will, within the service, that helps PWPs review their sizeable caseloads. Sometimes, for some, there is space in CMS for PWPs to discuss their own personal reflections about clients or the role in general, but more often than not there is a scarcity of this supportive emotional space for PWPs. It was evident during this research that PWPs have to develop high levels of resilience, their own internal scaffolding, that they utilise to support themselves with this role. Additionally, they appear to be able to draw upon the internal scaffolding within services, of collegial support. This sub-theme delineates the various ways in which PWPs glean support for their emotional needs outside of CMS.

The significance of having meaningful connections with co-workers seems to be a substantial source of validation for PWPs:

> *"Obviously I've got colleagues here who'll be kind enough to have informal talks too, so that's really valuable having the informal networks. That is really important because we are all in it together."* (Leanne)

Leanne uses language like *'kind enough'* to describe the people she works with and expresses her appreciation about having the *'informal networks'* to support her with undertaking the role of PWP. The unity of being *'in it together'* conjures up

images of comradery and connection within a system that arguably has made a substantial shift away from these values, in favour of a more mechanistic and target driven way of working. Other participants reflected on the wider setting of their day to day work and shared the ability to unearth additional support from these contexts:

> *"Just having a nice environment to work in, where people are friendly, a shared office.... They're pretty receptive to just having a bit of a chat… it was really, really helpful."* (Howard)

Howard identifies simple factors such as being grateful for having a *'nice'* atmosphere and setting that he works in; the notion of having a workspace that has a variety of other modalities, and therapists, from differing background appears to be an advantage for Howard, as he can have informal conversations with his colleagues. The concept of being surrounded by a sympathetic workforce has also been identified as a helpful factor by Jasmine:

> *"Having a really good team around me really, really helped, because we all were in it together… As well as seeing them in work you'd see them outside of work and I think it just helps to see the bigger picture of life, doesn't it? Of like, we're not all consumed by case management supervision and the nature of the job. We do have, you know, more things in life."* (Jasmine)

Jasmine notices the complex dynamics of her PWP team explaining that some of her teams have gripes about the role and the wider service but that this can be related to by incorporating a sense of a wider context and utilising humour. It could be argued that Jasmine evidences the ability to keep grounded by reminding herself of her life outside of the PWP role, which seems to be beneficial to her workplace wellbeing, once again the '*team'* she works with have been recognised as a strong source of support for the PWP role. The word *'team'* was used by the majority of participants interviewed, in relation to support they receive outside of CMS:

> *"I think one of the things that I really benefit from is just interaction with colleagues… You can just ask something and there's a real sense of being a team and working together."* (Beatrice)

The notion of team work and receiving assistance from fellow work associates is once again delineated by Beatrice, it is apparent that the sense of *'working*

together' is a strong source of unofficial support for PWPs. This informal and uncaptured support arguably could be contributing to the success of IAPT services thus far, but is at risk of being overlooked and rendered invisible. With no specific time officially outlined for peer support, there is a risk that managers and commissioners will neglect the importance of it, and not allow space for this vital part of IAPT services functioning.

The significance of this behind the scenes support is further explored in the following excerpt:

> *"Sometimes you just need to be able to talk to someone about it, just to say look I've just heard this really sad story and actually talking to another fellow colleague, you know it did feel like that was the best support. Really with the supervision it could've been there or not really, it was supportive in some ways so that you know actually I've ticked a box, I'm protected because I've spoken about this person, but actually it was more about talking to the colleagues and other people and other modalities as well, not just PWPs. We had counsellors that we could talk to about certain clients and things, so that was actually more helpful."* (Karen)

Karen portrays her version of what it is like to be a PWP interacting with a wide range of people accessing IAPT services. She identified that talking to colleagues, who can also relate to the unique experience of hearing emotive life stories, appears to be the favourable source of support over CMS or other formal channels of assistance. Karen specifically identifies her counsellor colleagues as being her personal preference for emotional support in the service. The concept of counsellors supporting PWPs in IAPT service is an interesting one, as not all IAPT services have a counselling team; due to counselling having less of a formal evidence base compared to CBT. The notion that Karen has pinpointed counsellors as being *'more helpful'* suggests something about the way counsellors are trained, potentially in the empathic realms, that helps support Karen in her role as PWP. A salient point to consider as the use of counselling techniques are less valued by IAPT services. It is possible that in reality counsellors demonstrate superior relational abilities in comparison to HI therapists, and this support is appreciated by Karen.

In general, the wider IAPT workforce seems to provide additional support for the majority of PWPs interviewed, there is a risk of this invisible provision being overlooked by IAPT services and the wider system, as it has not been formally

captured or made explicit. This subtheme has illuminated the significance of collegial support and the importance of PWPs being able to take their own initiative, to seek out additional support from their wider team. There may be an assumption that all PWPs are adept with regards to their own emotional wellbeing, which may not be the case in reality. It could be suggested that PWPs may need a more formal place to address their own emotional wellbeing outside of CMS and the informal channels of support from their teams.

The subthemes outlined here all relate to the main theme of *'Serving a Purpose'.* Overall this theme attempts to draw together all the positive aspects of the PWP role and explores how spaces outside of CMS appear to support this complex role. In addition, this theme strives to capture the informal networks of support that seem to be at play, under the formal radar, of protocol driven IAPT services. The importance of collegial support and a sense of community whilst working in these services seems to be crucial, however, there is a risk that this support is an invisible backbone for PWPs unrecognised by the formal supervision channels within IAPT.

Discussion

Summary of Findings

The findings of this study proffer insights into CMS for PWPs working within IAPT services. Three analytical themes have been presented, these include: *'Part of the IAPT Machine',* which outlines that PWPs and CMS operate as part of something bigger by exploring the distribution of power within CMS and in the broader service. CMS serves a function to assist IAPT services that are guided by concrete targets and outcomes. The second theme: '*Pitfalls of CMS'* presents the drawbacks of CMS. Thirdly, the theme of *'Serving a Purpose'*, delineates the encouraging aspects of CMS and the PWP role within the IAPT infrastructure. It is evident that each of these themes can stand alone to provide a partial response to the research question. However, by amalgamating these three themes and bringing them to bear on each other, this thesis arrives at a multidimensional and nuanced response to the research question.

Contextualising the Findings in the Existing Literature

The themes and subthemes presented here resonate with existing research and observations about IAPT services, whilst also corresponding, more broadly, with the role of PWP. As a result, this section will examine existing literature, focussing on CMS, the PWP role more generally and how this relates to counselling psychology.

Supervision for PWPs

Throughout the data collection process, I observed that the majority of participants in the study, expressed a sense of appreciation to me for providing them with a space in the interview to reflect upon their experience of the PWP role, and CMS. I was aware throughout the data collection, that my personal experience as a PWP dovetailed with the therapeutic learning on the counselling psychology doctorate, I noticed at times during interviews feeling the temptation to provide a supervisory space for the participants. I noted that participants used the interview to express their emotions and ambivalence regarding the PWP role. For example, Leanne, who became tearful when explaining her experience of feeling invalidated, both in CMS and in her IAPT service in general. The use of the interview in this way suggests that PWPs could possibly benefit from having a reflective one-to-one

space. Furthermore, room for reflection and validation may increase personal wellbeing of PWPs and may also serve to attend to levels of job satisfaction.

Due to working with high caseloads; two specific challenges within the role of PWP have been identified (Thwaites at al., 2015). Initially, PWPs do not have time to reflect or learn from their experiences in the role because of the fast-paced and high-volume nature of the work. Additionally, current PWP supervision provision does not appear to provide enough support to prevent burnout. Turpin & Wheeler (2008) observe the link between receiving supervision and how this reduces instances of burnout, specifically highlighting the relevance of this for low intensity (and therefore less rigorously trained) staff with high caseloads. In addition, it should be noted that the label 'low intensity' can be misleading for aspiring PWPs and the wider context of IAPT, as it refers to the level of severity of the client's issues and does not do justice to the subjectivity of the practitioner.

PWPs see more complex patients than they were originally trained for, according to Cairns (2014). PWPs in this study have demonstrated feeling like they need to do 'something' with these complex clients, yet they are left without a supervisory experience of commensurable complexity. There appears to be conflicting messages received by PWPs in CMS pertaining to issues of 'stay within your training' vs provide 'some sort of support' for clients. The burden of taking on unsuitable cases has also been noted by Shepherd & Rosairo (2008). It is important to consider that with increased complexity of patients, comes a higher risk of vicarious traumatisation for therapists; this refers to the therapist experiencing a traumatic response as a result of witnessing clients discussing their trauma. Indeed, supervision has been identified as a key measure, necessary to reduce this risk for therapists (Turpin & Wheeler, 2008).

Studies such as Cashwell & Dooley (2001), highlight the link between receiving supervision and greater feelings of self- efficacy; it is evident in the PWP role that self-efficacy is not encouraged (this is most potently captured in the subtheme *'Being a Robot'*). This lack of self-efficacy is in contrast to the ethos in counselling psychology and other therapeutic arenas which advocate use of self-awareness and autonomy. There appears to be a tension for PWPs between doing what they feel is right by using therapeutic intuition vs doing what they have been trained to do. It is important to consider the links between this didactic way of working and the lack of clinical supervision for PWPs. The supervision literature that

guides IAPT supervision for PWPs (Roth & Pilling, 2008) highlights explicitly that CMS is designed to prevent 'drift' into other areas, not covered in the PWP training, such as HI CBT interventions or person-centred counselling. There is marked focus on preventing this 'drift', with the possibility of prioritising this over and above emotional support, concern for the wellbeing of PWPs or validation of the difficulties of balancing client need and the interventions PWPs are trained to deliver. It feels futile to argue for clinical supervision or further reflective space for PWPs beyond CMS, as it appears that this does not fit with the IAPT service model, and may not be appreciated or fully utilised by some PWPs. It has become evident to me as the researcher through the process of this research is that there may be some confusion with regards to the function of CMS for PWPs: for example an assumption that CMS is interchangeable with clinical supervision.

What might be worth considering is the importance of the relationship between supervisor and supervisee. There is a corpus of clinical supervision research outlining the importance of the supervisory relationship, for establishing quality supervision (Bernard & Goodyear, 2004). It appears that the supervisory relationship between PWP and case management supervisor is not something that has been given adequate attention in IAPT literature. The importance of a safe supportive relationship in supervision was initially acknowledged by those developing IAPT services (Samuels & Veale, 2009). In a paper relating to supervision in IAPT, Turpin & Wheeler (2011) identify the importance of the 'working alliance' between supervisor and supervisee for effective supervision. Ladany (2004) further identifies that a good supervisory alliance is needed to prevent PWPs feeling shamed and not disclosing important clinical information as a result. Poor supervision occurs when supervisors pay little attention to supervisees' concerns (Shanfield et al., 2001) and there is a significant chance that CMS supervisors may not fully meet the emotional needs of PWPs. It seems this parameter is absent in the relevant protocols and has been overlooked in the reality of PWPs day-to-day work. Additionally, the differences between training for supervisors in IAPT calls for attention; some seem to have had a day of training, compared with others whose competencies encompass years of experience (Turpin et al., 2008).

From the findings there seems to be an unspoken implication that PWPs do not need a relationship with their supervisors, this is similar to the expectation that they do not have a relationship with their clients. Although literature informing IAPT

supervision nods at the supervisory alliance, there seems to be more emphasis on adhering to the evidence base rather than the complex human interactions in supervision and the impact that they have on PWPs. It is crucial to note that variability occurs across IAPT services with regards to who provides supervision for PWPs; experiences of CMS for PWPs is dependent on service, supervisor and the PWP themselves.

Therapist Wellbeing and Burnout

A strong trend in recent research centres on the wellbeing of therapists working within the NHS, and links between the pressures of front line mental health roles and burnout. Recent studies indicate an elevated level of burnout in IAPT workers (Westwood et al., 2017) and prominent levels of exhaustion in IAPT staff; this research also makes connections between this exhaustion and a potential impact on client outcomes (Steel et al., 2015). Lim et al., (2010), found that predictors of emotional exhaustion include high work demands and a lack of autonomy; these are both characteristics of current IAPT services (Steel et al. 2015). Burnout is a concern particularly for the role of PWP, which has been specifically designed to work with a high volume of people, but offers no protection with regards to professional identity or autonomy. This is in comparison with HI CBT therapists, who are safeguarded to a certain extent by their membership of the BABCP, which provides the Standards of Conduct Performance and Ethics (BABCP, 2017). It is evident that there is little room for therapist autonomy when working as a PWP in an IAPT service, and CMS supports this way of working.

The reality of working in a pressured environment such as IAPT is reflected in the recent results of a survey of over 1,300 psychological professionals within the NHS. This survey was conducted by the British Psychological Society, and the New Savoy Partnership (BPS, 2015); findings presented worryingly high levels of burnout, stress and depression in NHS staff members.

Development of, and within the PWP role

The role of PWP appears to have been introduced as a cost-saving measure for IAPT services to provide ‘therapy’ to people without the cost of paying a fully trained therapist. This has wider implications for more applied psychologist roles such as counselling psychology potentially serving to undermine the profession of

Psychology. The PWP role seems to have acquired a transient reputation; being utilised as a stepping stone to other careers such as HI CBT roles or applied psychologist training. Moreea (2015) identifies the lack of career progression within the role, leaving PWPs feeling ‘stagnant’ in their jobs and resulting in high turnover as they search for more fulfilling roles. It has been identified that the PWP role itself and PWP training positions have trouble reaching their full capacity (Moreea, 2015); as a result, it seems fitting to consider the nature of this role, and what the real-life impact may be for those moving in and out of the position.

