A QUALITATIVE STUDY EXPLORING THE SUPPORT EXPERIENCED BY STAFF MEMBERS FOLLOWING CLIENT RELATED VIOLENCE IN INPATIENT MENTAL HEALTH UNITS

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Introductory Chapter: Thesis Overview

An occupation in nursing can be stressful, with high workloads and poor support (Chang, Hancock, Johnson, Daly, & Jackson, 2005). Healthcare staff are at risk of experiencing violence and aggression in their workplace (Healthcare Commission, 2008; Anderson & West, 2011) which can increase strain and stress (Reid, et al., 1999), produce a mixture of difficult and confusing emotions (Reid, 2008) and negatively impact upon staff members' mental health (Cutcliffe, 1999).

There is a general consensus that aggression and violence cannot be fully eliminated from mental health settings (Paterson, Leadbetter, & Bowie, 1999). As such it seems important to be aware of how to protect the wellbeing of staff who are subjected to these experiences. However there is a lack of knowledge regarding what support is most beneficial for staff to receive (Rippon, 2000). Policy recommends that 'appropriate support' be provided following experiences of violence and aggression, however there is a lack of clarification about what appropriate support means or how to implement it in healthcare settings. Chapter One of this thesis aims to aggregate the few studies there are in this area by systematically reviewing the existing qualitative literature on staff members' experience of support following incidents of violence and aggression.

In addition to exploring what kinds of support staff members have already received, it is important to understand what they found beneficial about the support provided and what types of support they would prefer to receive following future experiences

of aggression. There have been repeated suggestions for staff to be specifically asked what support they would like following violent or aggressive incidents with clients (Whittington & Wykes, 1992; Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001). Chapter Two of this thesis is an empirical study which aims to explore staff members' answers to this question.

Both of the following chapters aim to consider and describe the practical and research implications of the findings that emerge from them, with a view to improving support for inpatient mental health staff following aggressive incidents.

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A QUALITATIVE SYSTEMATIC REVIEW EXPLORING THE SUPPORT RECEIVED BY INPATIENT MENTAL HEALTH STAFF FOLLOWING VIOLENT AND AGGRESSIVE INCIDENTS[1]

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[1] To be submitted to: *Journal of Advanced Nursing* (word limit, 5000, author guidelines in Appendix One)

ABSTRACT

Aims

To review qualitative literature examining the support inpatient mental health staff receive following violent and aggressive incidents.

Background

An occupation in mental health is often demanding, with violence and aggression placing further stress upon mental health staff. The potential impact on staff can depend upon their experience of subsequent support.

Design

A systematic review was undertaken to locate and synthesise relevant qualitative research.

Data Sources

Seven electronic databases were searched for studies published since 1999, using the terms “mental health” AND “inpatient” AND “staff” AND “violen* OR aggress*” AND “support” AND “qualitative”.

Review methods

A total of 1079 studies were returned, of which 1017 were excluded as irrelevant to the review question. Of the remaining 62 papers, 57 did not meet all inclusion criteria and were excluded, leaving 5 relevant papers. These 5 papers met quality appraisal standards and were included in the synthesis.

Results

Thematic synthesis resulted in three overarching themes: 1. the importance of support, 2. informal support (subtheme: peer support), and 3. formal support (subthemes: debriefing, managerial support, staff support groups, and supervision).

Conclusion

This review suggests that staff support is important following violent and aggressive incidents. Formal support received mixed feedback from staff. Peer support was the most commonly utilised source of support, but it is unclear whether this is due to a lack of alternative support options. Future research could specifically ask staff what support staff would find preferable.

SUMMARY STATEMENT

Why is this research or review needed?

- Mental health staff are at risk of experiencing violence and aggression in their workplace, and even more so in acute inpatient settings
- The mental health of staff members can be affected by experiences of violence and aggression
- Violence and aggression may not be fully preventable, therefore it is important to understand how best to support staff

What are the key findings?

- Support for staff was perceived as important in managing the emotional effects of violent and aggressive incidents
- Peer support was the most commonly utilised source of support
- Formal support received mixed views from staff on its usefulness as a source of support

How should the findings be used to influence policy/practice/research/education?

- This research demonstrates the importance of staff support in reducing the potential effects of experiencing violence and aggression
- Future research should ask staff what support they have found beneficial, and what support they would like to receive following future incidents of violence and aggression

Keywords: aggression, inpatient, mental health, qualitative research, staff, support, systematic review, violence

INTRODUCTION

Mental health practitioners are at risk of experiencing violence in their workplace (Chambers, 1998; Privitera, Weisman, Cerulli, Tu, & Groman, 2005). This review aims to aggregate the qualitative literature regarding the support staff have received following violent and aggressive incidents.

Background

Inpatient staff are likely to experience verbal and physical aggression from clients (Rippon, 2000), causing staff to feel unsafe in their workplace (Healthcare Commission, 2008). In response to violence and aggression in healthcare, the United Kingdom's National Health Service (NHS) introduced a 'Zero Tolerance' campaign (Department of Health, 1999). This aimed to provide reassurance that incidents would be responded to with potential prosecution, and to inform the public that unacceptable behaviour, such as aggression, would not be tolerated. Although it is desirable to reduce violence and aggression in healthcare, there is a consensus that it cannot be fully eliminated (Paterson et al., 1999; Totman, Hundt, Wearn, Paul, & Johnson, 2011). Therefore, understanding staff experiences and how to respond after incidents requires exploration.

Exposure to violence can produce devastating psychological effects (Anderson & West, 2011) with varying lengths of mixed and difficult emotional responses (Reid, 2008); for

example depressive or trauma symptoms can remain for six to twelve months post-incident (Paterson et al., 1999). Exposure to aggression in the workplace may lead to poorer mental health in staff members (Cutcliffe, 1999), and potentially cause ‘burn out’ (Reid, et al., 1999a).

Support may alleviate occupational stress in nursing (Donavan, Doody, & Lyons, 2013) and the availability of support can potentially reduce the negative psychological impact of client-related violence (Paterson et al., 1999; Totman et al., 2011). Staff may require support whether their experience involved actual physical harm or verbal aggression (Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001).

Greenwood, Rooney, and Ardino (2012) state that staff who work in challenging settings, such as inpatient units, should have access to a range of support services, as well as formal policies to support staff wellbeing. However, there is often limited staff support, despite policies declaring it should be available (Rippon, 2000; NICE, 2005; Irwin, 2006). Existing policies provide insufficient guidance on implementing support, external support sources, debriefing, and explaining support options to staff, which may lead to poor quality support and poor staff wellbeing (Greenwood et al., 2012). Nolan et al. (2001) questioned what support would be sufficient and appropriate, demonstrating a need to explore how to support staff (Rippon, 2000).

Systematic reviews can identify gaps in current literature, and provide answers to exploratory research questions. Aggregating qualitative literature can explore participant experiences and what they valued or did not value about these experiences (Noyes, Popay,

Pearson, Hannes, & Booth, 2008). This corresponds with this review's aim to explore staff experiences of support following violent or aggressive incidents.

THE REVIEW

Aim

The aim of this systematic review was to explore the current qualitative literature examining inpatient mental health staff members' experiences of support following violent and aggressive incidents.

Design

Systematic reviews can inform policy and practice (Noyes et al., 2008) and identify where there is a paucity of literature and potential for future research (CRD, 2009). The Centre for Reviews and Dissemination (CRD, 2009) states that systematic reviews use rigorous methods to identify, evaluate and summarise literature to answer a review question. Systematic review methods include predefining a review question, and setting inclusion and exclusion criteria to guide the collection of relevant literature. The collected literature is then assessed for relevance and quality, analysed and synthesised, and findings and conclusions are drawn (Parahoo, 2006; Cronin, Ryan, & Coughlan, 2008). Methods of thematic synthesis (Thomas & Harden, 2008) guided the present review. Thematic synthesis is an appropriate method when aggregating qualitative literature on opinions regarding healthcare issues (Noyes & Lewin, 2011).

