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C-TRU Complex Trauma and Resilience Research Unit

Staff Trauma in Inpatient MEntal health

NHS Greater Manchester Mental Health NHS Foundation Trust

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Time to talk about staff trauma on inpatient mental health wards

Report and recommendations for mental health organisations, ward managers, and ward staff from the Staff TIME Study

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Who is this report for?

This report is based on the perspectives of staff working on mental health wards, managers, and other leaders within healthcare.

The recommendations are organised in relation to different stakeholders.

Staff wellbeing is everybody's responsibility. However, it is especially important that senior leaders, including chief executives, Directors of Nursing and Quality, Human Resources (HR), People Directors, Organisational Development and other leaders responsible for workforce wellbeing take forward these recommendations, ensuring a structured approach to improving staff wellbeing and organisational resilience in order to bring about significant change.

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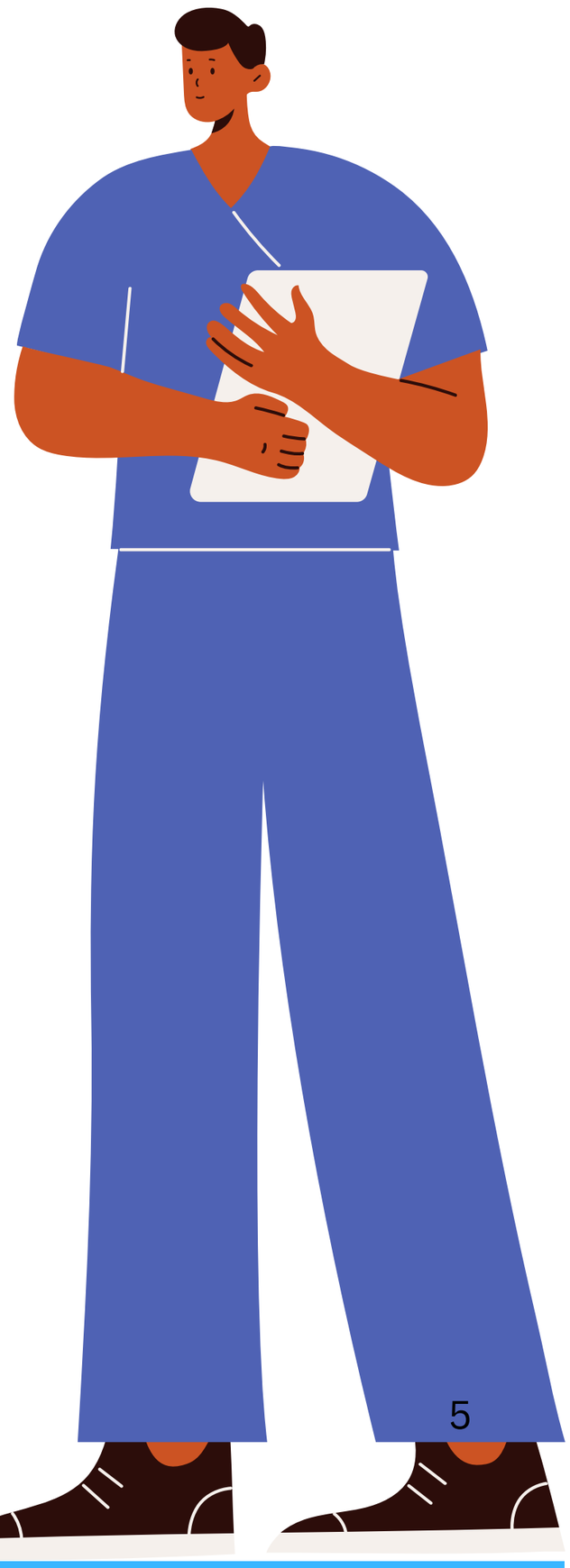
Background

Experiencing or witnessing verbal, physical and emotional abuse in the workplace is known as 'workplace trauma'.

For inpatient mental health staff, this involves experiencing or witnessing verbal and physical abuse [1], distress and fear when physically restraining patients [2], witnessing or hearing about distressing events such as self-harm [3], and violence or abuse against others [4]. Staff from minoritised groups (roughly 40% of the workforce) [5-7], experience racism, homophobia and abuse related to disabilities from both patients and/or co-workers in addition to other forms of abuse [5, 6, 8-11].