One important question to consider is; What is attracting PWPs to the role? The role could be compared to an assistant psychologist post; both provide budding psychology graduates with front line therapeutic experience within the NHS. The PWP training is marketed with an inspiring and positive invitation to join the ‘biggest revolution in mental health’ by undertaking ‘paid training in a paid role’ (UCL n.d.). The advert presented by the University College of London is obviously very enticing to psychology graduates, but understandably as their objective is to recruit future PWPs it does not outline the challenges of the role.

It is worthwhile to evaluate more what draws people to train as applied psychologists and other therapeutic roles such as a PWP. Motivating characteristics may include: a want to ‘help’ or ‘understand’ others, along with a ‘shadow side’ of early loss and early parentification (Barnett, 2007). People drawn to the PWP position would typically be early on in their journey to become recognised therapists, and may have many unconscious motivations to help others. It is also possible that PWPs may be drawn to the role because they identify with being wounded healers; a wounded healer being defined as, “someone who draws on their own psychic scars to gain the insight, strength, and interest necessary to attend to others’ problems in living” (Hadjiosif, 2015: p.311).

Findings in this study suggest that PWPs are concerned with doing the best for their patients but also want to provide further support than the role allows; this desire to go above and beyond their remit may indicate that some PWPs may identify as wounded healers. Alternatively, it could be that the PWP role reinforces a lack of personal and professional reflection. Many participants described feeling ‘deskilled’ in the role, noticing that some of their more therapeutic and reflective skills were being lost in the PWP role. These concerns have also been echoed in recent literature (Haarhoff, & Thwaites 2015). Some participants shared concerns that they

were not able to be as empathic as they would usually be with clients; this appeared directly attributed to the impact of high volume working combined with little time to contemplate their personal journey through the role. However, it is important to note that those that had been in the role for a longer time, up to seven years, indicated that no amount of extra supervision would change the structure of the service as a whole. This suggests a degree of desensitisation to the role's demands, as well as a moderation of what can be realistically achieved within the remit of CMS.

Whilst conducting the interviews, I understood that some participants like Leanne felt *'trapped in the role'* due to the lack of professional recognition and absence of professional development opportunities. Similarly, Lola indicated that the pressured nature of the PWP role may have taken up the time and energy that could have been used to consider further training or career progression. I wonder about the implications on staff morale when a workforce consists of people who feel 'trapped' in comparison to others that move on swiftly. The PWP role has been designed with little career progression (Moreea, 2015), meaning PWPs have to actively pursue further training to increase their employability in other areas. Not everyone can go on to a professional doctorate training, due to the competitive nature of these programs, the financial constraints involved and time commitment required. For some, however, it appears that the PWP contract is a mutually beneficial exchange; IAPT recruits a PWP and the PWPs depart the role with sufficient experience of working therapeutically within an NHS setting. This in turn, may help PWPs to secure further training.

Participants interviewed in this study conveyed creative ways in which they coped with the PWP role. For example, all participants, bar one, intimated that they had reduced their hours possibly to cope with the PWP role, some participants also had other roles in their services, such as counselling work. Rather disconcertingly, findings in this study suggest that PWPs may become acculturated to the mechanistic way of functioning in IAPT, potentially becoming passive and deskilled as a result of this. This inadvertent way of functioning arguably diminishes any possibility of pioneering or prompting service improvements from inside the IAPT system.

The IAPT System: Power, Business Culture and Complicity

Critiques of IAPT services specifically from the field of counselling psychology liken these services to machines and identify that these facilities within the NHS are being run as large businesses (Rizq, 2012a). With the privatisation and current structure of the NHS, it is no surprise that IAPT services are expected to function as businesses. The importance placed on creating capital, saving money and the introduction of a payment by results scheme (Yeomans, 2014), are all factors that add to the corporate culture of IAPT. It is important to consider the implications and effects, on staff and patients, of running a service to support people with mental health difficulties as a 'business'.

Alston et al., (2015) conducted Foucauldian discourse analysis and noted a 'top down' institutional discourse within their interview data. This indicates that managers and commissioners are key decision makers in IAPT services, resulting in the experiences and opinions of front line staff being disparaged. It could be naively expected that the priority and main aim of a service like IAPT would be to provide therapy for people who are suffering with their mental health. In reality, IAPT appears to be blindly guided by targets decided by people far removed from the reality of the therapist role, at the detriment of humans in distress (Hoggett, 2010). For example, the requirement for services to evidence that more than 50% of people 'recover' (Gyani et al., 2013) is surely an impractical expectation. There are many problems associated with this amorphous target: for example, 'recovery' is measured by questionnaires which do not capture the complexity of human suffering (Gask et al., 2008). Outcome measures utilised in IAPT focus solely on the internal experience of the patient and not any situational or environmental factors (Watts, 2016). Use of these reductive measures establish the belief that the 'problem' is lodged within the patient, rather than as a result of their interaction with their socio-political climates.

In what seems like a parallel process, if a PWP struggles in their role this may be viewed as something being wrong with the character or conduct of the PWP, rather than in the system they are interacting with and operating within. In a service that subtly disseminates the message that numbers and targets are more important than human emotions and responses, PWPs may internalise this message, converting it into '*my feelings and responses are not important'.* This theory is mirrored by Mackinnon & Murphy (2016), who suggest that IAPT structure serves to promote a particular way to be a therapist using the stepped care model, manualised

treatment and outcome measures. Use of these reductive resources serve to disregard the complex experiences PWPs may have when they interact with their patients.

Findings in this study suggest that PWPs experiences in IAPT services do not feel fully understood by their managers. The impact of this lack of comprehension for front-line staff serves to increase the chasm between the managers' virtual reality of numbers and figures, compared to the PWPs that conduct assessments. There appears to be a dissonance shown by managers both case management supervisors and managers of IAPT services, this includes oversights regarding their understanding of the intricacies of therapeutic work. However, it is important to note that those managing IAPT services, are also part of the system, and their role comes with the added complexity of having to defend staff endeavours to meet targets, to commissioners (Rizq, 2012a).

There is a cause to consider the possibility that IAPT services have implemented NICE guidelines in a rigid and structured way which disregards the therapists' autonomy (Harper, Cromby & Reavey, 2013). It appears that IAPT staff, PWPs in this case, are conforming to this model reluctantly whilst also feeling powerless to challenge the service structure. It has been suggested that line managers in IAPT services may come from more business-related backgrounds and are unlikely to be familiar with mental health and the issues involved in running a service of this nature (Shepherd & Rosairo, 2008). The implications of IAPT services being run by 'business people' will understandably lead to over simplified assumptions about the ease of treating such complex mental health difficulties. Following managers' oversight of the complexity of human processes, novice therapists with little experience, such as PWPs, may be applying NICE Guidelines in a way that suppresses previous professional knowledge and autonomy (Peacock-Brennan, 2016). This in turn has an impact upon people accessing IAPT services, who end up being bound by NICE criteria rather than approached as multidimensional individuals. It is, however, important to use research to interrogate the role that PWPs play within this system. The findings of this study indicate that despite not being entirely comfortable with the dominance of cognitivism in mental health; PWPs feel somewhat complicit in promoting this superficial way of working with complex mental health problems.

Links with Current Affairs

Findings in this study highlight the disparity between the real-life day-to-day work of a PWP, and the implementation and training literature that guides the role. The manualised modus operandi (Richards & Whyte, 2009) appears to be in direct opposition to the caring PWPs who are attempting to be flexible and accommodating in the face of the humans they see. It is important to situate IAPT in a wider political and socioeconomic landscape; what is happening in IAPT - such as the favouring of protocols and targets over individual wellbeing, appears to be mirroring a wider problem in current western society.

IAPT was born out of a report by an economist and a CBT Therapist (Layard & Clark, 2014). One of the main sentiments behind the introduction of IAPT services may be summarised as; if people who are depressed and anxious get treatment they can return to work and have less time off sick, which in turn saves the economy money. De Graaf, Wann & Naylor (2005) identify that capitalism and consumerism is promoting the expectation that people are faceless, robotic members of society; this is exacerbating feelings of powerlessness in terms of the potential for challenge or change in response to this. The focus on money is guided by the capitalist assumption of humans relating solely to each other with regards to what they can offer society, usually in exchange for money. For example, the belief that if you are off work you can't contribute to society and have less worth as a person feeds into a commodification of the individual human. This links considerably with inequality on a global scale; for instance, the concept of Necropolitics (Mbembe, 2008), which considers the assumption outlined in media campaigns of certain groups of humans' lives being disposable, compared to those with more money/status and/or power.

IAPT is a microclimate of what is happening on a global scale; there is a growing divide in equality in today's society (Hickle, 2017). The rich are getting richer while the poor are getting poorer. More people are becoming hopeless and despondent but are presented, on the face of it, with encouraging statistics about improving equality. However, these statistics do not accurately depict the lived reality. This dominant narrative is relevant to IAPT as it appears that people doing the PWP role are being seen as disposable, this is indicated by a lack of care for their wellbeing and lack of intrigue with regards to the high turnover of the PWP position. Furthermore, IAPT has been designed on skewed statistics about the efficiency of CBT (Tanenbaum, 2005). A recent Guardian article (Wren, 2017)

presents views from the frontline NHS staff that depict the reality of the effect austerity is having on how services are functioning, and the impact this has on staff wellbeing. There are gaps in the research directly relating to the distribution of power relating specifically to IAPT services, although, Rizq's (2012a) paper touches on theories behind this.

The findings in this study mirror current issues described in relevant psychological literature. In the latest edition of The Psychologist (BPS, 2017) an article poses the question 'What protection is there for graduates' eager to gain experience?'. This is a letter written by a psychology graduate keen to increase their experience in the therapeutic field; he outlines the risks of inadequate supervision on the wellbeing of graduates, exploring how this affects the trajectory of entering the therapeutic professions, implying that a lack of supervision and emotional support is turning graduates away from this career choice. Emergence of articles such as this, arguably appeal for those with therapeutic insight to scaffold the learning of psychotherapeutic practitioners, to safeguard graduates and service users, thus ensuring best practice from an early vocational stage.

Further Research

The high turnover of the PWP role potentially leads to many PWP experiences and opportunities for improvements remaining uncaptured. Future research aimed at CMS for PWPs could address the gap in the research with regards to PWP's relationship with their case management supervisors. More broadly, there is a lack of studies which focus particularly on the experience of supervision from the supervisee's perspective. Research of this nature could further explore the potential parallel processes that can occur if a PWP does not feel validated by their supervisor, which may lead to inadvertently invalidating their service users. This could be explored by utilising qualitative methods such as focus groups. The research could be grounded in the theory of the importance of a collaborative supervisory space; that facilitates and nurtures an awareness of emotional responses to clients, to help practitioners, become more comfortable working with transference (Raichelson et al., 1997).

What seems to be very clear from the data, is that CMS cannot be examined in isolation; as such, future research could focus on PWPs experiences in the role rather than looking specifically into CMS. It feels important to recommend future

research elucidating insights into the PWP role keeps PWPs experiences separate from other IAPT staff. Due to their lack of professional recognition, there is a risk that the voice of the PWP may get lost within the wider IAPT dialogue, leaving their experiences remaining uncaptured. There is a need for further information to be gleaned on how PWPs make sense of their role within IAPT services, to explore whether their expectations of the role were met and how the transient nature of the position is experienced. I believe in the importance of providing PWPs a voice outside of IAPT funded research, as this would provide deeper insight and avoid service exertions to mute the PWP experience, serving to safeguard recruitment for the role. Of equal importance is the experiences of case management supervisors; they could be included in research to capture their perspectives of CMS. A wider participant pool in relation to this, could be accessed by use of email survey's like the one used by the New Savoy Partnership (BPS, 2016).

Another potential angle for additional research could turn attention to the internal conflicts that occur within PWPs when they are trained in a previous therapeutic model. This follows research such as Owen-Pugh (2010), who outlines the challenges of learning CBT from a psychodynamic background. These findings indicate that PWPs may become 'acclimatised' to the IAPT way of working. Exploring this would aid understanding of the 'dehumanised therapist-client interaction' that has been reported in experienced therapists when joining IAPT services (Altson et al, 2015).

Findings in this study produce an argument for the review of the training manual for PWPs. I believe there is a robust rationale for nurturing PWPs individual awareness of the subjective experiences of the emotional demands of the job. This could possibly include recommendations and shared learning from previous PWPs. There also seems to be a need to create more meaningful progression in the PWP role, to ameliorate those who are feeling trapped or are not planning to do further psychologist or therapeutic training. It may also be pertinent to consider more creative ways of supporting PWPs with their wellbeing. For instance, to contemplate community interventions such as the creation of wider PWP communities, where PWPs can support each other within the role. An example of a more imaginative way of providing support for IAPT staff has been trailed by Dowthwaite (2016), who introduced a 'Happy Hour' into IAPT services based on the positive psychology movement. This introduction resulted in staff feeling happier and more uplifted at

work. Further creative trials along these lines may merit advanced exploration to promote PWP wellbeing.

How does this study relate to Counselling Psychology (CoP)?

Maxey (1999), identifies that we are more able to be creative in challenging oppression and disparity in power if we are able to critically reflect on our world, and our position in it. These are elements of CoP that can be applied to understanding CMS, PWPs and IAPT services as a whole. There have been many debates about how CoP views the changes within primary care services, particularly with regards to the introduction of IAPT services. Counselling psychologists such as Fairfax (2013) propose that CoP is accurately placed to help provide solutions for the difficulties encountered from the uncertainty and rapid changes in mental health services, such as the introduction of IAPT services.