Search methods

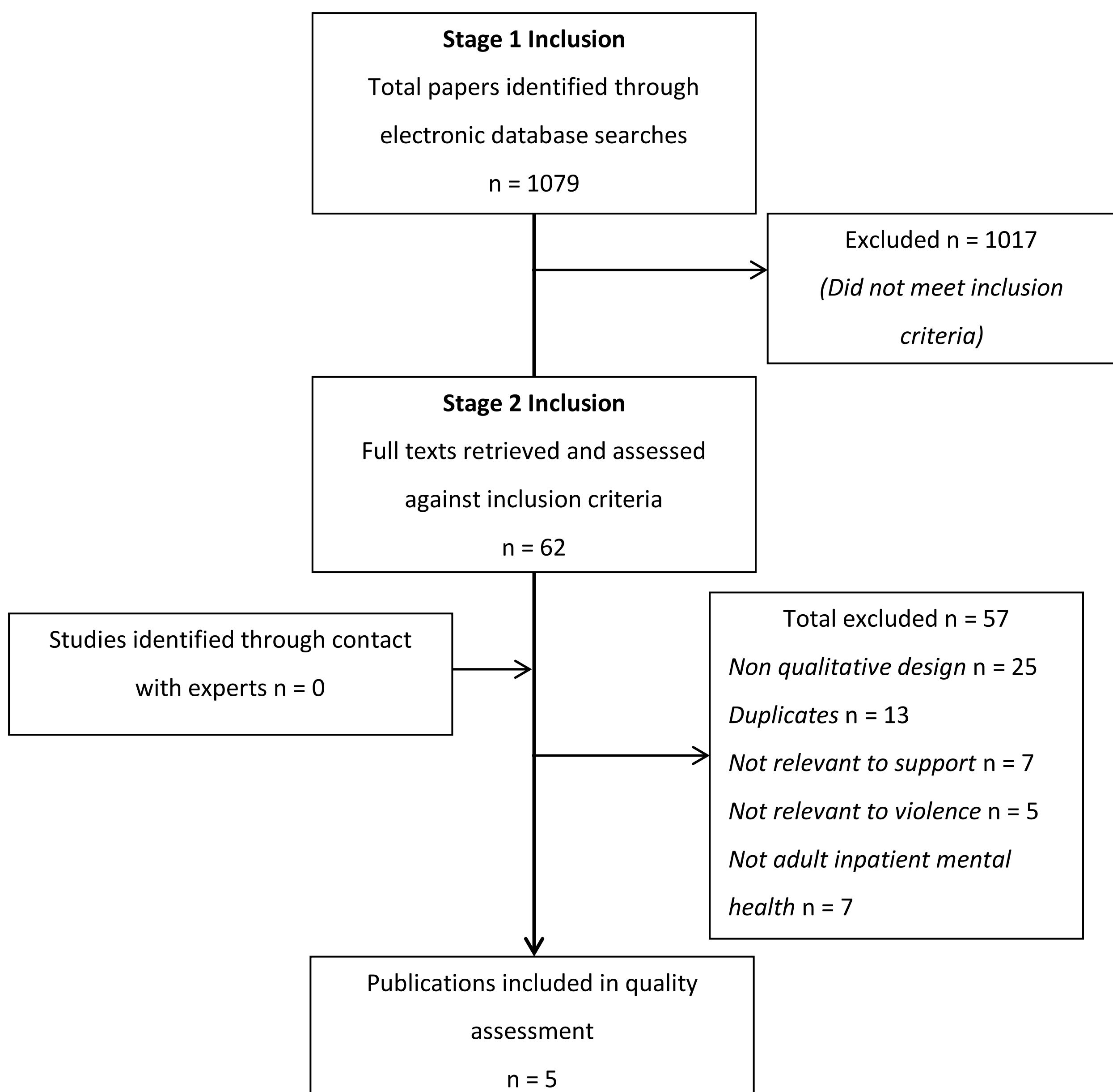
Search terms were chosen according to a PICo framework (Cherry, Perkins, Dickson, & Boland, 2014). The abbreviation refers respectively to **P**opulation (staff members), phenomenon of **I**nterest (the support experienced following violent and aggressive incidents), and the **Co**ntext (inpatient mental health units). Database search terms were: “mental health”, “inpatient”, “staff”, (“violen*” or “aggress*”), “support” and “qualitative”. It would be problematic to impose definitions on the inclusion criteria as participants’ perceptions determine different definitions. Therefore “support” and “violence and aggression” were chosen due to their consensual use in policies and literature in this area, which may influence the use of these terms in the participants’ language. Searches were limited to publications post 1999 due to the introduction of the ‘zero tolerance’ campaign (DoH, 1999) that year. This campaign legally established procedures in response to violence or aggression, which may have influenced participants’ experiences before and after its implementation. No language limitations were implemented; but no relevant non-English publications were returned. Studies were identified during May 2013 by electronic database searching (PubMed, Web of Knowledge, Medline, CINAHL Plus, PsycINFO, Scopus), including grey literature (SIGLE), scanning reference lists of returned papers, and consultation with a supervisor (RW). Correspondence authors of relevant papers were emailed to request further qualitative studies known to them; however no authors replied with suggestions.

Search outcome

Database searches returned 1079 potentially relevant papers (Figure 1). Qualitative papers identified as relevant during earlier scoping searches were returned by electronic searches. The returned studies’ titles and abstracts were screened and excluded if they did not meet

inclusion criteria (CRD, 2009; Dundar & Fleeman, 2014). Sixty-two articles appeared potentially relevant. Their full texts were obtained and further assessed against inclusion criteria (CRD, 2009; Dundar & Fleeman, 2014). Studies (n=57) were then excluded if they were non-qualitative on further exploration, lacked relevance to inclusion criteria, or were duplicates (see Figure 1), leaving five publications for quality appraisal. Throughout this process, supervisor RW provided consultation.

Figure 1: A Flowchart of the Study Inclusion Process (as recommended by CRD, 2009)



Quality appraisal

Quality assessment aims to determine whether studies have been rigorously designed, conducted and reported, and provide a meaningful response to review questions (Greenhalgh & Brown, 2014). There are disagreements whether quality assessing qualitative research is appropriate and which approach is most rigorous (Noyes et al., 2008). Advocates of qualitative research may find the concept of validity inappropriate; therefore it would be problematic to utilise quality appraisal methods which measure validity (Hannes, 2011). Qualitative researchers may place importance on different aspects of quality; therefore standardised checklists may be inappropriate (CRD, 2009). However, quality assessment intends to ensure systematic reviews are based upon the best quality evidence (CRD, 2009) and prevent them from drawing unreliable conclusions (Thomas & Harden, 2008).

The five studies retained through the inclusion process were quality assessed using the Critical Appraisal Skills Programme (CASP). The CASP is a critical appraisal framework designed to assess whether qualitative papers are credible and useful (CASP, 2013a). Despite the aforementioned issues surrounding quality appraisal, selecting a framework, such as the CASP, provides a standardised quality threshold (CRD, 2009). Qualitative reviews have utilised the CASP as it has been developed, tested, and is recommended for use within health research (Campbell, et al., 2003; Dixon-Woods, Agarwal, Jones, & Sutton, 2005; Campbell, et al., 2011). Four of the five papers demonstrated good quality in seven or more of the ten quality assessment criteria; except Bowers et al. (2006) which lacked in its description of methodology but demonstrated good quality on other assessment criteria and was retained. As a result, all five papers (in alphabetical order); Bimenyimana, Poggenpoel, Mybirgh, and van Niekerk, (2009), Bowers et al., (2006), Cutcliffe, (1999), Reid

et al., (1999b), Totman, Hundt, Wearn, Paul, and Johnson, (2011) met quality assessment criteria, and were included in the synthesis. This process was discussed with supervisor RW.

Data abstraction

Extracting data is more complex within qualitative reviews as 'findings' are more difficult to define than in quantitative research, which often consists of statistical findings (Thomas & Harden, 2008). Thomas and Harden (2008) suggest extracting the results sections of included papers, which often include key concepts, participant quotes and descriptions of findings, rather than interpretations. Campbell et al. (2003) concur that the findings sections include 'key concepts' to be analysed and synthesised. In accordance with this, the findings sections of the included papers, containing direct participant quotes, were electronically imported into QSR NVivo 10 software to explore the data and inform the synthesis. The paper by Bimenyimana et al. (2009) was written in two parts: a qualitative study and discussion of policies. Findings were extracted from the qualitative study in the first half of the paper only.

Synthesis

There is debate over whether qualitative research should be synthesised, due to qualitative systematic review methods being less fully developed than in quantitative reviews, a lack of published reviews to guide researchers, and whether it is appropriate to synthesise qualitative studies which are often idiographic (Thomas & Harden, 2008; CRD, 2009). However, synthesising qualitative studies and across methodologies may strengthen reviews (CRD, 2009). Synthesis allows reviewers to make observations about qualitative findings (CRD, 2009) and potentially inform policy and practice (Thomas & Harden, 2008).

Previously, synthesis methods have been diverse and lacking in rigour (Dixon-Woods et al., 2005). Thomas and Harden (2008) provided structured guidelines for thematic synthesis, which guided the present paper. When current literature is lacking, or when exploring healthcare topics, thematic synthesis can aggregate data (Hannes, 2011) by identifying prominent themes across studies (Dixon-Woods et al., 2005; Lucas, Baird, Arai, Law, & Roberts, 2007).