Workplace trauma causes staff mental ill health and high staff absenteeism and turnover [12-14]. The effects of workplace trauma may be particularly marked for staff from minoritised groups [15]. Poor staff mental health and high staff absenteeism and turnover caused by workplace trauma leads to poor patient care and consequent rises in patient aggression, self-harm and suicide [16-18]. There are also large National Health Service (NHS) costs associated with poor care, serious incidents, staff sickness and turnover [19, 20].

Healthcare organisations have a duty to protect staff from physical and psychological harm [21] and, increasingly, employers are seeing the benefits of wellbeing interventions to support staff [22]. However, there are inconsistencies and gaps across the NHS in terms of staff support systems [23]. Furthermore, most staff support systems have been developed without reference to the process of theory building and testing advocated by the Medical Research Council frameworks [24]. Current NHS staff support systems also fail to address the unique stressors associated with each workplace environment, barriers to access (e.g. stigma surrounding help-seeking) or characteristics of staff (e.g. proportion of staff from diverse ethnic communities and other minoritised groups) who may face additional barriers.



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Study Overview

The Staff TIME study was a 12-month research project, funded by a programme development grant from the National Institute for Health and Care Research (NIHR).

We recruited staff from 8 NHS Trusts who had current or recent (within two years) experience of working on acute mental health inpatient wards. All staff were eligible to participate, for example, clinical; admin; estates; domestic; and bank or agency staff.

We ensured that we interviewed a variety of different job roles and staff with protected characteristics e.g. from diverse ethnic communities, LGBTQIA+ communities, with a disability or identifying as neurodivergent.

We also interviewed other participants who we called ‘key stakeholders’. These were non-frontline professionals but were considered experts regionally or nationally in terms of staff support; equity, diversity and inclusion (EDI); and/or national policy.

Interview questions and data analysis were informed by the Consolidated Framework of Implementation Research, a commonly used framework which helps researchers to understand the contextual factors that may impact on the use of an intervention in health services. Template analysis was used to analyse the data, which is a form of qualitative analysis that supports the identification of commonly occurring ideas in the data.

Objective 1

To explore causes of distress for staff, and staff experiences of support currently available.

Objective 2

To identify barriers and facilitators to support access for workplace trauma in inpatient mental health wards.

Objective 3

To identify factors that make support systems for workplace trauma accessible and acceptable to staff from minoritised groups.

Objective 4

To develop and disseminate recommendations for best practice for workplace trauma support systems for all acute inpatient mental health staff.