Arguably CoP is accurately placed to provide a voice for PWPs that is rarely encountered in current research. Indeed, this research also serves to provide a voice for and insight into what it is like to be a PWP, although this was not the main aim of the research. CoP has been closely linked with being a scientist practitioner; being a clinician who also conducts research, with the aim of producing real world, applicable research. CoP training also provides skills development in areas such as raising consciousness in communities, political lobbying and awareness of the wider social and political contexts in which we live (Mallinckrodt, Miles & Levy, 2014). Findings in this study imply that the 'therapy' provided by PWPs in IAPT services may essentially lead to PWPs possibly needing to access the services they work in. There is a distinct irony to a service that has been introduced economically with the aim of reducing unemployment (Layard & Clark, 2014), yet has difficulty in retaining its own staff. Insights are emerging around the introduction of IAPT, such as 'psychology' being used to mask a wider problem of social and economic inequality, including ethical question marks around exacerbating the problem through compliance with IAPT services (Friedli & Stearn, 2015). There is also an aspect of therapy that is going unrecognised in PWP work; the therapeutic relationship. CoP can continue to reiterate the importance of the therapeutic relationship, which has been reported as the main benefit of attending therapy by clients (Norcross & Wampold, 2011).

PWPs interviewed, such as Karen, shared similar concerns as those detailed in CoP critiques of IAPT i.e., that IAPT services, particularly PWPs, may be providing a distorted experience of therapy to the public (Rizq, 2012b). Trepidation has been shown around this structure of working including CMS focusing on targets and outcomes. This can have a detrimental impact on clients and potentially does them a disservice, leaving them seeking private therapies to address needs not met by PWPs in IAPT.

CoP can bring a deeper understanding of the ethical implications of a mechanistic service such as IAPT. This awareness is needed in order to be in a position to try and challenge the structure of these services. Psychologist Bruce Scott (2017) unpicks the process behind the thought of free will and responsibility, claiming that we are encouraged to function as machines in society. He continues that mental health systems attempt to reinforce the notion that we are faulty and need 'fixing', emphasising how this links with capitalism. This promotion of having to be a certain way is reflected by Mackinnon & Murphy (2016), who suggest that IAPT lodges the 'problem' in individuals, providing speculation that as the system promotes ways of being a patient, it may also promote ways of being a mechanistic therapist.

CoP celebrates the unique experience of each individual human being, and PWPs are included in this. Thinking in this way is informed by applying a psychological understanding to why PWPs may be drawn to the role. For example, PWPs could be drawn to the job in the same way more traditional therapists may be; with the 'unconscious hope to confirm that they have sufficient internal goodness to repair damage in others' (Roberts, 1994, p. 116). This could be in terms of having past anxieties or experiences, that they have not yet fully processed. Additionally, therapists attempt to provide 'holding environments' for clients, by exhibiting the following behaviour: containment, empathic acknowledgement and an enabling perspective (Kahn, 2006), drawing on theory from Bion (Bion, 1985), Kohut (Kohut,1977), and Winnicott (Winnicott, 1960). It is apparent that PWPs may have similar hopes to provide empathy and support for their clients and may experience conflict if they are expected to not work in this way, especially if previously trained in another therapeutic model.

There is a distinct risk that PWPs attempts to help others is getting lost in the IAPT machine, leaving therapists at the beginning of their journey in the

psychological field demoralised, burned out and possibly vicariously traumatised. Clinical supervision could be a place to explore these feelings and support PWPs. This study adds to the organisational understanding of IAPT; if counselling psychologists do go into leadership positions in IAPT, possibly management positions, it is important to be aware of the landscape of IAPT and PWP experiences. Counselling psychologists have been identified as being well positioned to influence the structure of IAPT services (Fairfax, 2013) and would arguably be more aware of the wellbeing of the staff in services heeding the advice from the Foresight Report (2008) that states 'companies have a strong incentive to adopt working practices that look after the mental health and wellbeing of their employees' (p. 34).

Hoggett (2010) highlights that the introduction of services such as IAPT is undermining the importance of psychological understanding and roles in CoP. Services are providing less psychologically informed interventions in favour of cost-saving protocols and as a result, are employing less experienced staff (Hoggett, 2010). CoP can bring awareness of the rapidly changing landscape of psychological services in the NHS to the forefront of agendas. IAPT services can be viewed as a short-sighted replacement of psychologically informed services, leading to an oversight in the importance of psychological thinking.

CoP's links with community psychology may also be an important consideration, suggesting an alternative way of approaching people who are depressed. An example of this is The Beacon Project (Stuteley, 2002), which helped support people with depression through addressing their social needs. This was done by working with whole communities. Outcomes from this project suggest that promoting mutual support and building social capital in this way was beneficial for the whole community; perhaps a way of working like this could provide an alternative to the IAPT 'machine'.

CoP proffers a more flexible and inclusive way of understanding a problem drawing on systemic knowledge. Arguably a lack of research into supervision doesn't mean it is not beneficial (Olds & Hawkins, 2010). With such a massive emphasis on evidence-based practice in IAPT (McPherson, Evans, & Richardson, 2009), supervision, like many other things such as the therapeutic relationship, end up overlooked. It is not that the research doesn't exist to indicate clinical supervision would be beneficial for PWPs, it is that this research is not packaged in the same

way and thus is being disregarded. It is also pertinent to consider that potential clients of CoP's may have accessed IAPT services; an understanding of PWPs and how their role works may help with insight into what experience the client has already had in terms of 'therapy'.

PWPs could fall under the radar as they are not professionally recognised and are unlikely to have time to conduct their own research into their wellbeing. CoP can provide a deeper understanding of IAPT services; for example, considering the concept of containing the container (Bion, 1985). It could transpire that PWPs contain the anxieties of their clients', whilst working in a service that is designed to contain the society's unease around mental health in general. CoP can empathise with the pressure placed on PWPs to contain this as often 'inexperienced' therapists, with the added oversight of not having a reflective space in which to examine their own emotions. Mcneill & Worthen (1989) identify that parallel process originates from the concepts of transference and countertransference, where the supervisee and supervisor relationship can sometimes be experienced as parallel to the relationship of the client and therapist.

Overall, the findings in this study are relevant to the current research that is emerging around the wellbeing of mental health workers and burnout (BPS, 2016), with the lack of clinical supervision being implicated as a highly relevant factor.

Critical Evaluation of this Study

This study has only pinpointed a very particular area of the PWP role; specifically, their understanding and experience of CMS. As such, it is very likely that other aspects of the wider context of IAPT and the PWP position were overlooked. Thematic Analysis serves to identify themes within data, but can not provide any solutions or any real recommendations for the PWP role or CMS. My hope is that I have been able to explore the real-life application of these findings within this discussion.

It is important to note that as the researcher, I am not in control of how findings may be used by other people (Wilig, 2008). Qualitative research has the risk of subjective interpretations and other people performing Thematic Analysis on the data set might have come up with different conclusions (Sandelowski, 1995). I took self-reflection and the guidance of Braun & Clarke (2006) very seriously, in order to reduce possible researcher bias, although it is important to note that the researcher

position is part of the analysis in qualitative research. The use of semi-structured interviews (Kvale, 1996) has provided significant insights into PWPs experience of CMS. However, an example of my insider subjectivity and how this has impacted the data collection and analysis has become apparent. On reflection it is evident to me that I am also vulnerable to the rigid thinking evident in IAPT services. In hindsight at the beginning of this research I had the unconscious assumption that PWPs should have clinical supervision, due to being an 'insider' it was hard to identify this assumption. In addition, I feel that continuing to work in a positivist dominated environment whilst conducting this research at times made it difficult to maintain my critical realist stance when analysing my data. A further example of the impact of this is that some of the research questions needn't have been included in the interview schedule, such as; 'Where do you see your career in 3-5 years time?'. In hindsight, this question does not feel relevant with regards to CMS for PWPs. Completing this study focusing on CMS has led me to consider the importance of focusing on the PWP role in general, rather than focusing so specifically on one aspect of the role such as CMS. However, I believe that the use of Thematic Analysis (Braun & Clarke 2006) in this study has helped to create a 'thick' description (Geertz, 1973) of the sample of PWPs understanding and experiences of CMS.

I found that the process of TA tested me; my previous experiences in research are mainly quantitative, as a result I found transitioning to a qualitative method to be challenging at times. Familiarising myself with the data was something I found came naturally to me and I enjoyed making links between codes and beginning to develop potential themes. The most difficult part of the TA process was deciding on the presentation of coherent themes and narrowing these down to just three. I felt the reality of wanting to portray all of the experiences of my participants, as all points felt valid. However, over time I developed the skill of prioritising and creating coherent themes that were grounded in the data.

According to Yardley's (2000) seminal paper, the quality of qualitative research can be examined vis-à-vis four criteria. These are: A) Sensitivity to context. I feel this has been demonstrated within the comprehensive literature review. Furthermore, during my interviews with participants I established a safe space for PWPs to reflect on CMS, and I utilised my insider perspective and experience to approach the research in a thoughtful and sincere way. B) Commitment and rigour. My commitment to this research has not wavered; this has been evidenced by

completing it in a timely manner, undertaking regular conversations with my research supervisor and tracking my own responses to my research in a journal. This in turn has helped inform my write-up, which I have attempted to execute to a high standard. C) Transparency & coherence. I have made a clear rationale for this research and woven this throughout the write-up; it is evident that the study's aim of producing themes to further understand CMS and capture PWPs experiences of this has been achieved. The transparency of the study is evident in the audit trail I kept during the many stages of analysis and the evolution of the thematic map, which can be found in Appendix I. It is important to note that I have attempted to be reflexively transparent with my own processes as the researcher and be clear about how my positioning may have influenced the data collection, analysis and subsequent presentation, this has been extremely challenging at times as I have continued to work within an IAPT service. D) Impact & importance. I believe the findings of this study are useful, interesting and of importance; this was confirmed recently when I presented this research at a conference and it provoked an interesting debate with health psychologists and PWPs embarking on their training. Throughout this research, I have attempted to adhere to these principals, as posited by Yardley (2000) and these factors have been further digested in my development as a qualitative researcher.

In terms of critiquing this study, one of the main criticisms is relating to the sample, both the small sample size and a possible sampling bias ought to be acknowledged here. This study could have potentially attracted PWPs that had more difficulties within the role, particularly those who felt the need to have their challenging experiences witnessed. In terms of sample size, Braun & Clarke (2013) highlight that in terms of sample size for a professional doctoral study, eight participants are sufficient. Additionally, the data generated from the eight interviews was enough to provide material for a comprehensive Thematic Analysis able to answer the research question.

Final Reflections

The journey of conducting this research has provided me with many aspects to consider and this process has assisted me to establish my identity as a counselling psychologist. I set out probably much like any other eager trainee wanting to conduct my doctoral research into a world-changing area of research. At

the time, the experiences of CMS and being a PWP in IAPT felt like important aspects to capture. As the research has evolved, I have realised that PWPs and CMS are small facets of IAPT that present a metaphor for how society is functioning in general, that the 'problem' is located in the individual, rather than the amorphous collective that is society. The ever-growing pressure to be a robotic, unchallenging member of society was underscored for me. Findings in this study corroborate the disparity between how commissioners and wider political landscapes are so far removed from the frontline staff and the reality of the real-life humans they see. This is not exclusive to IAPT, as recent discussions about my research have indicated that this is happening on many levels across the NHS, for example, in general medicine services. It has been important for me to look after my own wellbeing throughout this journey, as it has been easy to fall into a pit of despair with regards to living in a society that prizes working like a machine, over celebrating the complexity of being a caring human that has chosen a vocation to help others. At times, I have felt very powerless in terms of challenging these dominant, overarching narratives; this has been additionally compounded as I currently remain employed in an IAPT service. This has been particularly challenging as it is harder for me to contest positivist attitudes whilst continuing to function within the system I have been critiquing. My own perfectionist tendencies and wanting things to be different may continue to create blind spots within my critical realist stance.

One of the particular challenges I found during this research was in the process of Thematic Analysis, and attempting to create themes which did not just confirm current critiques and my beliefs about IAPT. At times during the research process, I found myself wanting to take the data in a direction to prove my own point and my own experience. I became aware of the desire to control my data and this awareness compelled me to step back, giving me the opportunity to return more 'objectively' although this has still not been fully possible.

I was aware of the need to suspend my judgement whilst interviewing some participants who had different experiences to me. I attempted to examine the data with an open mind in order to be aware of any assumptions that may have led me to seek to confirm my own opinion, and those from literature that I have been drawn to. I frequently found myself needing to refocus the research to ensure it addressed CMS for PWPs, rather than getting too lost in other arguments and critiques of IAPT and wider societal systems and losing myself within the notion that PWP should

have a clinical supervisory space. Despite working hard to bracket my own experiences and assumptions to focus on self-awareness through the process of this research, it has not been fully possible to remove myself from the context I continue to work within.

It is evident IAPT and evidence-based research is dominated by positivist discourses (Kerr, 2014); that there is an ‘objectively knowable world’ and that language conveys the truth of this world (Morrow, 2008). It is understandable that people may be more drawn to this way of thinking as it provides some certainty and containment, I am not exempt from this as this is something that I have struggled with maintaining my critical realist stance throughout this research and write up as it has fed into my perfectionist tendencies and wanting things to be neat and not messy which is unrealistic. Reflecting on this provides me with further insight into may be why IAPT services are so focused on the evidence-base; as a defence from dealing with the messiness and complexities of life. I found it hard to provide balance in my research as often during the write-up it felt like a critique of the IAPT and CMS, without actually offering any alternative to this mechanistic way of working.

In specific relation to the PWP role and CMS, I am aware of the rapidly changing nature of IAPT and I am already concerned my research may be outdated, as talking to various new PWPs in my service highlighted the swift changes within the role. An instance of this was in a recent conversation with a PWP colleague, who was recently required to conduct twenty assessments a week, this is in comparison with the ten a week I performed during my time as a PWP in 2014. I have evolved personally and professionally alongside this project and I hope this research adds to the growing body of evidence that may help a review of IAPT services to take place.