RESULTS

The total number of participants from the studies was 126, including a mixture of professionals and a range of years of experience and ages (see Table 1). Four studies were conducted in the United Kingdom with one other, Bimenyimana et al. (2009), undertaken in Johannesburg, South Africa. Qualitative methodologies appeared appropriate to all of the studies' aims. The research objectives of three papers (Cutcliffe, 1999; Bowers, et al., 2006; Bimenyimana et al., 2009) focussed on violence. Bowers et al. (2006) included other serious untoward incidents (SUIs), such as suicide, violence, deaths and absconding. The remaining papers explored morale (Totman et al., 2011) and support in general (Reid, et al., 1999b), not specifically relating to violence and aggression. Bowers et al. (2006) and Cutcliffe (1999) did not state their sampling method or participants' age or gender. Totman et al. (2011) reported the number of participants who completed interviews, but not in focus groups. Bowers et al. (2006) and Bimenyimana et al. (2009) did not report their qualitative methodology, referring to their analysis as 'theme identification'. All of the studies suggested future clinical or research implications.

Table 1: Summary of the Included Studies

Author and year	Research aims	Sample	Sampling method	Methodology
Bimenyimana et al., 2009	To explore the experiences of aggression and violence from clients towards psychiatric nurses	10 participants 5 males and 5 females All participants were qualified mental health nurses with over 2years' inpatient experience Aged between 20-40years old	Purposive sampling	Coding and theme identification
Bowers, et al., 2006	To examine the impact of service user incidents (SUIs) on inpatient wards, and how those events affect subsequent practice	56 participants Comprising 16 ward managers, 17 qualified mental health nurses, 14 occupational therapists and 9 psychiatrists No ages or genders stated	Not stated	Coding and theme identification

(table continues)

Author and year	**Research aims**	**Sample size**	**Sampling method**	**Methodology**
Cutcliffe, 1999	To report nurses' experience of violence from individuals with mental health problems	6 participants All participants were qualified mental health nurses of 6 months to over 12years No ages or genders stated	Not stated	Thematic analysis
Reid, et al., 1999b	Explore mental health staff views on how to support them in their work and be protected from potential adverse effects	30 participants Comprising 9 community nurses, 6 ward nurses, 6 psychiatrists, 3 clinical psychologists, 3 occupational therapists and 3 social workers	Purposive sampling	Content analysis
Totman et al., 2011	To extend current understanding of the mechanisms underlying morale on inpatient wards, and generate strategies for improving morale	24 participants Participants including managers and 'non managers' but the proportions are not stated This study included focus groups but did not state the number of participants	Purposive sampling	Thematic analysis

Guided by the review question, an inductive thematic analysis of the studies' findings was undertaken. Thirty-seven initial codes were generated from data extracts and given descriptive labels (Table 2). Supporting quotes for codes and themes were discussed with supervisor RW.

Table 2: An example of generating codes and themes from a data excerpt

Data excerpt	**Initial descriptive codes**	**Theme**
"we had a dreadful management structure" (Ward manager, Bowers et al., 2006, p. 229)	Poor management Managerial support Formal support	Theme: Formal support Subtheme: Managerial support

Similarities and differences were identified between initial codes to create descriptive themes (Thomas & Harden, 2008; Fletcher, Gheorghe, Moore, Wilson, & Damery, 2012). Descriptive codes were clustered based on commonalties to produce three overarching themes**:** 1. the importance of support, 2. informal support (subtheme: peer support) and, 3. formal support (subthemes: debriefing, managerial support, staff support groups, and supervision). The studies varied in their reporting of the themes (Table 3).

Table 3: The Themes and Subthemes Identified in the Included Studies

Themes	**Studies which Contributed to the Themes**				
	Bimenyimana et al., 2009	Bowers, et al., 2006	Cutcliffe, 1999	Reid, et al., 1999b	Totman et al., 2011
1. The importance of support	✓	✓	✓	✓	✓
2. Informal support	✓	✓	✓	✓	✓
Peer support	✓	✓	✓	✓	✓
3. Formal support	✓	✓	✓	✓	✓
Debriefing		✓	✓		
Managerial support	✓	✓			✓
Staff support group				✓	✓
Supervision			✓	✓	✓

Theme 1: The importance of support

Overall, the studies lacked in their definition of support. Cutcliffe (1999) and Reid et al. (1999b) described support as an opportunity to discuss anxieties and feelings. Despite a lack of definition, participants in all of the included studies demonstrated that support is important following experiences of violence and aggression in mental health inpatient settings:

> "*participants expressed their feelings of isolation and dissatisfaction with the support"* (Bimenyimana et al., 2009, p. 7)

> "*support was, of course, received very positively by staff"* (Bowers et al., 2006, p. 230)

> *"I use all kinds of support that are available to me, and I need them all."* (Nurse, Cutcliffe, 1999, p. 111).

> *"I feel very supported and that's important"* (Psychologist, Reid et al, 1999, p. 312)

> *"*[Support] *was the most discussed issue… Support following violent incidents was seen as important by staff on every ward"* (Totman et al., 2011, p. 15).

The importance of support was demonstrated by participants' views on the emotional consequences of both utilising support, and of the lack of available support:

> *"These things* [a lack of support] *end up causing emotional stress to nursing staff and this leads to alcohol abuses and a high rate of absenteeism"* (Bimenyimana et al., 2009, p. 9)

> "[Support may lead to] *reducing the stress produced in nurses following a violent incident."* (Cutcliffe, 1999, p. 112)

> "[Support] *helps to ease some of the stress"* (Team leader, Reid et al., 1999, p. 311).

Support was described as important because it could affect how staff members interact with clients:

> *"*[Staff] *working in extremely demanding, frustrating, or boring jobs, became less trusting and sympathetic toward clients."* (Bimenyimana et al., p. 9)

> "*the relationship between the nurse's level of support and how this support enables them to go on dealing with violent incidents"* (Cutcliffe, 1999, p. 111)

> *"if the staff are not feeling contained and heard… then it's almost as though they then can't give that to the patients that they're caring for and the whole thing falls apart"* (Acute Clinical Psychologist, Totman et al., 2011, p. 15).

Different types of support were mentioned by participants, and will be discussed in the following themes.

Theme 2: Informal support

All five papers commented on informal support. Whilst they did not provide definitions of formal or informal support, there appeared to be consensus across the papers that informal support involved socialising with colleagues in the workplace or peers outside of work, and formal support involved organised meetings. Informal support included talking to friends or family, taking a break from work, or utilising stress-reducing activities such as exercise or listening to music. However the most commonly mentioned informal support was peer support in the workplace.

Peer support

All of the papers, except Bimenyimana et al. (2009), mentioned positive effects of peer support. Bimenyimana et al. (2009) commented that a lack of peer support could lead to absenteeism from work. The other four studies described peer support as talking to colleagues about difficult work situations, such as violence or aggression, but they did not explicitly describe what emotional support this provides. Reid et al. (1999b) and Totman et al. (2011) suggested that peer support provides a sense of shared responsibility. These supportive relationships with colleagues may positively affect staff stress and morale:

> *"we support each other on here, and that makes such a difference. Just being encouraged to talk through the incident really helps me."* (Cutcliffe, 1999, p. 111)

> *"other team members were most commonly mentioned as an important source of support at work"* (Reid et al, 1999b, p. 310)

> *"Effective team working and good relationships with colleagues were the most highly valued positive influences on morale. Staff on two 'high morale' wards… were especially positive about a sense of shared responsibility and their reliance on peer support"* (Totman et al., 2011, p. 14).

Theme 3: Formal support

Totman et al. (2011, p. 15) described formal support as *"vital for a successful team"*. There may be an *"explicit need for formal support systems"* (Cutcliffe, 1999, p. 113) to enable staff to work therapeutically with aggressive clients. A lack of structured guidelines can prevent implementation and maintenance of support systems.

> *"Formal frameworks were also seen as vital for the maintenance of regular supervision and team meetings, which otherwise tended to fall by the wayside"* (Totman et al., 2011, p. 16).

Formal support was referred to in various forms, as demonstrated by the following subthemes.

Debrief

Debrief was less commonly reported (two of the five studies). Debriefing was described as happening "*at different levels"* (Bowers et al., 2006, p. 230) with

colleagues or with a manager. Cutcliffe (1999, p. 111) stated that debrief could identify areas for improvement and learning, as well as provide emotional support. Some participants described debrief as helpful whereas others felt it could be unsupportive if there was fear of blame present.

> *"If you haven't debriefed, dealt with the last incident, then your unresolved issues will affect the way you deal with the next incident"* (Interviewee, Cutcliffe, 1999, p. 111)

> *"at these meetings difficult questions might be asked about why certain actions were or were not carried out, hence they could be uncomfortable."* (Bowers et al., 2006, p.230).