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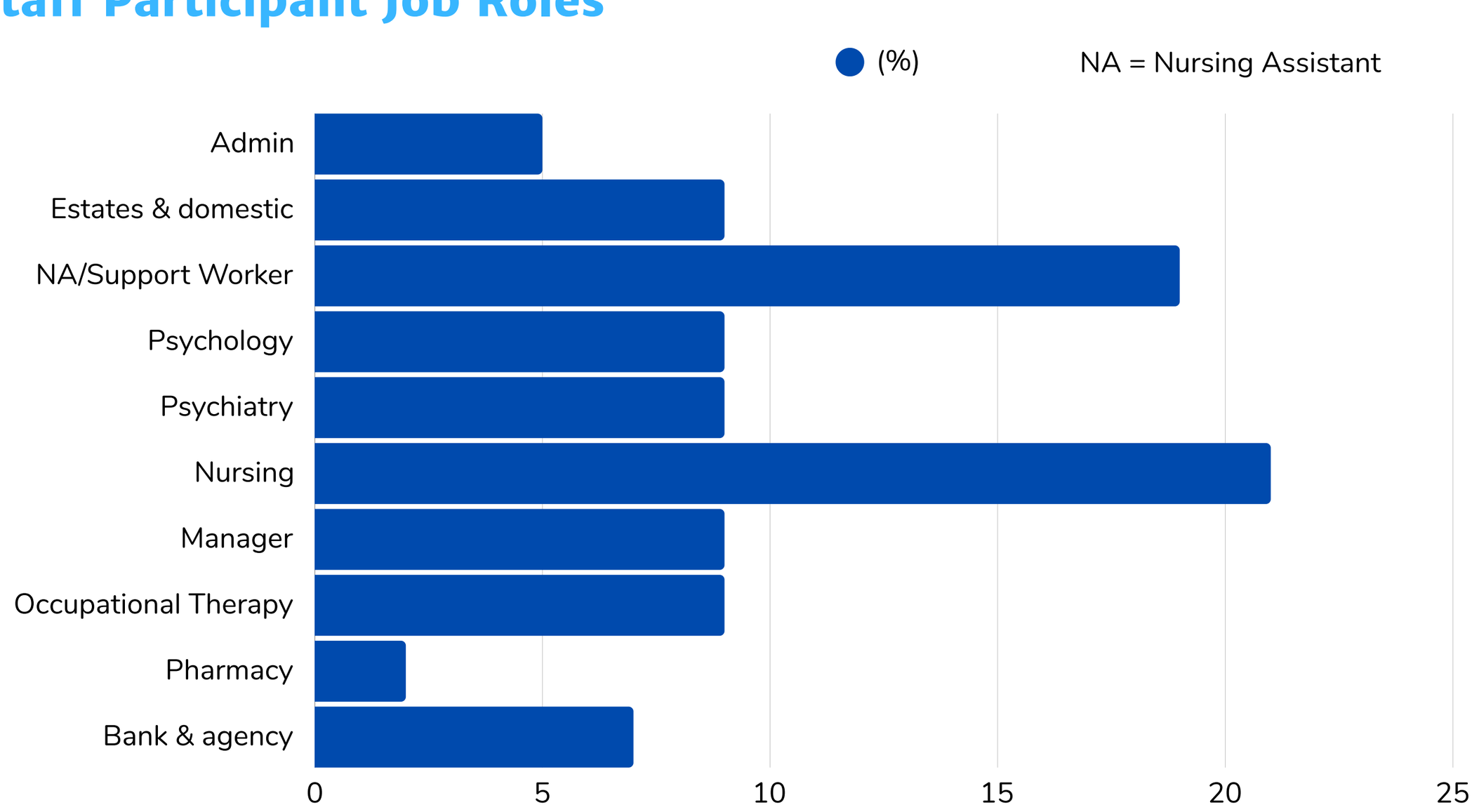
Participant Demographics

We interviewed **43 inpatient mental health staff** and **10 key stakeholders** between December 2023 and August 2024. Thirty percent of stakeholders had experience implementing or providing staff support; 30% were equity, diversity and inclusion specialists and 40% were experts in national policy.

Staff Participant Job Roles



Protected Characteristics

of staff participants identified with at least one protected characteristic

Gender Identity

Sixty-seven percent of staff participants identified as women, and 33% identified as men. Of our stakeholder participants, 50% identified as women, 40% identified as men, and 10% preferred not to say.

Trans Status

We asked all our participants whether their gender was the same as the sex they were assigned at birth. Of our staff participants, 98% answered ‘Yes’ and 2% answered ‘No.’ Of our stakeholder participants, 100% answered ‘Yes’.