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Appendix A- Participant Information Sheet

University of the West of England
BRISTOL

PARTICIPANT INFORMATION SHEET

Study title

Case Management Supervision for Psychological Wellbeing Practitioners working within IAPT Services: A Thematic Analysis

Respondent Invitation

You are being invited to take part in a research study regarding supervision for PWP's. Before you decide to participate it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and decide if you are still interested. If there is anything that is not clear or if you would like more information please feel free to ask. Take some time to decide whether or not you wish to fully participate.

What is the purpose of the study?

To explore Case Management Supervision for PWPs working within IAPT services.

Why have I been chosen?

You will be chosen for this study as you are a PWP or you have previously had a role as a PWP. The Researcher is aiming to interview approximately 8-12 participants in order to explore supervision and the role of PWP's.

Do I have to take part?

No, participating in this research in completely voluntary. It is up to you to decide whether or not you want to share your experience with the Researcher. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time before April 2017.

What do I have to do if I choose to take part?

You will be asked to answer a demographic sheet detailing your information. These details can be brief as the purpose is to verify your position meets the requirements of the study before being invited to participate.

You will then be invited to take part in semi-structured face-to-face or virtual (i.e. Skype) interview. Face-to-face interviews will be held in a suitable room near your location, with no distractions (other people, mobile phones etc.), location will be decided on between you and the Researcher to suit your needs. If you would like to participate virtually will be asked to ensure you are alone, in a quiet location and free from distractions for the time of the interview. With no distractions it will allow you to fully engage with the questions and have space to reflect and contribute wholly to the study. Interviews will take place at a convenient time for you and will last approximately 1 hour each, sometimes interviews won't last the full hour whereas others may last longer than 1 hour, this will be discussed on an individual basis and a further follow up interview arranged if needed.

All information shared will be used to help the Researcher to understand the topic however your identity and personal details will all remain confidential. (See more on confidentiality below)

What are the possible disadvantages and risks of taking part?

Although unlikely, the interviews could cause you to have a heightened emotional experience as you reflect on your job role. After the interview, supportive resources will be offered should you need to speak with

someone further about the research. Please note, as I'm sure you are aware if at any time you mention activity that demonstrates you may be of harm to yourself or others this will be discussed with you and you will be signposted to safeguarding procedures to ensure safety. The study has gained full ethical approval from the University of West England (UWE) Research Ethics Committee.

What are the possible benefits of taking part?

This study will only allow you an opportunity to share your experiences and thoughts with regards to case management supervision for PWP's. There are no monetary or other benefits to participating.

What happens if I wish to withdraw from the study?

If at any time you wish to withdraw from the study please either discuss this face to face with the researcher or if it feels more comfortable please inform the researcher on the email address below. You have the right to withdraw from the study at any point during the data collection phase which will be between December 2015 and December 2016.

In the event of withdrawing from the study your recording and transcript will be securely destroyed. Please be advised that there will be a point when the research is submitted that will mean that it is no longer to withdraw from the research this will be April 2017.

If for any reason there are concerns with the research you can contact the Researchers Head of Department Zoe Thomas on Zoe2.Thomas@uwe.ac.uk, my Researcher Supervisor Miltos Hadjiosif on Miltos.Hadjiosif@uwe.ac.uk or University of the West of England on 0117 965 6261. In any event the Researcher will always discuss any matters that require extra guidance with the allocated Research Supervisors.

Will my taking part in this study be kept confidential?

All information and interview recordings will be anonymized with code names and numbers to ensure no participant is identifiable. Supervisors of this research will have limited access to identifying information, however they equally abide by confidentiality policies.

What will happen to the results of the research study?

The results of this study will likely be published in 2017 as a part of the Researchers dissertation and in publishable journals. If you are interested in a copy of the findings you can contact the researcher on Alexandra2.Painter@live.uwe.ac.uk. The interviews will be analysed and results will be used to understand the thoughts, feelings and lived experiences of PWP's. You as a participant will not be identified in any of the research.

Who is organising and funding the research?

This research will be self-funded by the Researcher of this study.

Contact for Further Information

If you require any further information including any signposting to further support please do not hesitate to contact me, Lexi Painter, the researcher of this study on Alexandra2.Painter@live.uwe.ac.uk.. A copy of this participant information sheet and your signed consent form will be given to you for your reference.

A final note from the Researcher

Thank you for your interest in this research and for taking the time to read this form. I feel that it is so important to capture experiences of PWP's and give your experiences a voice. Your willingness to participate is truly appreciated, however please remember you do not have to participate if you are not comfortable with doing so.

Best Wishes

Lexi Painter - Trainee Counselling Psychologist

Appendix B– Study Advert

Case Management Supervision for PWP's

Does the above statement mean anything to you?

Are you a PWP/Senior PWP with 1 year post training experience?

Do you have previous experience of working as a PWP?

If you have answered yes to any of the above questions I would really appreciate it if you would take the time to read about a study I am conducting. Information can be found below (attached).

Please email me on Alexandra2.Painter@live.uwe.ac.uk if you have any further questions or would like to take part in the study.

Your time reading this is much appreciated.

Lexi Painter

Trainee Counselling Psychologist at University of West England

University of the West of England
BRISTOL

Appendix C - Copy of Email Cascaded to Potential Participants

From: Alexandra Painter
Sent: 24 February 2016 15:57
To: [Removed to Protect Confidentiality]
Subject: Research Looking to Recruit PWP's

Dear Reader,

Attached to this email is information about a Qualitative study I am conducting with regards to PWP's (current and former) experiences.

If you have a spare second (which I am aware is rare for PWP's) please have a look at the attached information and if you would like to take part please email me on Alexandra2.Painter@live.uwe.ac.uk.

Please forward this email and attachments on to anyone else you feel may be suitable or interested in taking part in this study.

I am looking to recruit participants as soon as possible within the next few months, if you would like to take part please get in touch as soon as you can.

Thank you so much for taking the time to read this.

Best Wishes

Lexi Painter
Trainee Counselling Psychologist

(I attached Appendix A and B to this email)

Appendix D – Participant Consent Form

University of the West of England
BRISTOL

PARTICPANT CONSENT FORM

Title of Project:
Case Management Supervision for Psychological Wellbeing Practitioners working within IAPT Services: A Thematic Analysis.

Name of Researcher: Lexi Painter

1. I confirm that I have read and understand the Participant Information Sheet for the above study which explains what the researcher is asking of participants and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. (If for any reason you wish to withdraw, please contact the researcher named above and consult your patient information sheet for further guidance)

3. I understand that any information given by me, may be used in future reports, articles or presentations by the Researcher.

4. I agree to interviews being audiotaped and transcribed for the purpose of research.

5. I understand my real name or any other identifying information about me (i.e. location) **will not** be used.

I have read and understand the above information and by signing and dating below I agree to take part in the study.

Name of Participant	**Date**	**Signature**
Researcher	**Date**	**Signature**

Please return the signed copy of this consent form to Alexandra2.Painter@live.uwe.ac.uk.
A copy of this form will be returned for your reference, with the signature of the Researcher.

Appendix E – Background Information

University of the West of England

BACKGROUND INFORMATION

Please answer all questions as accurately as possible.

Demographics

First Name: Surname:

Age: Sex:

Current Job Title:

Study Related Questions
If you are currently a PWP/Senior PWP please complete section a. If you no longer work as a PWP/Senior PWP please complete section b.

a) Have you been a PWP/Senior PWP (post training) for longer than 1 year? **YES/NO**

Please specify approximately how long you have been a PWP for?

b) Did you leave the PWP role more than 2years ago? **YES/NO**

If no please specify how long ago you left the PWP role:

How long were you a PWP for?

All above information shared will remain confidential and will only be seen by the Researcher and Supervisors of this research. Please note this information is to confirm you are meeting all requirements of the study, which is focused on better understanding of Supervision for PWPs. By signing below you agree that all the information submitted on this form is true and accurate to the best of your knowledge.

Name of Participant	**Date**	**Signature**
Researcher	**Date**	**Signature**

Please return the signed copy of this consent form to Alexandra2.Painter@live.uwe.ac.uk.
A copy of this form will be returned for your reference, with the signature of the Researcher.

Appendix F – Debrief Information Sheet

University of the West of England
BRISTOL

DEBRIEF INFORMATION SHEET

Study title

Case Management Supervision for Psychological Wellbeing Practitioners working within IAPT Services: A Thematic Analysis

What happens if I wish to withdraw from the study?

If at any time you wish to withdraw from the study please either discuss this face to face with the researcher or if it feels more comfortable please inform the researcher on the email address below. You have the right to withdraw from the study at any point during the data collection phase which will be between December 2015 and December 2016.

In the event of withdrawing from the study your recording and transcript will be securely destroyed. Please be advised that there will be a point when the research is submitted that will mean that it is no longer to withdraw from the research this will be April 2017.

If for any reason there are concerns with the research you can contact the Researchers Head of Department Zoe Thomas on Zoe2.Thomas@uwe.ac.uk, my Researcher Supervisor Miltos Hadjiosif on Miltos.Hadjiosif@uwe.ac.uk or University of the West of England on 0117 965 6261. In any event the Researcher will always discuss any matters that require extra guidance with the allocated Research Supervisors.

What will happen to the results of the research study?

The results of this study will likely be published in 2017 as a part of the Researchers dissertation and in publishable journals. If you are interested in a copy of the findings you can contact the researcher on Alexandra2.Painter@live.uwe.ac.uk. The interviews will be analysed and results will be used to understand the experiences of CMS for PWP's. You as a participant will not be identified in any of the research.

Contact for Further Information

If you require any further information including any signposting to further support please do not hesitate to contact me, Lexi Painter, the researcher of this study on Alexandra2.Painter@live.uwe.ac.uk.. A copy of this participant information sheet and your signed consent form will be given to you for your reference.

Thank you very much for taking part in this research!

Appendix G - Questions for Semi Structured Interview

1. When I say case management supervision what does it mean to you?

2. Could you tell me about your experience if case management supervision? (caseload number, how many discussed in supervision)

3. (a) Can you say something about how the supervision may have supported your work as a PWP?

   (b) Can you say something about how the supervision may not have supported your work as a PWP?

4. What impact (if any) does your experience of case management supervision as a PWP effect your client work? (And your client themselves?)

5. Can you say how your experience of CMS compares with other experiences of supervision you may have had?

6. Describe the relationship with your case management supervisor?

7. Can you say something about what may have helped you manage the role of PWP outside of case management supervision? Inside or outside of work?

8. What keeps/kept you in the role of PWP?

9. Have you noticed any change in your lifestyle since taking on the PWP role/leaving the PWP role?

10. Where do you see your career in a 3-5 years time?

11. Do you have any recommendations in regards to the PWP role and Case Management Supervision?

12. Is there anything else you would like to add? Ask?

Appendix H - Example Transcript with Initial Codes

Lola	
Transcript	**Initial Codes**
Interviewer: Lola thank you so much for coming today	
Lola: you're welcome	
Interviewer: yeah so basically this study is to look at supervision for PWPs. Now when I say case management supervision, what does that kind of mean to you	
Lola: Umm I suppose, being a PWP it means looking over everybody that needs it, that I've seen really and reviewing them and deciding on a treatment pathway. Umm reviewing risk all that kind of stuff. I think that's pretty much everything, it's just managing your case load which can be up to whatever at the moment I mean around 90 people so it's just reviewing people as they come in and also through treatment and maybe when they're coming to the end of treatment as well	Reviewing people as they come in High caseload
Interviewer: *[Removed for confidentiality reasons]*	
Lola: yes, yeah	
Interviewer: ok with a case load of 90	
Lola: yeah	
Interviewer: and can you tell me a bit more about your experience of case management supervision. What's it been like for you	
Lola: yeah I've had two different supervisors so I suppose that can open up different things for you. It's very structured, but perhaps one supervisor was more structured than another. Umm so I've had different experiences over the course of the last 18 months in regards to that. Umm previously being from a different background I suppose case management is very different to supervision for me so I don't really get to explore the therapeutic work as much as I'd like but the, I don't know I suppose it's yeah very structured, oh you have tick off certain boxes and make sure you covered certain things which is fine and really helpful in many ways, so I'm kind of supported in the sense of risk to some degree so I know how to look after a patient and what to do, If I'm not sure. Umm I don't think it meets all my needs as a practitioner therapeutically umm	Supervisor differences A different kind of supervision Tick box Helpful All needs not met
Interviewer: I guess that's something that we can kind of look at the further we go along	

Lola: yeah, yeah, absolutely	
Interviewer: if you want to in the interview	
Lola: yeah I don't think there's anything else really to cover on that, it's really just my experience isn't it. Just very structured	Structured
Interviewer: so that's its very structured for you	
Lola: yeah it does feel like that but different between the two supervisors; there's one that felt more structured than the other	Structure and supervisor
Interviewer: ok. Can you tell me a bit more about that, so the one that's very structured and the one that wasn't very structured? How did those kind of two different ways work for you	
Lola: I mean it still basically comes round the same thing and so we decide a treatment plan and cover things like risk and, more with the unstructured type I got to explore a bit more of how I helped in the room so that was good to a degree but then in regards to the role it felt like you often feel like you don't have enough time, so if felt like it was almost going over my supervision hour or my case management hour. So that was stressful in some respects, umm but then the structured way of things is ok but I don't feel I've enough time to explore and often I'm concerned about my treatment decision at the end of it and I kind of go away thinking I'm not sure about that. So I don't as certain, not that you ever do really I've got to say	Time pressures Worry and uncertainty around plan due to lack of time
Interviewer: was that something maybe you got a bit more of with your unstructured supervisor? You felt more certain about what you were doing or	
Lola: possibly to a degree, I wouldn't say every time, I guess that can happen, but yeah I'd felt like, it felt a bit firmer	Firmer: authoritarian?
Interviewer: ok thank you. Umm kind of following on that vein really can you say something about how supervision, the case management supervision may have supported or does support your work as a PWP	
Lola: yeah, umm yeah I know why, it's there for a reason, you know there are good positive aspects of having it because we have such a high volume of people so it is good that you're touching on everyone. Umm will you say that again	Purpose Review everyone
Interviewer: yeah that's absolutely fine. So something about how case management supervision supports you with the PWP	
Lola: yeah ok	
Interviewer: (overlap) work	