Managerial support

Views on managerial support were also mixed. Some participants stated that weak leadership could lead to *"ambiguity and uncertainty"* (Totman et al., 2011, p. 15) with management having little understanding of staff workloads, and rarely providing recognition or praise.

> *"I think the management fails to see that we need support"* (Participant, Bimenyimana et al., 2009, p. 7).

In response to violence and aggression, some staff felt that management were blaming rather than supportive of staff.

> *"management is not there to help but to emphasise the mistakes made by nurses"* (Bimenyimana et al., 2009, p. 7).

However, when management was perceived as present on the wards, with a strong, consistent and communicative approach, staff felt more supported.

> *"staff stressed the importance of strong and effective leadership"* (Totman et al., 2011, p. 15)

> *"*[Management] *used to come down afterwards and check if everyone was alright and that's important*" (Staff nurse, Totman et al., 2011, p. 15).

Staff support group

Two studies described mixed views on staff support groups. Reid et al. (1999b) described a staff support group as:

> "*a facilitated staff group… in which they* [staff] *had the opportunity to discuss patients"* (Reid et al., 1999b, p. 312).

Staff support groups were reported to be potentially ineffective, uncomfortable and unpopular for varying reasons such as uncertainty how to use the group, feeling unsafe to share, and a lack of time to attend.

> *"It's far too large. I don't feel safe talking in it."* (Occupational Therapist, Reid et al., 1999b, p. 312)

> *"Some find it helpful and a useful medium or forum and then others find it a complete waste of time."* (Team leader, Reid et al., 1999b, p. 312).

Some staff felt groups were an opportunity to address personal and professional difficulties, discuss clients and change practice.

> *"with the staff support group also highly valued on this ward"* (Totman et al., 2011, p. 15)

> *"The clinical support group, everybody really enjoyed that and found it helpful. That involves talking about difficult patients or anything clinical."* (Junior psychiatrist, Reid et al., 1999b, p. 313).

Supervision

Clinical supervision was reported to have multiple functions: to cope with work demands, to aid decision making, an opportunity to develop skills and educational aspects, time to reflect and discuss clinical difficulties, as well as express anxieties, and gain support and reassurance.

> *"It helps me to check things out, that I am doing things correctly, it helps me to release some of my frustrations. I think I learn as well from supervision, I get ideas. I get support"* (Team leader, Reid et al., 1999b, p. 312)

> *"supervision was said to help solidify roles and responsibilities and improve confidence"* (Totman et al., 2011, p. 15)

> *"*[Supervision] *was mentioned… as a way of coping with the demands and pressures of the work"* (Reid et al., 1999b, p. 311).

However, participants reported that supervision can be infrequent, and "*it may not be enough support"* (Nurse, Cutcliffe, 1999, p. 111).

> *"*[Supervision's] *frequency varied from once a fortnight to every 6 weeks"* (Reid et al., 1999b, p. 311)

> *"Clinical supervision is useful for dealing with incidents produced in response to the incident, although on its own, it is too infrequent."* (Interviewee, Cutcliffe, 1999, p. 111).

DISCUSSION

This review's findings highlighted inpatient mental health staff members' views on the support that they have received following violent and aggressive incidents. Support was viewed as important, affecting staff emotionally and professionally, with peer support receiving the most positive appraisals, whereas debriefing, support groups and supervision received mixed opinions.

Inpatient wards have been described as demanding in both quantitative and qualitative literature, with staff managing high workloads, lack of staffing, and experiences of violence and aggression, all contributing to staff stress (Jenkins & Elliot,

2004; Johansson, Skarsater, & Danielson, 2012). In order to cope with these stressors, it is understandable that support would be viewed as important to staff members, as demonstrated in this review. The participants in this review stated that support could positively affect them emotionally. Previous research supports this; if staff perceive support as available and effective, it can mitigate the psychological impact of violence and aggression (Paterson et al., 1999). A perceived lack of support or ineffective support can negatively affect staff-client relationships and potentially increase further violence (Irwin, 2006).

Although general coping mechanisms such as socialising or exercise were included as informal sources of support, peer support from colleagues was most commonly referred to. The importance of peer support has been similarly reported in quantitative studies. Arnetz and Arnetz (2001) found staff sought support most commonly from co-workers (49%), from other people outside the workplace which may include counselling services (18%) and less often from supervisors (14%). Whittington and Wykes (1992) found that most support in inpatient units is provided informally, such as from work colleagues or family members or friends outside of work.

Formal support mechanisms received mixed responses in this review. Similarly, research is inconsistent concerning the value of debriefing, which may be useful in identifying antecedents to violent incidents (Rippon, 2000) and learning from incidents (NICE, 2005). However, a systematic review exploring single-session debrief concluded that studies researching debrief are often methodologically flawed, but

despite this lack of evidence for its efficacy in preventing psychological trauma, debrief is commonly used (Rose, Bisson, & Wessely, 2003). Another systematic review concluded that although emotional trauma may not be prevented by debriefing, participants felt debrief was useful nonetheless (Arendt & Elklit, 2001). This varying support for debrief was reflected in this review as demonstrated by the participants' mixed views on the value of debrief.

Staff support groups have generated mixed reactions (Reid, et al., 1999b; NIHR, 2011). Thomas (2001) reported that staff support groups may reduce stress and absenteeism. Robertson and Davison (1997) concluded from a quantitative survey that staff support groups can be sometimes met with anxiety and confusion about their purpose, which may correspond with the mixed opinions about staff groups demonstrated in this review. An unclear purpose and anxiety about staff groups may prevent their establishment in routine practice (Montgomery, 2002). An NHS systematic review suggested research is required to explore the efficacy of support groups due to previous research being underpowered (NCCSDO, 2004). Perhaps this lack of research provides insight as to why there is a variation in the implementation of staff support groups (NIHR, 2011), and why it was not commonly mentioned across the included studies.

Clinical supervision can promote reflection (Cleary & Freeman, 2005), encourage skill development, and provide peer support for nurses in acute mental health settings (Bishop, 1998; Brunero & Stein-Parbury, 2008). However its implementation is often thwarted by unpredictable workloads, time pressures and changing rosters (Bishop,

1998; Cleary & Freeman, 2005). The studies included in this review described multiple functions and frequencies of supervision, which is perhaps related to the lack of structure regarding clinical supervision's use (NIHR, 2011). A lack of structure can confuse the function of clinical supervision, and contribute to variations in supervision as part of routine practice (Cleary & Freeman, 2005).

The reported varying uses and frequency of supervision and informal or formal debrief is perhaps a reflection of inconsistent policies which have been noted across the UK (Noak, et al., 2002), as it could be suggested that staff members are not receiving similar experiences of support. This corresponds with the continued debate on what types of support is beneficial to staff who are exposed to violence (Nolan et al., 2001; Paterson, Leadbetter, & Miller, 2005). Although this review demonstrated the importance of support, the value of peer support and mixed reviews of formal support, it did not clarify whether this support was sufficient, and if not, what alternatives would be preferable. Further investigation is required concerning what support would be considered useful for mental health staff following violent and aggressive incidents (Nolan et al., 2001).

Strengths and Limitations

Despite disagreements surrounding systematic reviews of qualitative literature, following thematic synthesis guidelines allowed this review to be carried out in a rigorous manner: explicitly reporting the methods used, using comprehensive search strategies, excluding non-relevant studies, and appraising the quality of studies before inclusion in the synthesis (Thomas & Harden, 2008). Systematic reviews are

increasingly utilising thematic synthesis (Harden, et al., 2004; Harden, Brunton, Fletcher, & Oakley, 2009; Morton, Tong, Howard, Snelling, & Webster, 2010; Fletcher et al., 2012) furthering evidence that systematic reviews of qualitative literature can be a valuable contribution to policies and practice (Hannes, 2011). This review could attain quality assessment criteria of a clearly focussed question, choosing appropriate studies to answer the review question, quality assessing the included studies and clearly displaying the results and synthesis (CASP, 2013b).

The included studies did not specifically ask participants about the support they received following aggressive incidents. Bowers et al. (2006) included experiences of various SUIs, and it could not be determined which findings related to violence and aggression specifically. Bimenyimana et al. (2009) asked violence related questions, but did not focus on support, although participants commented on it. Cutcliffe (1999) investigated morale on inpatient units, which although may be affected by aggression and support, it was not a specific focus. Some of the studies only interviewed nurses, which is not representative of all inpatient staff, as different roles may provide different experiences. For example, psychiatrists may receive less support than nurses (Nolan et al, 2001). Reid et al. (1999b) included community staff, as well as inpatient, but their results were explicitly presented. Therefore the reviewer (EF) could determine whether the excerpts were from ward or community staff. All five studies contributed to understanding aspects of support within this setting, and therefore can provide some insight into the review question.