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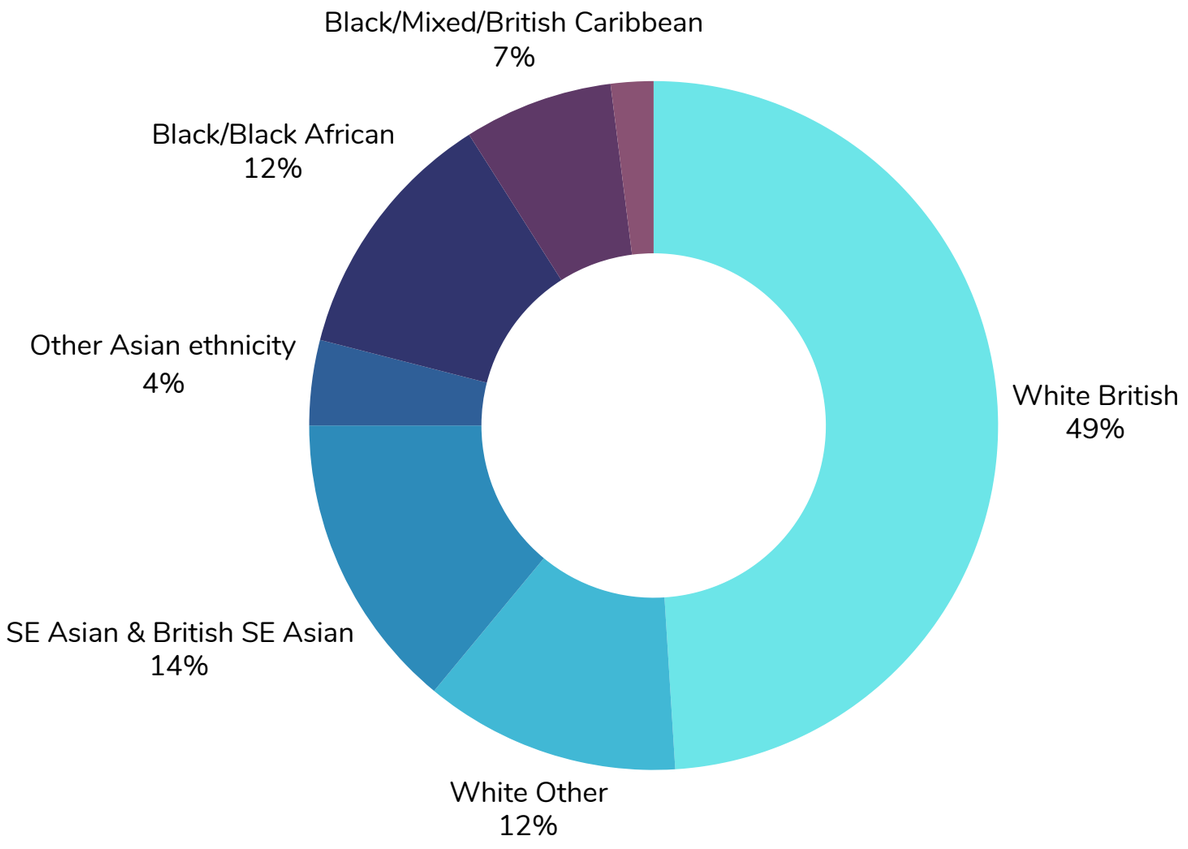