Lola: yeah I really aware I might veer off into what's not supportive as well	
Interviewer: that's ok, no that's fine. That question is coming up next so	
Lola: yeah ok. Umm so, supportive. Yes, I suppose it is, definitely about the people coming in, not so much during treatment I don't feel that supported of that, oh I'm already going into that. Yeah so definitely with regards to risk, further decision making it can be, not always but it can be helpful. I don't know how else it's supportive, I guess it's someone else to discuss so it's, you're not working on your own that way you'll always talk to someone else I suppose that's good, that's very good because it can be quite solo at times	Reluctance to discuss support Risk Management Discussing with another
Interviewer: does it feel like you want to move onto the next question	
Lola: I feel like I want to be able to say more but	
Interviewer: yeah that's absolutely fine say more if you like	
Lola: I'm not able to right now, no I don't feel like I can. I'm kind of like I wish I could say more about being supportive but it can depend on who you are working with as well and the relationship that you have with them so, maybe that comes into play I don't know, but yeah no that's probably all I want to say to the question	Importance of relationship
Interviewer: so if you've, sorry just to double check that, so if you've got a say a supportive supervisor then that feels more supported to your PWP work or	
Lola: yeah I don't, yeah I suppose to some degree but I don't know if I've ever really experienced that support or that encouragement from my senior PWP unfortunately, umm to a degree but I don't know if I felt it which is umm not very fair but that's how I feel at times	Lack of support/encouragement Hard to summon positive feelings about supervision/CMS?
Interviewer: ok yeah, do you feel that maybe if support is shown its not necessarily genuine or something	
Lola: yeah that's exactly what I mean yeah. Umm so I mean it is supportive in the context of what I said, I get to review all my patients so I have to have a chat and touch base with them which is good, but then when it comes the treatment I'm not so sure if that's helpful. So assessments that's where I feel a bit more supported there with regards to risk and regard to future planning	More support with assessments
Interviewer: so do you want to move onto the	
Lola: yeah	
Interviewer: part of how case management supervision may not, might not support you as a PWP	

Lola: yeah well I suppose maybe it is just that focussing on the negative but, yeah sometimes in this role I don't think you feel very heard or you feel undervalued or underappreciated for the work that you do and I think that is possibly because of how fast paced it is, but actually case management could be a chance to feel more supported by your supervisor, umm and I'm not sure that really happens for me. We don't talk about therapeutic work and how you feel in the session and the impact it has on you as a practitioner and I think that's upsetting. When I do reflect on it my working days upsetting I don't, you don't even stop and think about that when you're in the day to day of it, so yeah I think it doesn't encompass that which in this role is really difficult. You need that emotional support as well and although its offered out, its offered out in a very management style. So yeah, I suppose your needs and your own personal reflections and development I don't think that's supported as much as the patient; I know the patient is the main thing but actually that effects the patient too. So yes	Easier to talk about lack of support/undervalued /unappreciated Loss of potential for support Expression of emotion 'upsetting' Lack of time to express emotions Not supported but providing this support to patients
Interviewer: was there anything else there or are you happy for me to move onto the next question	
Lola: yeah, no I'm finished, thank you	
Interviewer: Umm this is similar kind of as we're as we're following on from that really, what impact if any does your experience of case management supervision as a PWP effect your client work and maybe the client's themselves, so similar like you said, were saying just then, umm if there's anything, any impact a case management has on your client work, or your client	
Lola: yeah, umm I guess it can have a huge impact, because what you decide in case management decides their path really in many ways. So I know it's about patient choice but actually if it's about a certain pathway it is more appropriate and I know clinically there are directed treatments. So it could either start off the therapeutic relationship or it could end it and pass it along. Umm case management supervision; how does that impact my, is it my relationship or is it more the effect on them?	Deciding the path Is it about the patient or the directed treatments?
Interviewer: either, either	
Lola: oh whatever my interpretation is. Umm I don't feel it does apart from the treatment pathway, I ought to think about this one alright	
Interviewer: I guess it could effect in either way, it can or not	
Lola: oh yeah exactly, yeah, I just don't think case management supervision	
Interviewer: or just not add anything at all	

Lola: yeah I don't really know if it does, because it decides treatment and pathway but it doesn't really work on what's going on with me and the patient. I don't tackle that. Yeah it really just comes down to treatment and what we're going to do. So it feels very directed and structured as well, yeah don't really know	No exploration of the relationship between PWP and patient
Interviewer: I guess you've alluded to this a little bit but could you say a bit more about how your experience of case management supervision compares with other experiences of supervision that you might've had	
Lola: Yeah, umm yeah well very different. In all respects really. It's very, it feels very 'tick the box' because it has to be because this whatever policy I get that. Umm but previous supervision has in ways it bought up more for me or has been more challenging. Umm I don't feel overly challenged by this supervision which I think leads to a bit of boredom with it umm and not looking forward to it in ways, whereas other supervisions have let me experience the supervisory relationship and what's going on there but also what is going on with my clients in a different way, in a therapeutic relationship way that case management supervision won't allow me to do, because you don't have the time for that. Too pressured I suppose. I know I said earlier on as well that one supervisor let me do a little bit more but it wasn't in the way I used to have it I guess. In the way I used to have it	Box ticking Disengagement and boredom Restrictions around PWPs process
Interviewer: what kind of context was	
Lola: yeah sorry yeah well counselling context but also in previous job roles even just having supervision just to check in and in like care and support roles that I've been in before. Umm so it did feel a bit more focussed on me, umm which is helpful I think in this work. You feel like you need to be supported a bit more, so yeah it was, but also how to further your work or if there's blockages how to do that. I know there's areas where you could use that in the PWP sense but it's not in case management supervision and there's not enough of that I don't feel. Umm so I don't really know how to explain the difference; I think it's just more open. You can focus on somebody perhaps for longer. That is maybe important for you to do and I think you know more about yourself, which I think is helpful for your work but I see why the PWP role is all about guided self help and why that is not happening, so yes	Comparisons with counselling supervision Less focus on 'me' Lack of progression in CMS Not enough progression? Importance of self reflection assumption this is not needed for guided self help
Interviewer: thank you	
Lola: alright thank you for asking	Appreciation of her experience being heard?
Interviewer: yeah kind of following off the back of that as well is there, I don't know I guess you kind of have answered this question already	
Lola: that's ok	
Interviewer: or whether there is anything else you want to kind of add to it, but the relationship whether you can describe the relationship you have	

with your case management supervisor and kind of what that supervisory relationship **Lola:** so more **Interviewer:** and I guess you've kind of alluded to that a bit **Lola:** yeah is it more about my present supervisor then or do I have to **Interviewer:** yeah or yeah your experience with both, but it feels like you've kind of covered that, I just wondered whether there was anything else you wanted to add	
Lola: no I feel like that relationship itself doesn't always feel, maybe I did say it doesn't always feel genuine. Umm and that there's kind of you're doing really well and just kind of slipped in there but doesn't feel real. I mean the relationship is ok to an extent at the moment with my present supervisor and I am always really honest with them if I feel communication is bad during that. I guess I do feel heard to some extent in terms of treatment choices but then sometimes I don't and I walk out and feel I've not been understood or taken seriously. Yeah I don't feel that really close with my supervisor or always that supported **Interviewer:** does that differ to maybe previous experiences of supervision for you	Superficial encouragement Heard in some ways and not in others
Lola: outside of the PWP context? Umm I've had interesting experiences of supervision in the past. It was just very different and I had group supervision and things like that. Umm and as, sometimes as difficult as some of those experiences were I still feel like I learnt so much more from them so I had experiences with supervisors that I haven't got on with at all before and I still feel like I've learnt a lot from that, as horrible as it was, but then I've had good experiences too so yeah umm yeah it does feel different, not always supported in those either but it'd feel like I'd got more from that, but maybe it's just because I'm still in it right now I don't know **Interviewer:** so maybe when you say different there's the connection that you have with your supervisor has been there in previous supervisions but **Lola:** yeah **Interviewer:** maybe isn't as strong in PWP, I don't, is that what you mean?	Learning from difficult experiences Difficulty reflecting whilst doing the role
Respondent: yeah I think that is it. More so with my most recent one, there was an interesting bond with my last supervisor. I don't know what that was and yeah well now I'm just reflecting on it so I don't really know what that was but it still wasn't coming from me, it was more them. **Interviewer:** was she the more structured or unstructured	What supervisor brings effects the CMS

Lola: unstructured	
Interviewer: so the one you have now is more structured	
Lola: yes, yeah, umm but I don't know there was a sort of closer bond with the last one but I think that was the men more to the women. Anyway that's totally aside I suppose but yeah so it was more unstructured	Complex gender dynamics?
Interviewer: moving on slightly	
Lola: yes	
Interviewer: if there's anything, nothing else you want to say	
Lola: no nothing	
Interviewer: so could you say something about what might help you manage the role of PWP outside of case management supervision	
Lola: yeah, actually well that's what I've been doing a lot lately	
Interviewer: and that's inside or outside of work	
Lola: oh ok, I was going to ask that. Umm yeah I think lately I have taken my lunch break for the first week last week in ages and that's actually been really helpful. Just getting out has been a joy, which I haven't been doing and to be fair last week I felt like I had some space for some reason. I think I had more cancellations or something that I had been having so that's been really helpful. I think I just need to maintain that, umm even if like everything else is piling up. Umm so things like that and	Taking lunch break Can only have a break if there is a cancelation?
Interviewer: prioritising your lunch break	
Respondent: yeah I mean I'm pretty good outside of work, I am pretty like umm I socialise and I'm meditating at the moment, like every day. I'm exercising, I know that's standard what people say but I am actually doing it and it's been really nice. Umm but I do still feel like I'm taking the role, over the last month I think I've taken the role home more than I've done in the past, so I've been really conscious of that and actually making that change in regards to lunch. I think I'm not really being heard by management and supervisors and stuff, it feels like a really sticky point and I really do feel like I just have to look after myself and maybe change my own thoughts around certain things too, because that's really all I can do. All the other stuff gets to you, service stuff. Not really being heard and supported and undervalued doesn't help so you get on with it. It kind of grinds you down and when it's so fast paced and so much emotion you're carrying it can so I think I just need to focus on things like actually these people are getting a service. *[Section removed due to*	Self care 'Taking the role home' Taking responsibility for own processes Culture of being disregarded as a PWP? Transient nature of the job

confidentiality] for me it's not something that I want to stay in forever. I can temporarily kind of look after myself	
Interviewer: anything inside of work that helps other than case management supervision at all	
Lola: oh so things like, well not really, we don't have clinical skills as regularly and things like that as we should but we do have our reflective practice which is outside of our service *[Section removed due to confidentiality]* I have to say, I don't know about other services if they have that space it's different to clinical skills, which I don't actually find that useful apart from information sharing	Some other support received outside of CMS
Interviewer: how often is the clinical skills	
Respondent: umm I think it's meant to be once a month now . *[Section removed due to confidentiality]* it doesn't feel very, again about you and all the emotion that you're dealing with. *[Section removed due to confidentiality]*. Umm I also talk to my colleagues which actually I've found really useful. I mean it brings up other kind of negative thoughts I think sometimes too so it's not always helpful, but actually my colleagues, yeah the team itself. I should've said that really earlier on, I feel quite bad now that I didn't, but yeah they are saving grace really in there. It's nice and it's good when you have a laugh as well. And yeah the PWP team is really great, I wish that there was more community spirit amongst modalities to be honest but there isn't unfortunately, but still everybody there I really, I do like you know so that's helpful.	No room for emotions Collegial support Humour as a way of coping in role
Interviewer: ok so yeah, kind of moving again slightly away from that subject, what keeps you in the role of a PWP	
Lola: good question *[Interviewer's name]* oh god well what's kept me for a while it was experience and building up confidence and it's possibly like the best role to do that because you don't have a choice but to just keep going and keep progressing and meet new people. Umm I don't know if, right now applying for other things is like extra thought and energy. It's not stopping me from thinking about other things and applying for those places. Umm, I don't feel like I'm gaining anything extra by being a PWP now so for me I'm at the point where I'm moving on. So nothing's necessary other than being paid regularly and getting some of those elements of why I went into therapy to meet new people, to hear their stories and to offer them some sort of support. Other than those, probably three things then I'm not really up for hanging around. I feel like I've got what I wanted to get and that was building up my confidence. The other thing is the applications it does kind of drain the resources. You're pretty knackered after a week or a day of being a PWP, so yeah that tiredness then impacts outside I think of what you pursue so that would keep you yeah	Building confidence Limited energy to move on from role Expression a desire to leave the role Exhaustion in the role
Interviewer: and I guess yeah following on from that is, have you noticed any change in your lifestyles since taking on PWP role	