CONCLUSION

This review aggregated the findings of qualitative research on mental health inpatient staff experiences of support following violent and aggressive incidents. The participants in the reviewed studies demonstrated the importance of support. Although peer support was the most commonly mentioned informal support mechanism, it should not be assumed that it alone is sufficient. Formal support received mixed views from the participants, which continues the debate as to what types of support staff would find beneficial. Therefore future research should explore what support acute inpatient mental health staff would prefer to receive following experiences of violence and aggression.

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A QUALITATIVE STUDY EXPLORING THE SUPPORT EXPERIENCED BY STAFF MEMBERS FOLLOWING CLIENT RELATED VIOLENCE IN INPATIENT MENTAL HEALTH UNITS[2]

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ABSTRACT

Aim

To explore mental health inpatient staff members' experiences of the support they have received following client related aggressive incidents.

Background

Mental health inpatient staff members are exposed to verbal and physical violence and aggression from their clients. It is important to understand how staff make sense of their experiences, the support they receive and what support they would prefer following future aggressive incidents.

Design

A single-cohort study employing qualitative, in-depth interviews. Qualitative thematic analysis was conducted within a social constructionist perspective.

Methods

A qualitative study using semi-structured interviews conducted in 2013 in the North West of England. Fourteen mental health inpatient unit staff were recruited using purposive sampling.

Findings

Thematic analysis identified five overarching themes: opportunities for reflection, making sense, staff self-esteem, feeling valued, and avoidant coping strategies. A thematic map was

created to demonstrate the relationships between these themes, and their relevant subthemes.

Conclusion: Inpatient mental health staff requested opportunities to reflect as a source of support after incidents of violence and aggression, and for management to acknowledge these difficult experiences. Participants suggested that their professional self-esteem and interaction with clients could be positively affected if they were given an opportunity to reflect after violent and aggressive incidents. Staff self-esteem was further influenced by feeling valued by management and other teams. If opportunities for reflection and managerial support are not provided there may be an increased risk that staff will rely on avoidant coping strategies. Further research could explore the relationships between the concepts of support described in this study.

SUMMARY STATEMENT

Why is this research or review needed?

- Mental health staff are likely to experience violence and aggression
- Mental health staff may feel unsupported following violent and aggressive incidents which can impact upon their own mental health
- Previous research has recommended asking staff about their experiences of support and what support they would prefer

What are the key findings?

- This study proposes an understanding of how aspects of support interrelate
- Opportunities for reflection was the most frequently mentioned type of support in helping staff to cope with violent and aggressive incidents, and consequently influencing client care
- Management and the healthcare organisation play a vital role in acknowledging staff experiences and enabling access to support

How should the findings be used to influence policy/practice/research/education?

- The findings in this paper suggest how staff can be supported in coping with experiences of violence and aggression
- Further research can explore the concept of reflection, its relationship with staff wellbeing, and any subsequent effect on client care
- Healthcare organisations are recommended to explore how to implement opportunities for reflection in order to help their staff to feel supported

Keywords: Acknowledgement, aggression, avoidant coping, nurses, inpatient, mental health, qualitative, reflection, support

INTRODUCTION

Aggression from clients can be experienced by mental health staff, particularly in acute inpatient settings (Healthcare Commission, 2008). The study aimed to explore acute inpatient mental health staff's experiences of support following aggressive incidents, what has/has not been helpful about the support provided, and what staff support would prefer to receive in future.

Background

In 1999 a 'zero tolerance' campaign aimed to support NHS healthcare staff to come to work without fear of violence (Department of Health, 1999), however, staff continue to be at risk of verbal and physical aggression from clients (Rippon, 2000; Anderson & West, 2011). These experiences can affect the mental health of staff members (Cutcliffe, 1999), detrimentally affecting psychological wellbeing similarly to a physical assault in any other context (Anderson & West, 2011). A quantitative staff survey demonstrated that threats of violence (Arnetz & Arnetz, 2001), or 'minor' physical assaults can have lasting psychological effects (Rippon, 2000). Staff reactions can be complex, engendering emotions such as guilt, anger (Reid, 2008), post-traumatic and/or depressive symptoms, which can endure for months after the event (Paterson, Leadbetter, & Bowie, 1999; Arnetz & Arnetz, 2001). Poor staff mental health may subsequently impair therapeutic alliances and client care (Arnetz & Arnetz, 2001; Pich,

Hazelton, Sundin, & Kable, 2011; Totman, Hundt, Wearn, Paul, & Johnson, 2011). A quantitative study which assessed post-traumatic symptoms in staff stated that assaulted staff could experience post-traumatic symptoms (Richter & Berger, 2006), and although these authors did not explore support, they concluded that support could alleviate these symptoms nonetheless.

Support may be termed 'formal', which includes debriefing, managerial support, and clinical supervision, or 'informal' for instance, talking with colleagues (Cutcliffe, 1999). Debriefing is a common support mechanism, although research into its effectiveness appears flawed due to small sample sizes and varying debriefing methods (Regel, 2007). Arnetz and Arnetz (2001) found staff most commonly sought support from co-workers and least frequently from supervisors. However, they reported the types of support staff currently utilised, not whether it was beneficial or what staff would prefer to receive. Totman et al. (2011) reported that all support is useful; however this study did not explore support following aggressive incidents specifically.

National healthcare policy recommends 'appropriate support' following aggressive incidents (NHS, 2011a); however there is little guidance as to what 'appropriate support' means. UK policies regarding violence and aggression lack clear guidance, generating inconsistent approaches to support (Noak, et al., 2002). A lack of clear policies and uncertainty regarding what support to provide could relate to a lack of post-incident analysis (Irwin, 2006) and/or staff feeling unsupported by management (Cutcliffe, 1999; Rippon, 2000; Pich et al., 2011). Nurses and psychiatrists indicated in quantitative surveys that they received a lack of support following aggressive

incidents; although most reported support would have been beneficial (Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001). A lack of support can affect staff psychological wellbeing and potentially, therapeutic relationships with clients (Rippon, 2000; Irwin, 2006).

Despite uncertainty concerning how to support staff, there is a consensus that support is important (Paterson, Leadbetter, & Miller, 2005). Exploratory research, such as the present study, can potentially increase clarity for healthcare organisations and policies regarding staff support (Rippon, 2000; Nolan et al., 2001; Richter & Berger, 2006). Quantitative research, which demonstrated a lack of support for staff (Whittington & Wykes, 1992), stated that staff should be asked what previous support has been helpful and what support they prefer. Nolan et al. (2001) repeated there is a need to explicitly ask staff about the support they receive following aggressive incidents; however, this question remained unanswered. Reid et al. (1999a) recommend qualitative methodology to allow staff to give complex descriptions of their work, experiences and opinions. This study aims to allow staff to speak openly about their experiences, their views on support, and what support is preferable.

THE STUDY

Aim

The aim of the study was to explore mental health inpatient staff experiences of violence and aggression. The study's focus was on the support staff found beneficial following incidents, and what support staff would prefer.

Design

This single-cohort study employed thematic analysis within a social constructionist approach to explore participants' subjective understanding of their experiences and enable a rich description of the data (Braun & Clarke, 2006). Social constructionism implies that the participants' and researcher's social and historical contexts influences their understanding, or 'constructions' (Cresswell, 2003; Harper, 2012). Generating themes across data can demonstrate collective constructions (Guba & Lincoln, 1994; Schwandt, 1994). It is the researcher's responsibility to explore the data, and describe the complexity of participants' multiple and potentially differing views (Cresswell, 2003). This fits with the process of exploring similarities and differences across data and generating themes using thematic analysis (Braun & Clarke, 2006).

Participants

The study was conducted across three NHS adult acute mental health inpatient wards (one male, one female, and one mixed ward) in the North West region of England. When proposing the study to hospital management, they reported frequent aggressive incidents, which is consistent with national audit findings that inpatient wards report high frequencies and severity of violence and aggression (Healthcare Commission, 2008). This audit reported that 72% of inpatient staff have been threatened or made to feel unsafe in their workplace, with 46% experiencing personal physical assaults. Due to the aforementioned, inpatient settings were chosen for this study due to the likelihood that staff may have experienced aggression from clients, and potentially experienced subsequent support.

The study employed purposive sampling. Inviting participants from an information-rich population of interest limits queries as to why some participants were selected and not others, therefore increasing credibility (Patton, 2002). Inclusion criteria were: any acute inpatient mental health staff members who have directly experienced or witnessed aggression at work. Staff members with direct involvement in client care, such as nurses, nursing assistants and psychiatrists, are likely to experience aggression (Chambers, 1998). The researcher provided information sheets whilst present on the wards and in staff meetings. Prospective participants were given opportunity to consider the information before completing a consent form (NHS, 2011b).