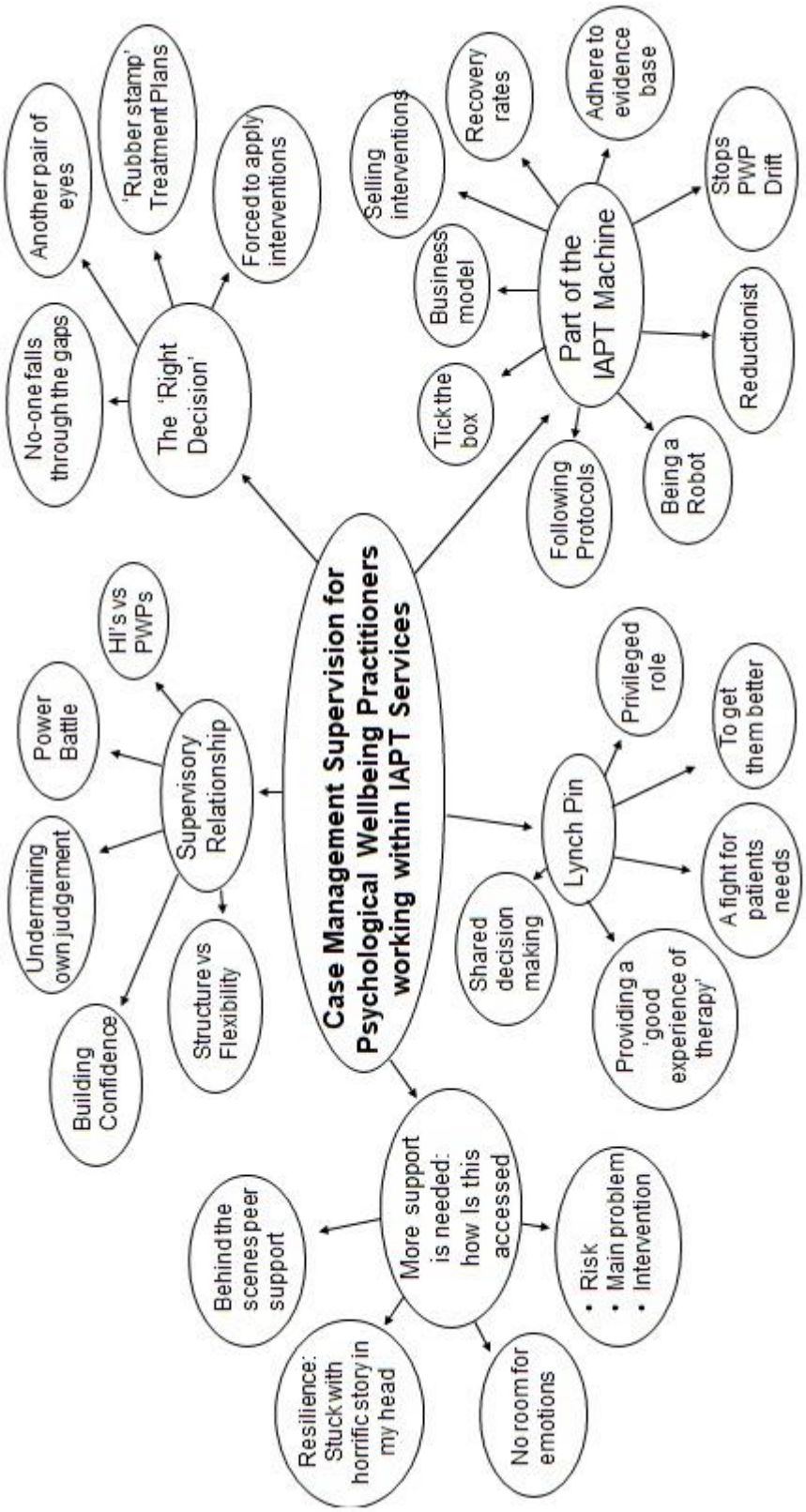
Lola: Umm *[Section removed due to confidentiality]* I do I feel more confident, I think it's helped and that's why I got into it. I mean I feel deskilled in other ways but I do feel more confident in doing therapeutic work to some degree. If that makes sense, I know that's a bit of a contradiction	Deskilled but more confident
Interviewer: yeah can I follow up on the deskills thing and what is there anything specific you feel deskilled in	
Lola: yeah in, because I was trained in counselling so I feel a bit more deskilled on explorative stuff with patients because that's not what I do it's very directive and exploring myself as well personally. Developing that way. I try to stay on top of that but there's not much time to even think about yourself or the patients much, after one session you're into the next. So I feel like I've lost a bit of that. I possibly have and I think it just makes me a bit more concerned that I've lost those kind of skills and I know how important personal awareness is for your therapeutic work if you're a counsellor. Yeah I think it's just the more the exploration and there's certain skills that perhaps are more, it's more about not being so guided and not being so directed being with the person and just letting them explore that, umm yeah I think that's what it is. Umm but I don't know, what was the initial thing again? What did I side track away from?	Deskilled because of being directive Lack of time Less focus on personal awareness Lack of autonomy
Interviewer: umm just if there's any change with your lifestyle and you mentioned earlier about feeling more tired during the PWP role, has that impacted your life	
Lola: maybe to some degree earlier on I think I've made a lot of changes over the last few months actually and I think I do a lot of goal setting actually in some of the course that we were and actually I've started doing things through that. That's been quite good for me, so actually setting goals with patients or if I'm running a course it has been quite beneficial in ways. So that's nice umm but other than that I don't know I feel like there is but I can't think of it right here, right now	Using some of the guided self help herself
Interviewer: that's ok if you can't, you don't want to say anymore on that **Lola:** yeah know I feel like I did but I just don't know, I'm blanking it **Interviewer:** ok if it comes back to you, you can always add it in **Lola:** cool **Interviewer:** so just a few more questions left Lola. Thank you for your patience **Lola:** no, no thank you for yours *[Section removed in order to protect confidentiality]*	Difficulties reflecting on role and PWP due to nature of the job not allowing for reflection?

Interviewer: umm a really important question I think, do you have any recommendations in regard to the PWP role and case management supervision	
Lola: how long have we got, erm oh important recommendations, I think just a bit more space and reflection and I don't know, I know why the role is the way it is but it's changed so much, in terms of what they set out initially to do I think. It's not realistic	Reality vs idea of how the role was designed
Interviewer: what changes do you think, putting you on the spot again	
Lola: yeah well it's not mild to moderate anxiety and depression, that's not what you get in on a day to day basis. I mean yes if you're lucky you know it's a low percentage, I'd say. There's very much a lot of core mobility and umm complexity and I think the timings are just way off. I know it's all about money and business but actually this is therapeutic work and there needs to be more time given if PWPs are supposed to be in it a long term you know. It's not sustainable emotionally for people as well. Umm I think it would be beneficial to have supervision with a different person to your case load management. I get why case load management is there it can be helpful to a degree but I think, but and I'm not sure how you'd use supervision because it is so fast paced and you don't reflect in the moment really and sometimes the relationship it's developed, but maybe with less people maybe would be doable like not as many assessments or treatments then maybe it would be beneficial to have that. It's hard to think because it is the role that you just become to know. I mean I'm sure I'd make a million changes but it would be completely changing the role entirely	Working with more complexity Time pressures Not a long term role Would more supervision make a difference in reality Acclimatised to the role Changing the role
Interviewer: is there anything you would specifically change about supervision and case management	
Lola: I think well I think it would just be more, maybe not longer. I get why it is the way it is. It had, it does serve a purpose. I think it's just you don't get to explore anything yourself. I think that's important but then like I said it's hard to do that when you're not actually sure what's going on and you're a bit like a robot going from one person to the next	Reflection not realistic in the role: feeling like a robot
Interviewer: if you had that space, so a clinical supervision space similar to what you've experienced before, do you think you would use it in the PWP role	
Lola: umm I think personally yes. I'm not sure all PWPs would see it as effective but I would, personally I would like it	Differences in opinion and experiences
[Section removed in order to protect confidentiality]	
Lola: yeah, yeah whatever kind of comes up. Because there is stuff and there's heavy things that come into assessments that you don't really get to process and actually having that time and space could help with management supervision. That would give me the chance to make it more	No processing time

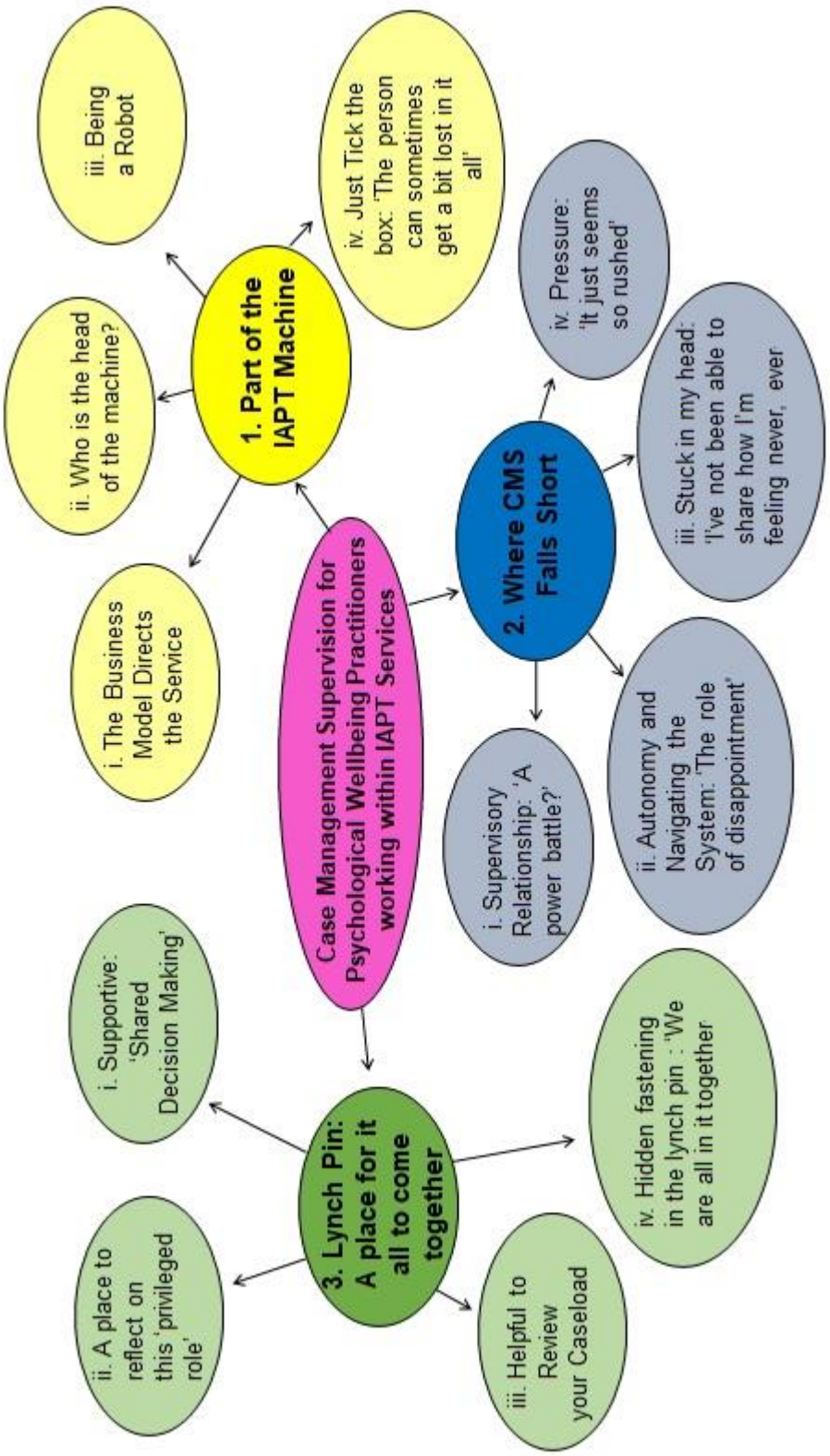
of my own decision on what's about to happen or perhaps the treatment that's being a bit stuck maybe that we can give them more guidance and a time to reflect on that and yeah I would do that I think **Interviewer:** umm is there anything else we've missed out Holly? Anything else you'd like to add to what we've spoken about **Lola:** no thank you for giving me the opportunity to speak about it. We don't get to speak about much about how it all feels **Interviewer:** are there any questions you'd like to ask me **Lola:** umm I don't think so **Interviewer:** so there's nothing else to add **Lola:** nothing. Thank you **Interviewer:** thank you	Use of interview to reflect on feelings and appreciation of this

Appendix I – Two Early Drafts of the Thematic Map

First Draft of the Thematic Map



Second Draft of the Thematic Map



Appendix J- Journal Article

‘Part of the IAPT Machine’: Psychological Wellbeing Practitioners’ accounts of Case Management Supervision.

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Paper prepared in accordance with the author guidelines from the Counselling Psychology Review.

Abstract

The spread of Improving Access to Psychological Therapies (IAPT) services in the National Health Service (NHS) in England required a new role called a Psychological Wellbeing Practitioner (PWP). The PWP role was envisioned as a frontline position requiring substantially less training than practitioner psychologists, to deliver brief evidence based therapy techniques. PWPs partake in what is called case management supervision (CMS), designed in order to support their unique role. The aim of this qualitative study is to ascertain PWPs understanding and experiences of the case management supervision they partake in. Data was collected by conducting semi-structured interviews with eight PWPs. Interviews were recorded and transcribed and Thematic Analysis (Braun & Clarke, 2006) was used to identify recurring patterns of meaning, or themes, in the data. Three main themes were identified by the researcher including: *'Part of the IAPT Machine'*, *'Pitfalls of CMS'*, and *'Serving a Purpose'.* These themes illustrate expectations of, struggles with and implicit realisations about the role that CMS has within the broader remit of IAPT services. Due to the word limit this journal article will concentrate on exploring the first theme of *'Part of the IAPT Machine'.* The findings of this study are discussed in relation to existing literature, current developments and personal observations about the PWP role, whilst also corresponding, more broadly, to the social and political positioning of IAPT services.

Literature Review

Improving Access to Psychological Therapies (IAPT) programmes were introduced by the Labour government (Clark, 2011) following an economic report (Layard et al. 2006). IAPT was designed to help people to return to work by making psychological therapies more widely available as an alternative or supplement to medication, to facilitate the treatment of common mental health problems such as anxiety and depression (DoH, 2012). IAPT services have now been established in 95% of Primary Care Trusts across England (Clark, 2011).

The evolution of IAPT services in the National Health Service (NHS) in England pioneered new therapeutic roles, specifically in the modality of Cognitive Behavioural Therapy (CBT). Between 2008–2011, a reported 3,600 new psychological therapists (60% high-intensity CBT therapists, 40% PWPs) were trained to provide 900,000 people with access to psychological therapies, that otherwise would not have had access to a service (Clark, 2011).

The current IAPT workforce consists of step 2 and step 3 workers within the stepped care approach (Richards et al. 2010). Step 2 psychological wellbeing practitioners (PWPs) or low intensity workers (LI) provide low intensity CBT treatment and assessments at a high volume, for mild to moderate depression and anxiety (Richards & Whyte, 2009). PWP work centres around guided self-help, or brief face-to-face psychological interventions (up to seven sessions) as recommended by the National Institute for Health and Care Excellence (NICE, 2011).

The Role of PWP

The role of PWP has evolved from graduate mental health workers (GMHW) or primary care mental health workers (PCMHW) roles which were initially established to work with brief evidence-based therapy techniques, to assist General Practitioners (GPs) in managing common mental health problems (Schafer & Wrycraft. 2007). PWPs do more guided self-help than GMHWs, advocating a greater emphasis on patient self-management compared to other therapeutic interventions (Richardson & Richards, 2010). There is also more of a focus on medication management and signposting to other agencies (Richards, Farrand & Chellingsworth, 2011).

Like the GMHW, the role of PWP is a non-professionally orientated role; trainee and qualified PWPs are predominantly graduates in Psychology. It has been noted that PWPs can be 'without prior formal qualifications in health' (Bennett-Levy at al., 2010). PWPs undertake a 45-day training programme that requires over a year to complete. Supported by 'intensive supervision' PWPs can offer 'evidence-based interventions' to a large number of patients' (Thwaites et al., 2015).

The PWP role has been compared to that of a 'coach' (Richards et al., 2010); this would imply that a PWP is to mental health what a personal trainer is to physical health. The coach helps to develop a plan of action with their client, whilst acknowledging that the 'real work' is done by the service user. PWPs work at a high volume; this can mean up to 45 active cases at any one time (Richards et al., 2011). The Department of Health's (DoH, 2008) implementation plan for IAPT identifies that PWP's will, on average, work with 175–250 patients per year, thus becoming highly skilled in their trained interventions.

There is a high turnover of PWPs linked to burnout in the role (Steel et al., 2015). The high turnover may also be due to the fact there is limited career progression for a PWP; the role can sometimes be a stepping stone to further training such as HI training and clinical or counselling psychology doctorates. Furthermore, the high volume of work, lack of professional identity (Rizq, 2014) and growing complexity of clients may contribute to a lack of job satisfaction and frequent staff departures.

Supervision

The word supervision is used commonly across health and social services; it can be used to describe widely differing activities and has varying meanings worldwide. It is utilised in areas including management, personal development or clinical supervision. It can be informally or formally undertaken, occur individually or in groups. The focus of supervision can also vary; there may be a focus on outcomes or on the process itself be this the therapeutic process, clients process or a mixture of the two (Turpin & Wheeler, 2011).

Supervision can encompass many things (Carroll, 2007) and is 'multifaceted' but is primarily used to help supervisees with their client work (Morrissey & Tribe, 2001). Supervision relates to a space to be reflective, enhance skill sets and foster both personal and professional development (Lane & Corrie, 2006).

'We are living through a period of upheaval in the field of the psychological therapies' (Rizq, 2012b. p. 9) as a result, there may be an increased need for clinical supervision (Nellaney & Sloan, 2013). Supervision is connected to better client outcomes in a range of health worker professions (Holloway & Neufeldt, 1995.; Roth & Pilling, 2007.; Freitas, 2002). Supervision literature relating to a range of healthcare roles identifies that clinical supervision is linked to improved outcomes for clients, regardless of job role (Spence et al., 2001).

Supervision in IAPT

Supervision differs between modalities in IAPT services. CMS is defined **as** **'**the regular review of the caseloads of practitioners, providing low intensity interventions, within IAPT stepped care services' (Turpin & Wheeler, 2011). CMS differs to clinical supervision, in that the immediate focus is on adhering to the CBT evidence base, (Richards et al., 2010). This leaves little room for personal or professional growth although worker support has been identified as one of the purposes of CMS (Turpin & Wheeler, 2011)

PWP supervision is used for 'the safe and effective management of high volumes of patients' (Benett-Levy et al., 2010) and PWPs should have one hour per week of CMS (Turpin & Wheeler, 2011). A high case load of clinical work can be demanding, and supervision is as important for adhering to the evidence base as clinical work (Roth & Pilling, 2007). Without CMS, managing a high volume of work may not be as effective (Pullen & Loudon, 2006), although it has been identified that different IAPT services may place different values on supervision for PWPs (Elkin,1999).

CMS supervisors are usually former PWPs who have undertaken the formal CMS training. The IAPT specified supervision training lasts 5-6 days (Roth & Pilling, 2008). CMS supervisors can also be HI workers or psychologists depending on different service resources.

There is no mandatory, formal wellbeing or reflective space provided to PWPs. Rizq et al., (2010) suggests that reflective spaces are needed for PWPs as their training doesn't address the reality or complexity of referrals

IAPT is ever-evolving and rapidly changing within the NHS (Rizq, 2012b; Fonagy & Clark, 2015; Jolley et al., 2015; Wroe et al., 2015). No doubt the PWP role will be diversifying alongside these changes, which may add to the increasing

demands upon PWPs with already abundant caseloads. It has been revealed that due to the rapid introduction of IAPT, there was little time for a thorough review of supervision literature when considering the supervision provided for PWPs (Turpin & Wheeler, 2011).

Furthermore, much of the IAPT research is financially supported by the Department of Health IAPT Programme, highlighting conflicts of interest. A pertinent example of this is disclosed by David Richards (Richards & Borglin, 2011). This suggests that IAPT research is becoming more insular and possibly biased due to financial implications and NHS structures and systems.

With recent studies showing high burnout (Steel et al., 2015) and a lack of professional identity for PWPs (Rizq et al., 2010), along with the fact that they are seeing increasing numbers of complex cases (Houghton, 2007) and experiencing clients with 'high intensity emotions' (Bennett-Levy at al., 2010) an exploration into the supervision for PWPs will hopefully inform their future working.

Method

Research Design

A qualitative design has been chosen to address the aim of this study. Qualitative research fits with the ethos of counselling psychology and its commitment to the scientist practitioner model (Woolfe, 2010).

Qualitative researchers are interested in what it is like to experience conditions rather than reducing them to quantifiable variables or cause and effect (Willig, 2001). A qualitative method is preferred over a quantitative method with regards to this study because the aim is exploring PWPs understanding and experience of CMS.

I approached the study from a critical realist perspective, this refers to marrying "the positivist's search for evidence of a reality external to human consciousness, with the insistence that all meaning to be made of that reality is socially constructed" (Oliver, 2011. p. 2). The goal of this piece of research is to produce useful and local, rather than objective and global knowledge, this is according to recognising the limitations of generalising claims based on a few interviews.

The method of data analysis selected was Thematic Analysis (TA), which has been used by a large body of research within qualitative psychology to identify, analyse and report patterns or themes in language-based data (Braun & Clarke, 2006). The procedure for TA outlined by Braun & Clark (2006) was used as a guideline to provide structure to the convoluted process of detecting recurring themes, or central organising concepts, in PWPs' accounts. Critical realism and TA are compatible as TA is flexible and not tied to any particular epistemological viewpoint (Braun & Clarke, 2006).

The aim for this research was to analyse the whole data set rather than focusing on one aspect. The data was analysed inductively rather than being theoretically driven: with a focus on developing latent themes and further exploring the meanings conveyed through language.

Six phases of Thematic Analysis were followed for this study (Braun & Clarke, 2006). The phases are described as follows: Phase 1: Familiarisation of the data. This was done through the process of transcribing the interviews (Riessman, 1993). Phase 2: Generating initial codes. This was undertaken by taking the preliminary

notes and organising these into collections of codes. Phase 3: Searching for themes; this included sorting the codes that were identified by the researcher into broader themes. Phase 4: Reviewing the themes: which included creation of the thematic map. Phase 5: Defining and naming themes, was done alongside Phase 4 and creating the thematic map. Phase 6: Writing up the report, this was a crucial part of the TA as during the write up the themes were reviewed numerous times, and renamed in some instances, to ensure a considerate and rigorous analysis of the data was undertaken.

Participants

The criteria for selecting participants included the following: Participants held a current role as a PWP in an IAPT service, and had more than 1 year of experience in the role following the completion of their PWP training. This ensured that participants had enough time to get a full picture of the job role and the CMS provided.

Participants were also eligible to take part if they had prior experience of the PWP role, and had worked as a PWP for at least 1 year post their PWP training. However, if previous PWPs reported being in another job for longer than 2 years they were excluded from the study, this was implemented to make sure participants experiences were not outdated due to the rapid changes in IAPT. These criteria enabled the researcher to recruit participants due to the high turnover of the role.

Recruitment for this study had a narrow sample to enlist participants from regarding the inclusion/exclusion criteria. Snowball sampling was purposive, with the aim of generating ‘insight and in-depth understanding’ with regards to this topic (Patton, 2002).

In total, eight participants were eligible to participate in the study, and eight research interviews were conducted. Interviews were all conducted face to face, in a place convenient for the participant, this was usually a confidential privately rented therapeutic room.

Table 1 outlines participant information relevant to the study.

Table 1: Participant Details

Participants (Pseudonyms)	**Gender**	**Approximate Age**	**Approximate Time spent as a PWP**
Jasmine	Female	26	1 years
Beatrice	Female	59	3 years
Rebecca	Female	28	2 years
Howard	Male	30	4 years
Louisa	Female	38	7 years
Lola	Female	29	2 years
Karen	Female	35	5 years
Leanne	Female	52	6 years

Findings

Analysis of the data set generated three overall themes, an overview of these themes is shown in Table 2 and Table 3.

Table 2: Themes and Subthemes generated during Thematic Analysis

List of Themes with further Subthemes

1. Part of the IAPT Machine

iii. Who is the head of the machine?
iv. Being a Robot

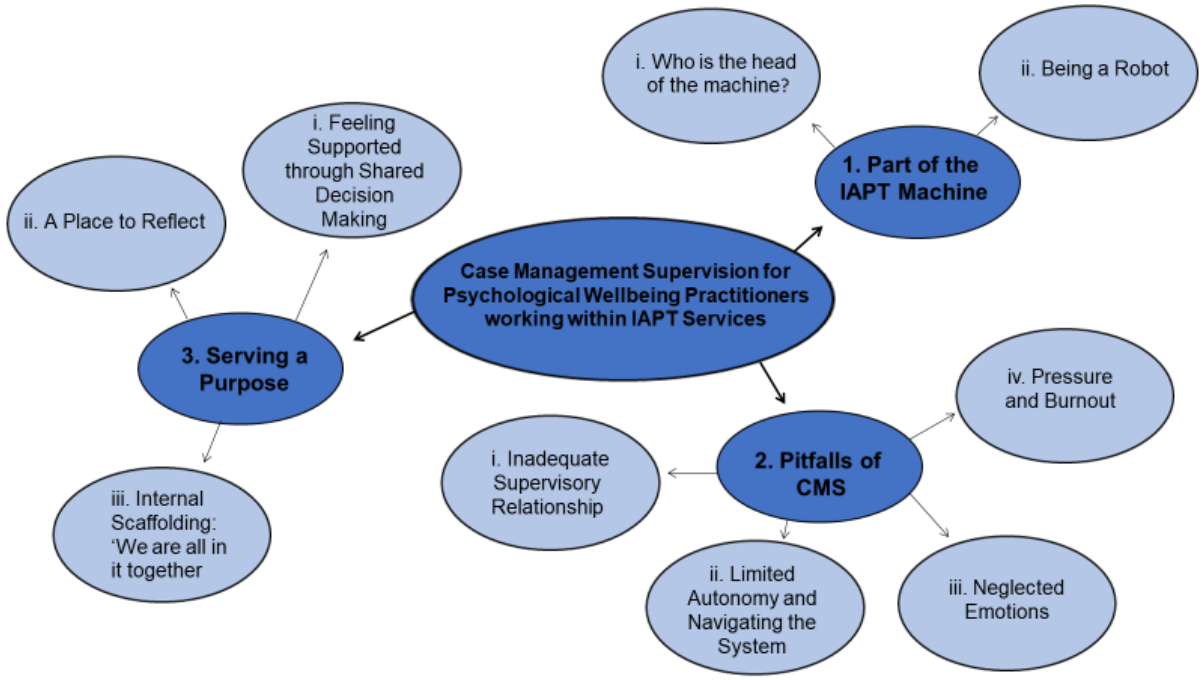
2. Pitfalls of CMS

v. Inadequate Supervisory Relationship
vi. Limited Autonomy and Navigating the System
vii. Neglected Emotions
viii. Pressure and Burnout

3. Serving a Purpose

iv. Feeling Supported through Shared Decision Making
v. A Place to Reflect
vi. Internal Scaffolding: 'We are all in it together'

Table 3: Thematic Map



Limitations with regards to space do not permit me to explore every theme and subtheme in depth. As a result, this journal will focus on presenting the first theme of *'Part of the IAPT Machine'* and the subthemes of: *'Who is the head of the machine?'* and *'Being a Robot'.*

Part of the IAPT Machine

This theme focuses on meaning patterns within the data set that illustrate participants' understanding of CMS as being part of the IAPT service structure. The term machine refers to; 'an apparatus using mechanical power and having several parts, each with a definite function and together performing a particular task.' (Oxford Dictionary of English, 2017). IAPT services can be understood in terms of being part of a wider political machine. Moreover, services themselves have been likened to a machine, the concept of IAPT being a 'machine' is further outlined in literature such as Rizq (2012a).