Guest, Bunce and Johnson (2006) suggest data saturation can be reached in twelve interviews when utilising purposive sampling. Further recruitment may account for data variation, for example a mixture of information-rich data or short interviews where data demonstrates a lack of depth. This study therefore aimed to recruit ten to fifteen participants.

Data collection

Data were collected between September and December 2013 using face-to-face semi-structured interviews at the participants' workplace. Interviews were audio recorded digitally. Before each interview, participants were reminded of the rights to consent and withdrawal. Demographic questions were asked, such as age and years of experience in mental health, to increase trust and relax the participant (Jacob & Furgerson, 2012). Following an interview guide allowed comparisons to be made across participant responses (Bernard & Ryan, 2010), although the sequencing of

questions were adapted according to participant responses (Wilkinson, Joffe, & Yardley, 2004). Interview questions explored past experiences which can focus participants on particular events, creating clearer accounts (Reid et al., 1999b). Interview questions aimed to answer queries concerning how to improve support (Totman et al., 2011) and what support staff want (Whittington & Wykes, 1992; Nolan et al., 2001). Interview questions were discussed with supervisors (JM and RW) and feedback was requested from the first interviewee, but no overlooked aspects were identified. Participants were asked to add anything significant that had not been discussed (Jacob & Furgerson, 2012).

Ethical considerations

A research proposal was submitted and approved by the Department of Clinical Psychology Research Committee, the relevant University research ethics committee and the local NHS Research and Development department in July 2013. Ethical considerations such as informed consent, right to withdraw without consequence, and confidentiality were upheld. At the end of each interview, participants were informed of the availability of a staff support service.

Data analysis

Interview recordings were stored separately and securely from consent forms to protect confidentiality. Pseudonyms, such as ‘Nursing Assistant 1’, were assigned to interview recordings and transcripts. University approved transcribers transcribed the interviews verbatim. The researcher (EF) checked transcripts for accuracy whilst

listening to the recordings which allowed data familiarisation, and noting of potential codes.

An inductive thematic analysis was conducted using qualitative data analysis software QSR NVivo 10 (2012), allowing themes to be strongly linked to data. Sixty-two initial descriptive codes were generated at a semantic level. Descriptive codes were clustered based on commonalities to create overarching salient themes and subthemes (Attride-Stirling, 2001; Braun & Clarke, 2006) (Table 1). Themes attempted to summarise data observed across participants (Attride-Stirling, 2001; Braun & Clarke, 2006). Themes were reviewed and refined by searching for similarities and differences across codes and themes (Braun & Clarke, 2006).

Table 1: An example of generating codes and themes from a data excerpt

Quote	**Initial descriptive codes**	**Themes**
"someone who is acutely unwell, as a lot of our patients are, that [being restrained] *must be horrendous"* Deputy Ward Manager 1, line 20	Control and Restraint Restrictive Practice Effect on clients	Theme: Making sense Subtheme: Restrictive Practice

Validity, reliability and rigour

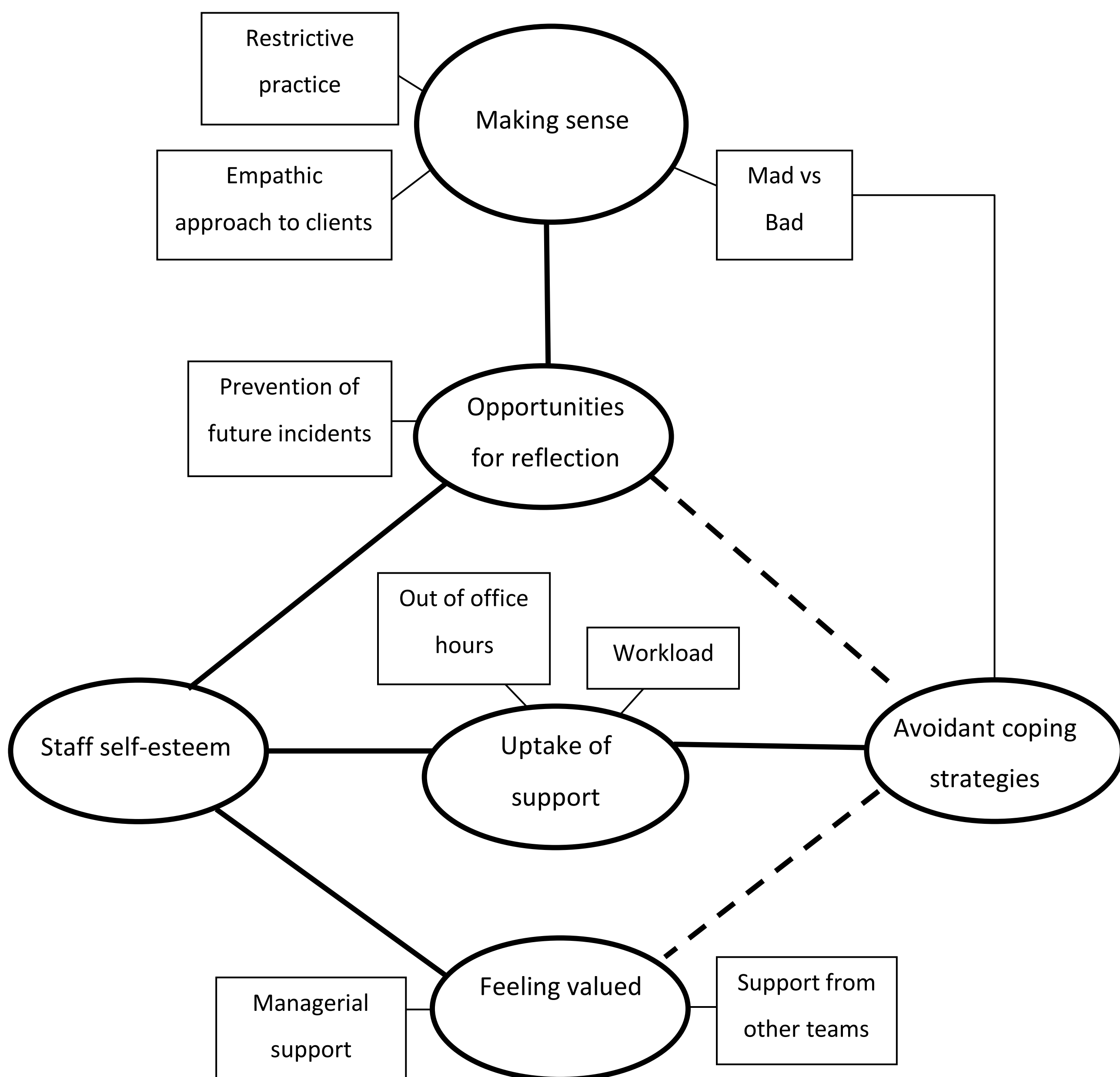
Following structured methods, such as thematic analysis, increases rigour (Fereday & Muir-Cochrane, 2006). Thematic analysis requires an explicit process of analysis (Braun & Clarke, 2006). This was achieved by providing data excerpts to support the findings, thus strengthening validity and credibility (Fereday & Muir-Cochrane, 2006). Researchers often bring their own preconceptions about the subject matter (Cresswell, 2003). Rigour was increased by noting ideas about the data throughout analysis, and considering alternative interpretations (Vaismoradi, Turunen, & Bondas, 2013). Inter-rater agreement improves reliability (Vaismoradi et al., 2013), as such the researcher EF shared all of the initial codes with MS and reviewed whether they captured the data excerpts. EF shared a draft thematic map with JM and questioned whether an 'empathic approach to clients' and 'prevention of future incidents' could be amalgamated into one theme. However it was agreed that these felt separate. MS questioned the links between map elements and it was agreed that 'mad/bad' related to 'avoidant coping' and 'lack of opportunities to reflect', and that 'feeling unvalued' could affect staff self-esteem.

FINDINGS

Of the fourteen participants there were: five registered mental nurses (RMNs), four nursing assistants (NAs), two deputy ward managers, one ward manager, one occupational therapist (OT) and one senior hospital manager. Participants were mixed in gender (male N=5, female N= 9), age (between 23 and 63years old) and years of experience (between 3 and 32years).

Six overarching themes (represented by oval boxes on the thematic map) with associated subthemes (rectangular boxes), became apparent (Figure 1). Solid lines represent the relationships between these themes, such as when reflection is present it can lead to making sense. Dashed lines represent when these aspects are diminished, or absent, for example avoidant coping may be more prevalent if there are reduced opportunities for reflection.

Figure 1: Thematic map



The themes, subthemes and their relationships will now be discussed with supporting data excerpts.

THEME 1: Opportunities for reflection

Thirteen participants across all three wards stated that an opportunity to reflect had been their most helpful experience of support and the most preferred source of support in future, however, only the female ward engaged in formal reflection groups.

> *"we reflect on what happened as a team"* (Deputy Ward Manager 2, line 75)

> *"you reflect as well on yourself, could I have acted differently"* (Ward Manager, line 47).

> *"a reflective practice meeting for staff would be really useful"* (OT, line 265)

> *"sitting down with everyone and saying, what didn't you like about that, what didn't work, and then moving forwards from it… that would probably be quite supportive for staff"* (Deputy Ward Manager 1, line 207)

> *"people find it* [reflective group] *really helpful and like to go as often as possible"* (Deputy Ward Manager 2, line 108).

Prevention of future incidents

Six participants stated that these opportunities to reflect could inform prevention of future incidents.

> "*we could talk about where a patient's coming from, and how best to support them through this time, and then obviously how that's going to avoid them getting angry"* (Deputy Ward Manager 1, line 240)

> *"talk about what happens, what do we think it, it was that led to that escalating… then what could we do to prevent that"* (Deputy Ward Manager 1, line 182)

> *"we reflect… about how it happened, and how it felt, and if there was ways we could maybe do things differently next time"* (Deputy Ward Manager 2, line 75)

> *"*[Reflecting on an incident] *would just make you look at it in a different way and then if you could see a pattern coming the next time… it might give you a bit of an idea of what to do so that it doesn't escalate"* (NA 1, line 178).

THEME 2: Making sense

All participants stated that reflection (see Theme 1) could inform how they made sense of:

> *"why they've* [clients] *lost their temper"* (NA 4, line 20)

> *"why they might behave in this way"* (Deputy Ward Manager 2, line 226).

Participants stated that this sense-making could inform their understanding of a client's perspective, for instance how restrictive practice affects clients, how understanding a client's perspective affects staff approach to clients (see the following subthemes) and the aforementioned prevention of future aggression. It could be suggested that this informed understanding of aggression could increase staff self-esteem (Theme 3). This will be further explored in the discussion.

Restrictive practice

Twelve participants made sense of how ward regulations, enforced medication (and potential use of control and restraint), the ward environment (limited space, locked doors, lack of activity), and other restrictions of inpatient wards could affect clients, and increase aggression:

> *"someone's frustrated because of the system"* (RMN 2, line 78)

> *"not being able to leave the ward, or maybe they are not wanting to take the medication"* (NA 4, line 23)

> *"give people an activity… if people are bored, that's going to increase the levels of violence"* (Senior Manager, line 323)

> *"you do try and talk people into it, but if they refuse… you have to enforce it and put hands on, and that's caused… assaults and injuries"* (Senior Manager, line 57).

Empathic approach to clients

Five participants demonstrated that making sense of aggression could increase empathy with a client's perspective, and influence their interaction with clients. These respondents also stated that this empathic approach could inform the aforementioned prevention of future incidents.

> *"they become frustrated and they start swearing but… it's just a normal reaction so I would do the same too"* (RMN 2, line 81)

> *"If somebody spoke down to me, or… disrespected me, I'd probably act in the same way. I'd probably feel angry… probably become violent as well… this is how people, how anybody, reacts in social situations"* (Senior Manager, line 78)

> "[Being] *more person-centred… trying to make these wards… accommodating to service users' needs, so less like prison…* [with] *stupid rules really that didn't need to be there, but that would cause violence and aggression"* (Deputy Ward Manager 1, line 253).

> *"they'll* [clients] *talk about their experiences as an inpatient, to try and get staff to see it from a different perspective… that's really helped… change staff attitudes towards service users"* (Deputy Ward Manager 2, line 223).

Bad vs Mad

If opportunities for reflection are not provided as a source of support, staff may be unable to make sense of a client's perspective regarding aggressive incidents. It could be suggested that staff may subsequently rely on reductionist explanations of aggression, such as diagnosis, substance misuse or personal dislike. Thirteen participants made reflections such as these.

"*due to symptoms of their illness they become quite aggressive"* (Deputy Ward Manager 2, line 4)

"[Aggression is] *usually directed by, from patients who have either taken drugs or alcohol"* (RMN 1, line 3)

"he just thumped me cause he didn't like me" (RMN 3, line 12)

"she just did it out of sheer nastiness" (Ward Manager, line 34).

As aforementioned, an informed understanding of a client's perspective may lead to suggestions regarding how to prevent future incidents, whereas a lack of sense-making may result in staff feeling a sense of hopelessness, or lack of influence over aggression, as though there is *"nothing you can do about it"* (NA 2, line 68). This may increase the utilisation of avoidant coping strategies (discussed in Theme 6).

<u>THEME 3: Staff self-esteem</u>

Ten participants stated that support (opportunities to reflect, and the support from other teams and managerial support described in Theme 4) could positively affect staff self-esteem.

"[Opportunities to reflect are] *good for staff's self-esteem and motivation… and maybe some agreement as to how we can support each other"* (OT, line 290)

> *"get together afterwards and sit down and say… this is what we did well and this is what we didn't do so well"* (Deputy Ward Manager 1, line 96)

> *"*[After a reflective practice group] *you'd come on the ward and… you'd be ready and raring to go again"* (NA 3, line 125)

> *"*[After reflecting on incidents] *the team would… feel more cohesive and more supportive with each other"* (OT, line 272).

<u>THEME 4: Feeling valued</u>

Seven participants stated that if support (opportunities to reflect, and the following subthemes of support from other teams and managerial support) was implemented; they would feel valued by others, which could also impact upon staff self-esteem (Theme 3).

> "[If staff had opportunities to reflect, it could feel as though] *we're being taken care of, as a group of people"* (OT, line 257)

> *"I deserve a pat on the back, nobody gets that"* (Deputy Ward Manager 1, line 85)

> *"it'd be nice to be told now and again that you were doing your job properly"* (NA 2, line 213).

Support from other teams

All participants had received training in conflict management, breakaway and physical restraint techniques from a Management of Violence and Aggression (MVA) team, and recently the wards appointed a police liaison officer to advise on assaults and potential prosecution. Eleven participants commented on the support they received from the MVA team and police liaison, as well as the support from staff on other wards, engendering increased self-esteem and feelings of being valued:

> *"*[Police liaison] *support the staff, so I think that's increased morale"* (Senior Manager, line 306)

> *"*[Police liaison is] *a good resource, and it's a positive move… support towards staff"* (NA 4, line 109)

> *"*[We] *let the other wards know if we're struggling"* (RMN 4, line 51)

> *"staff then came from the other wards to support"* (OT, line 67)

> *"what I am trying to encourage staff to do…the nurse in charge or the other nurse on another ward, will come over and say "I appreciate this has happened, is everybody ok? Does anybody just want to have a cup of tea and come into a room and talk about it?""* (Senior Manager, line 188)

> *"*[The MVA team] *will call and ask about what happened and offer support"* (Deputy Ward Manager 2, line 82).

Managerial support

Eleven participants requested more managerial support following incidents:

> *"the offer…a manager talking to you about it"* (RMN 1, line 267)

> *"the managers… if they'd... come up with support a bit more"* (RMN 4, line 85)

> *"she* [manager] *would… offer support and make sure you were ok"* (OT, line 167).

Participants suggested that managers could acknowledge experiences of violence and aggression by talking to staff and asking *"if there's anything they can do to offer additional support"* (Deputy Ward Manager 2, line 138). Without acknowledgment and managerial support, staff may feel unvalued by management which may impact upon self-esteem.

> *"you do go home and you think "nobody gives a damn"… you feel undervalued"* (NA 1, line 187)

> *"*[Support] *would increase morale… it would make people feel more valued"* (Senior Manager, line 301).

<u>THEME 5: Uptake of support</u>

Ten participants gave mixed views on their past experiences of support:

> "*there should be more support*" (NA 4, line 115)

"I don't think anybody will come to me and say… "are you alright?"" (Ward Manager, line 142)

"you feel there's no support" (NA 1, line 221)

"There is a lot of stuff in place, like supervision, and people you can talk to" (RMN 5, line 63)

"we did get quite a lot of support off the management" (NA 2, line 98).

The remaining four participants reported wholly positively about support (three of whom had the fewest years of experience in mental health out of the overall sample; between two and five years). Participants described that even when support was available to them they felt impeded from accessing it due to the following barriers.

Workload

Six participants stated that workload pressures could impede their utilisation of available support and opportunities to reflect.

"the wards are so busy sometimes… it's quite easy to leave it like that and not revisit it" (Deputy Ward Manager 2, line 143)

"[Support mechanisms] *are already invented, it's just having the capacity to implement them"* (Ward Manager, line 269)

> *"because the wards are so busy, it doesn't tend to happen"* (Senior Manager, line 214)

> *"you can talk to someone about it, but sometimes there's not the opportunity"* (NA 1, line 104).