Analysis of the data has identified a theme of the mechanical nature of the job role of a PWP, and how CMS helps to support this way of working in the wider machine of IAPT. The following excerpt outlines this:

> *"Doing the role has really kind of stressed to me how much I don't want to be in that kind of machine of seeing that many people each week, because I just don't think it's healthy for anyone."* (Karen)

It seems that Karen has picked up on the machine analogy, and she conveys the potential pitfalls of working as a human, in an area that requires such a high volume and mechanistic way of working.

CMS appears to be an integral part of the IAPT machine; helping the service run smoothly to deliver what it is required to, but working in this way seems challenging for the humans within the machine.

> *"Everything in IAPT is so high pressure, so high volume and so you know rat a tat tat in terms of let's get all this information out. It can feel a bit like a machine sometimes and maybe, maybe you feel like the person can sometimes get a bit lost in it all.*" (Beatrice)

This quote implies that Beatrice also identifies with IAPT feeling like being in a machine and the use of her language converys that the '*person'* can

get *'lost'*, this seems to be a negligent oversight in a service that claims to work with mental health difficulties, such as anxiety and depression.

The following quote provides a summary in relation to this theme:

> "*I know it's all about money and business but actually this is therapeutic work and there needs to be more time given, if PWPs are supposed to be in it a long time you know."* (Lola)

Lola's language identifies a culture in the IAPT machine that emphasises money and business over the therapeutic work, there also seems to be an acceptance or resignation of this just being the way it is. There seems to be a conflict with regards to the values of the PWPs and the wider service.

Within the broader theme of '*Part of the IAPT Machine'* are two subthemes: *'Who is Head of the Machine?*' and *'Being a Robot'.*

Who is head of the Machine?

This subtheme problematizes power dynamics that appear to occur within CMS between the PWP and their supervisor, and additionally with both PWP and supervisor and the wider context of IAPT. This includes who or what holds the power in the IAPT service structure, and how CMS supports or opposes this.

The term *'stepped care'* was spoken about by most of the participants interviewed and CMS's function is to ensure that '*stepped care'* is adhered to. It could be that the service model holds the power in the IAPT machine, but it appears that this 'model' is followed with no deviation in the face of human complexity. Many participants also spoke of being guided by *'outcomes'* suggesting that IAPT targets may direct the work:

> *"I know they say being a PWP isn't about relationship or anything like that, is it? but still. Well there's all kinds of different reasons aren't there really like the stress element; there's a high burn out, isn't there, amongst PWPs and obviously it's going to affect how we interact with people and so they're not going to get the best. I don't think they're going to get the best outcomes, if somebody is deeply affected by what they're saying"* (Leanne)

This extract from Leanne's interview highlights a few important aspects to consider. She seems to be implying that a relational dimension is overlooked as a

factor in the PWP role. Leanne appears to be directly linking stress levels and burnout with the lack of recognition of the relational aspects of the role. It could be surmised that CMS does not provide a space for exploration if a PWP is *'deeply affected',* as there is an expectation that this would not be the case. Although not made explicit Leanne's use of the word *'they'* in this statement suggests that there is a wider context, possibly governmental policies or commissioners. It is possible that who Leanne refers to as *'they'* could be holding the power over the IAPT agenda and overlooking the importance of the relationship in the PWP role. The term *'they'* suggests that there is a higher power, a person, group or body that is calling the shots with regards to IAPT. Specifically, who *'they'* are is implied and eluded to rather than spoken about explicitly. This leaves an air of mystery or assumption in the culture of IAPT in the suggestion of an invisible and hard to pinpoint higher power, renders the system harder to challenge.

Being a Robot

This subtheme relates to the subjective experience of feeling like a robot who is part of the machine and feeling pressure to put individual complexity and needs (the clients as well as the practitioner's) aside. Many PWPs interviewed noted a systematic way of working and pressure to function as part of the wider IAPT machine. Being a 'robot' appears to be one of the ways PWPs try to survive this challenging role and CMS seems to support this robotic way of working.

> *"I get why it is the way it is. It does serve a purpose. I think it's just you don't get to explore anything yourself. I think that's important but then like I said it's hard to do that when you're not actually sure what's going on and you're a bit like a robot going from one person to the next."*
> (Lola)

Lola conveys an insight into the nature of IAPT and the need for CMS to support this work, alternatively she also seems to be expressing some of the difficulties of not being able to *'explore'* her own feelings or experience within IAPT, a lack of space to explore this seems to add to her confusion in the role exacerbating the need to act like a robot.

Other participants reflected on the details of CMS, and what this was like to experience:

> *"It was going through, almost like a checklist but I guess that was the thing that I didn't like about it, on the sort of negative side now was that it did feel quite procedural and quite rushed, but then that was the nature of the job. You know that was the nature of how I had to be, probably, with clients as well. So, I wonder if the supervision kind of mirrors how you have to be in sessions because of the time limits of the role and the heavy reliance on procedure and manualised treatments."* (Jasmine)

This extract from Jasmine identifies the possibility of how the robotic nature of CMS also echoes how she is expected to work with clients. She appears to accept that this formulaic way of working is a given attribute of the PWP role and the CMS received.

CMS seems to support the notion of being a PWP robot. This sub-theme powerfully portrays many of the critiques that have been directed at the IAPT model; especially from the perspective of counselling psychology.

Discussion

Although the focus has been on the first theme of *'Part of the IAPT Machine'*, findings outlined in this research illuminate the role of PWP; whilst also corresponding with existing research and observations about IAPT services, more broadly.

Supervision for PWPs

Throughout the data collection process, the majority of participants expressed a sense of appreciation to me, for providing them with a space in the interview to reflect upon their experience of the PWP role, and CMS.

Due to working with high caseloads; two specific challenges within the role of PWP have been identified (Thwaites at al., 2015). Initially, PWPs do not have time to reflect or learn from their experiences in the role because of the fast-paced and high-volume nature of the work. Additionally, current PWP supervision provision does not appear to provide ample worker support to prevent burnout. Turpin & Wheeler (2008) observe the link between receiving supervision and how this reduces instances of burnout, specifically highlighting the relevance of this for low intensity staff with high caseloads. Links have been made between receiving supervision and greater feelings of self- efficacy (Cashwell & Dooley, 2001); however, it is evident in the PWP role that self-efficacy is not encouraged (this is most potently captured in the subtheme *'Being a Robot'*).

It feels futile to argue for clinical supervision or further reflective space for PWPs beyond CMS, as it appears that this does not fit with the IAPT service model, and may not be appreciated or fully utilised by some PWPs.

What might be worth considering is the importance of the relationship between supervisor and supervisee. There is a corpus of clinical supervision research outlining the importance of the supervisory relationship for establishing quality supervision (Bernard & Goodyear, 2004). It appears that the supervisory relationship between PWP and case management supervisor is not something that has been given adequate attention in IAPT literature.

Therapist Wellbeing and Burnout

A strong trend in recent research centres on the wellbeing of therapists working within the NHS, and links between the pressures of front line mental health roles and burnout. Recent studies indicate elevated levels of burnout in IAPT workers (Westwood et al., 2017) and prominent levels of exhaustion in IAPT staff; this research also makes connections between this exhaustion and a potential impact on client outcomes (Steel et al., 2015). Lim et al., (2010), found that predictors of emotional exhaustion include high work demands and a lack of autonomy; these are both characteristics of current IAPT services (Steel et al. 2015).

Development of the PWP role

The role of PWP appears to have been introduced as a cost-saving measure for IAPT services to provide ‘therapy’ to people without the cost of paying a fully trained therapist. Being a PWP seems to have acquired a transient reputation; being utilised as a stepping stone to other careers such as HI CBT roles or applied psychologist training. Moreea (2015) identifies the lack of career progression within the role, leaving PWPs feeling ‘stagnant’ in their jobs and resulting in high turnover as they search for more fulfilling roles. It has been identified that the PWP role itself and PWP training positions have trouble reaching their full capacity (Moreea, 2015); as a result, it seems fitting to consider the nature of this role, and what the real-life impact may be for those moving in and out of the position.

It is worthwhile to evaluate what draws people to train as Psychologists or other therapeutic roles such as PWP. A want to ‘help’ or ‘understand’ others has been identified as a motivator, along with the ‘shadow side’ of early loss and early parentification (Barnett, 2007). People drawn to the PWP position would typically be early on in their journey to become recognised therapists and may have many unconscious motivations to help others. It is possible that PWPs are drawn to the role because they identify with being wounded healers; a wounded healer being defined as, “someone who draws on their own psychic scars to gain the insight, strength, and interest necessary to attend to others’ problems in living” (Hadjiosif, 2015: p.311).

Findings in this study suggest that PWPs are concerned with doing the best for their patients but also want to provide further support than the role allows; this desire to go above and beyond their remit may indicate that some PWPs may

identify as wounded healers. Furthermore, it could be that the PWP role and CMS reinforces a lack of personal and professional reflection.

The IAPT System: Power, Business Culture and Complicity

Critiques of IAPT services liken them to machines and identify that these facilities within the NHS are being run as large businesses (Rizq, 2012a). With the privatisation and current structure of the NHS, it is no surprise that IAPT services are expected to function as businesses. The importance placed on creating capital, saving money and the introduction of a payment by results scheme (Yeomans, 2014), are all factors that add to the corporate culture of IAPT. It is important to consider the implications and effects, on staff and patients, of running a service to support people with mental health difficulties as a 'business'.

In what seems like a parallel process, if a PWP struggles in their role this may be viewed as something being wrong with the character or conduct of the PWP, rather than in the system they are interacting with and operating within. In a service that subtly disseminates the message that numbers and targets are more important than human emotions and responses, PWPs may internalise this message, converting it into '*my feelings and responses are not important'.* This theory is mirrored by Mackinnon & Murphy (2016), who suggest that IAPT structure serves to promote a particular way to be a therapist using the stepped care model, manualised treatment and outcome measures. Use of these reductive resources serve to disregard the complex experiences PWPs may have when they interact with their patients.

Links with Current Affairs

Findings in this study highlight the disparity between the real-life, day-to-day work of a PWP, and the implementation and training literature that guides the role. The manualised modus operandi appears to be in direct opposition to the caring PWPs who are attempting to be flexible and accommodating in the face of the humans they see. It is important to situate IAPT in a wider political and socioeconomic landscape; what is happening in IAPT - such as the favouring of protocols and targets over individual wellbeing, appears to be mirroring a wider problem in current western society.

De Graaf, Wann & Naylor (2005) identify that capitalism and consumerism is promoting the expectation that people are faceless, robotic members of society; this is exacerbating feelings of powerlessness in terms of the potential for challenge or change in response to this.

A recent Guardian article (Wren, 2017) presents views from the frontline NHS staff that depict the reality of the effect austerity is having on how services are functioning, and the impact this has on staff wellbeing. There are gaps in the research directly relating to the distribution of power relating specifically to IAPT services, although, Rizq's (2012a) paper touches on pertinent theories.

The findings in this study mirror current issues described in relevant psychological literature. In the latest edition of The Psychologist (BPS, 2017) an article poses the question 'What protection is there for graduates' eager to gain experience?'. This is a letter written by a psychology graduate keen to increase their experience in the therapeutic field; he outlines the risks of inadequate supervision on the wellbeing of graduates, exploring how this affects the trajectory of entering the therapeutic professions, implying that a lack of supervision and emotional support is turning graduates away from this career choice. Emergence of articles such as this arguably appeal for those with therapeutic insight to scaffold the learning of psychotherapeutic practitioners, to safeguard graduates and service users, thus ensuring best practice from an early vocational stage.

Critical Evaluation of this Study

This study has only pinpointed a very particular area of the PWP role; specifically, their experience of CMS. As such, it is very likely that other aspects of the wider context of IAPT and the PWP position were overlooked.

One of the main criticisms of the study relates to the subtle assumption that CMS should provide a space comparable to clinical supervision, this is something the researcher has only become evident since undertaking the study. It is also important to note a possible sampling bias. This study could have potentially attracted PWPs that had more difficulties within the role, who felt the need to have their challenging experiences witnessed.

Further Research

The high turnover of the PWP role leads to many PWP experiences and opportunities for improvements remaining uncaptured. What seems to be very clear from the data, is that CMS cannot be examined in isolation; as such, future research could focus on PWPs experiences in the role rather than looking specifically at CMS. It feels important to recommend future research that elucidates PWPs experiences, are kept separate from other IAPT staff. Due to their lack of professional recognition, there is a risk that the voice of the PWP may get lost within the wider IAPT dialogue, leaving their experiences eluded. There is a need for further information to be gleaned on how PWPs make sense of their role within IAPT services, to explore whether their expectations of the role were met and how the transient nature of the position is experienced.

It is pertinent to consider more creative ways of supporting PWPs with their wellbeing. For instance, community interventions such as the creation of wider PWP communities, where PWPs can support each other within the role. An example of a more imaginative way of providing support for IAPT staff has been trailed by Dowthwaite (2016), who introduced a ‘Happy Hour’ into IAPT services based on the positive psychology movement. This introduction resulted in staff feeling happier and more uplifted at work. Further creative trials along these lines may merit advanced exploration to promote PWP wellbeing.

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