Out of office hours

Six participants described the unavailability of support due to unsociable working hours, such as at night or the weekend:

> *"things happen in the night… you don't get any support"* (RMN 4, line 103)

> *"it's hard at weekends, it's hard at night, because that person* [someone offering support] *isn't really there"* (Senior Manager, line 310)

> *"a lot of incidents that occur at weekends… there is not people around to help… maybe if that support could be more flexible"* (Deputy Ward Manager 2, line 91).

THEME 6: Avoidant coping strategies

All fourteen participants described avoidant coping strategies, such as a lack of acknowledgment of their emotions following aggressive incidents and the potential effect of these experiences:

> *"it would affect most people, but… it just goes over my head"* (RMN 1, line 126)

"it didn't affect me one bit… I just leave the shift and forget about it." (RMN 5, line 60)

"I've kind of got used to it and you become a little bit desensitised to it" (Deputy Ward Manager 2, line 42)

"we probably do all suppress the emotions that we feel because of the assault to deal with them to come back into work the next day" (Ward Manager, line 290)

"if you're hurt… you just get on with it… you just brush it under the carpet" (NA 1, line 97)

"you still have to go on… and we tend not to talk about it" (RMN 2, line 38).

The dashed lines on the thematic map suggest that when opportunities to reflect are less available, staff may be more likely to use avoidant coping strategies, feel unvalued and be less able to make sense of the violent and aggressive incident. Avoidant coping may further prevent the uptake of support as staff may feel that they work in *"a culture where it's been accepted"* (RMN 1, line 205), and it is accepted that staff *"don't really talk about it"* (RMN 3, line 131), *"you just keep the lid on"* (Ward Manager, line 329).

DISCUSSION

This study explored staff experiences of support following violent and aggressive incidents. In addition to supporting staff self-esteem and emotional needs, opportunities to reflect and make sense of a client's perspective, could potentially inform staff's approach to clients and management of future aggression. Staff described being impeded from accessing available support due to workload pressures and shift patterns. Participants suggested managers could acknowledge staff experiences of aggression to help them to feel supported and valued. A lack of support, such as opportunities for reflection, or feeling devalued may lead to avoidant coping strategies.

Opportunities for reflection

Although evidence for reflective practice appears to be largely theoretical, it is popular in healthcare professions (Mann, Gordon, & MacLeod, 2009). Opportunities for reflection were not only the most commonly mentioned source of support which participants found useful, but also the support staff would most prefer in future. Reflection entails making sense of an experience by examining personal thoughts and actions (Somerville & Keeling, 2004). As demonstrated in the findings, opportunities for reflection can increase a sense of feeling supported and valued (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005).

Research supports this study's findings that reflection and making sense can inform staff understanding of a client's perspective (Hahn, Needham, Abderhalden, Duxbury,

& Halfens, 2006). Making sense and developing a shared understanding of a client's perspective can be reached through the use of psychological team formulation (Johnstone & Dallos, 2013). Formulation in teams can be useful to understand complex clients, how transference and countertransference may play out within the team, and inform person-centred care and intervention (BPS, 2007). A role of inpatient psychology could be to encourage reflection and sense making through team formulation, which can increase psychological thinking about the client (BPS, 2007) and increase staff confidence in their approach to clients they find challenging (Cole, 2013), which could include understanding violence and aggression from a client's perspective.

Understanding a client's perspective may subsequently influence staff approach to clients and inform future prevention of aggression by engaging with the client (Bowen et al., 2011), working collaboratively (Duxbury, 2002), formulating (Paterson et al., 2005), and informing future practice (Coakley & Scoble, 2003). These potential outcomes of formulation and reflection fit with aims to improve staff understanding of causes of aggression (NHS, 2005). This study suggested that an approach informed by reflection could increase staff self-esteem. Quantitative surveys of staff confidence demonstrated that team morale, knowledge of the client, and an informed interpersonal approach could increase staff confidence (Martin & Daffern, 2006).

Similarly to the findings in this study, quantitatively measuring stress in nursing staff demonstrated that a lack of reflection may lead to staff feeling devalued and unsupported, affecting their capacity to provide therapeutic approaches (Jenkins &

Elliot, 2004). A lack of reflection may also lead to attributing blame to the client following aggressive incidents (Duxbury, 2002; Hahn et al., 2006), as observed by participants attributing blame to diagnosis, substance use or personality, with a lack of reflection on the client's perspective. Placing blame within the client may be reassuring for staff as they can relinquish responsibility (Hahn et al., 2006), but this may also diminish their sense of influence over the management of violence and aggression. This perceived lack of control can increase avoidant coping strategies (Ben-Zur & Michael, 2007).

Avoidant coping strategies

This relationship between a lack of reflection and avoidant coping appears likely as avoidance involves distancing or shielding oneself from difficult thoughts and feelings (Fearon & Nicol, 2011), rather than active reflection on them. A quantitative study which measured burnout in psychiatric inpatient staff (Corrigan et al., 1994) stated that avoiding emotions may be temporarily protective if there is a lack of support for staff, which Paterson et al. (1999) concurred with. However, staff who engage in avoidance may experience reduced feelings of accomplishment (Jenkins & Elliot, 2004), which may support the relationship between avoidant coping strategies, reduced self-esteem and sense of devalue observed in this study.

A passive and avoidant response to violence and aggression can be mitigated by supportive strategies (Paterson et al., 1999). Reflection, which was the most commonly mentioned source of support, can be provided through clinical supervision (Cleary & Freeman, 2005), staff meetings, debriefing, external resources such as

counselling, and management ‘checking in’ with staff (Clements et al., 2005), which also corresponds with the participants’ requests to feel acknowledged by management.

Acknowledgment

Acknowledgement from managers has been noted as deficient in inpatient settings, as has a lack of praise (Currid, 2008). Healthcare staff in brain injury units have also requested managerial acknowledgment following aggressive incidents (Badger & Mullan, 2004). Providing supportive praise, and acknowledging staff experiences of aggression can increase staff self-esteem (Chambers, 1998), as described by participants in this study who stated they would feel more supported, confident and valued if their experiences were acknowledged by management.

Participants described how other teams supported them by checking on their welfare. Small acts of support, such as this, can enable staff to feel cared for and valued (Totman et al., 2011). This acknowledgement and support from other teams may be related to the importance of peer support in this setting (Reid, et al., 1999b; Richter & Berger, 2006).

Clinical implications

All fourteen participants stated that support is important following violent and aggressive incidents. Support in general, not solely following incidents, may prevent the psychological impact of aggression (Paterson et al., 2005) and increase staff wellbeing and capacity to cope with the stressful demands of their work (Greenwood,

Rooney, & Ardino, 2012). Support has also been shown to foster good standards of care in cross sectional surveys (Holden, et al., 2011) and meet the physical, psychological and emotional needs of clients (Bowen et al., 2011).

Organisational factors, such as workload pressures and shift patterns described by participants in this study, can impede opportunities to reflect, leading to poor and varying use (Mantzoukas & Jasper, 2004). Management can address these barriers and foster supportive environments by providing policies, post-incident reviews and clear leadership (Paterson et al., 1999). It is important to note that every individual may respond to aggression differently (Clements et al., 2005) therefore, flexible policies and guidelines must meet individual differences and address barriers to support. Staff members can shape policies and decision making by asserting their needs (Currid, 2008) for opportunities for reflection and flexible support, which may prevent the use of avoidant coping strategies and positively affect staff wellbeing and client care.

Strengths and Limitations

This study aimed to increase understanding of staff support following aggression in acute inpatient settings. Although this study included a small qualitative sample from one geographical area, it increased its breadth by encompassing different professionals and levels of seniority.

Some individuals within this study may not have shared all of their views and experiences with the researcher due to the sensitivity of the topic. Research in

violence and aggression can involve distress and socially unacceptable emotions (Rippon, 2000), such as feeling angry with clients, or with the employees' organisation. Participants therefore may have felt anxious about sharing their experiences and omitted certain aspects. However, participants did in fact share difficult opinions and emotions. The researcher has a professional inpatient mental health background which may have encouraged the participants to feel that the researcher shared their views, but was also an outside party and confidentiality was explicit. The themes found in the study were also supported by previous literature as seen in the discussion, thus increasing credibility.

CONCLUSION

This study has furthered existing understanding by capturing the complexity of practitioners' responses and suggesting how concepts of support may interact. In acute inpatient mental health settings, opportunities for reflection can be supportive and may increase staff wellbeing, self-esteem and sense of value, which impacts upon client care. Potential areas for furthering this research could be to explore the relationships described in this study: whether opportunities to reflect increases empathy with clients, aids prevention of future incidents, and/or increases feelings of being valued and self-esteem, and if further supporting evidence is found, how to implement these suggestions.

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