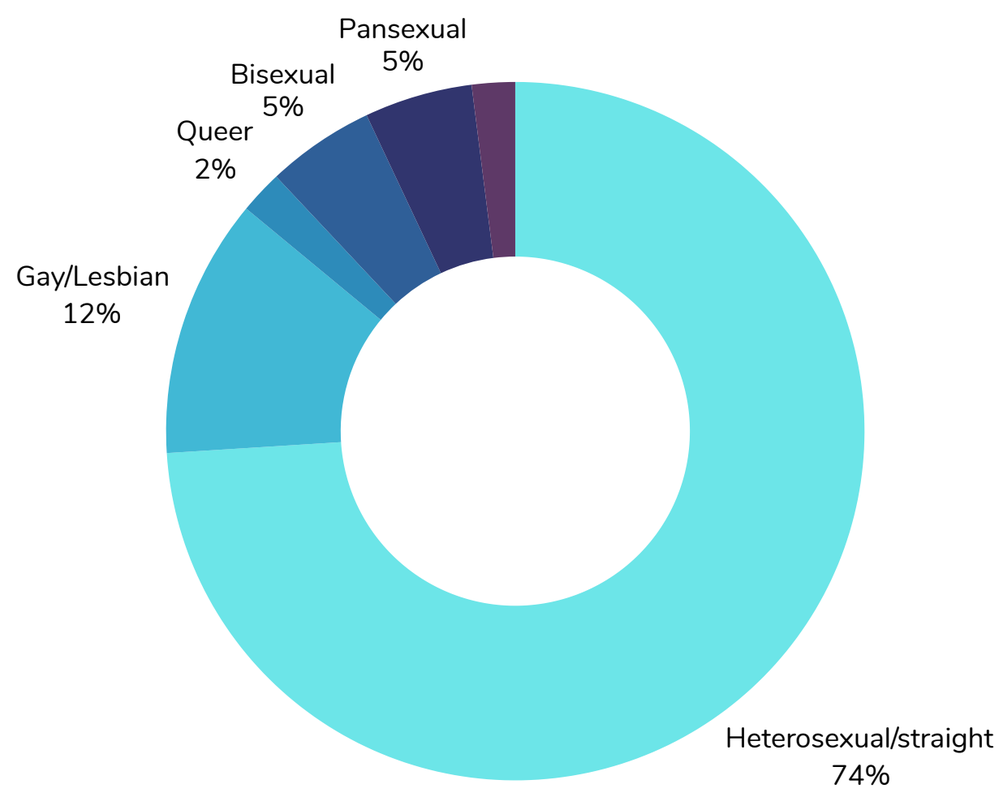
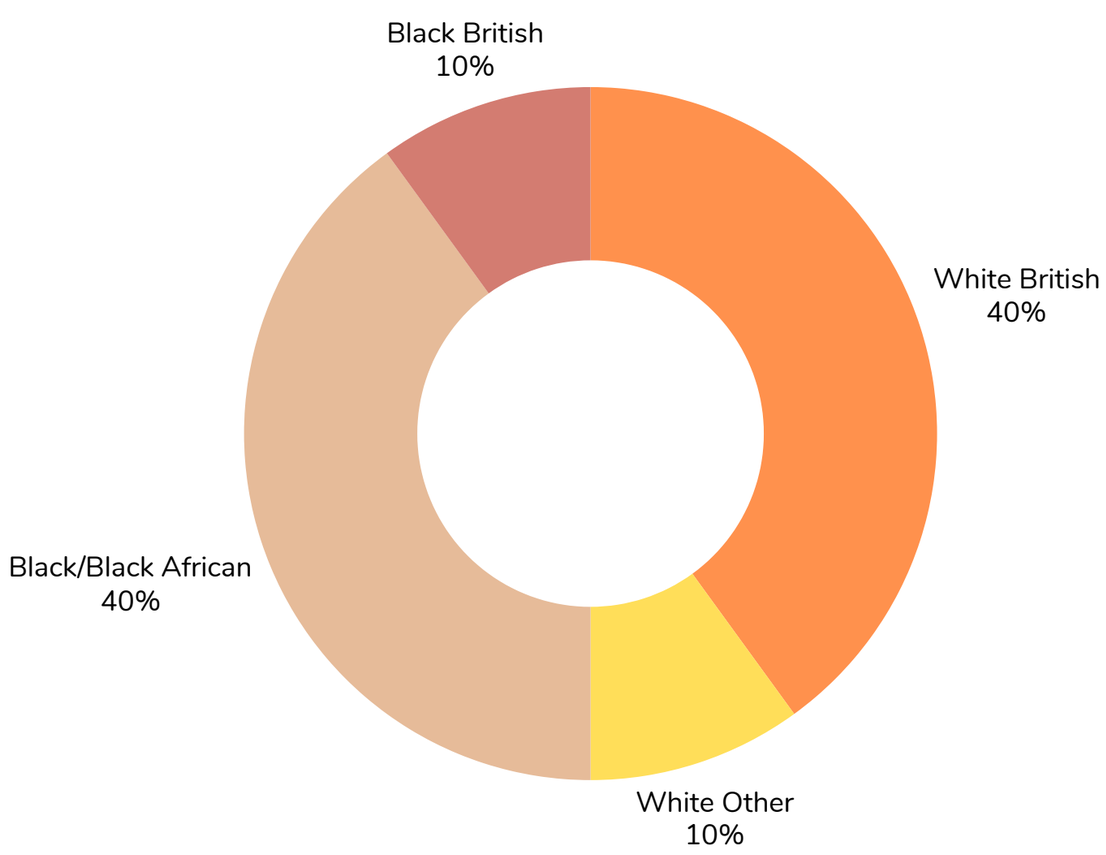
Staff Participants

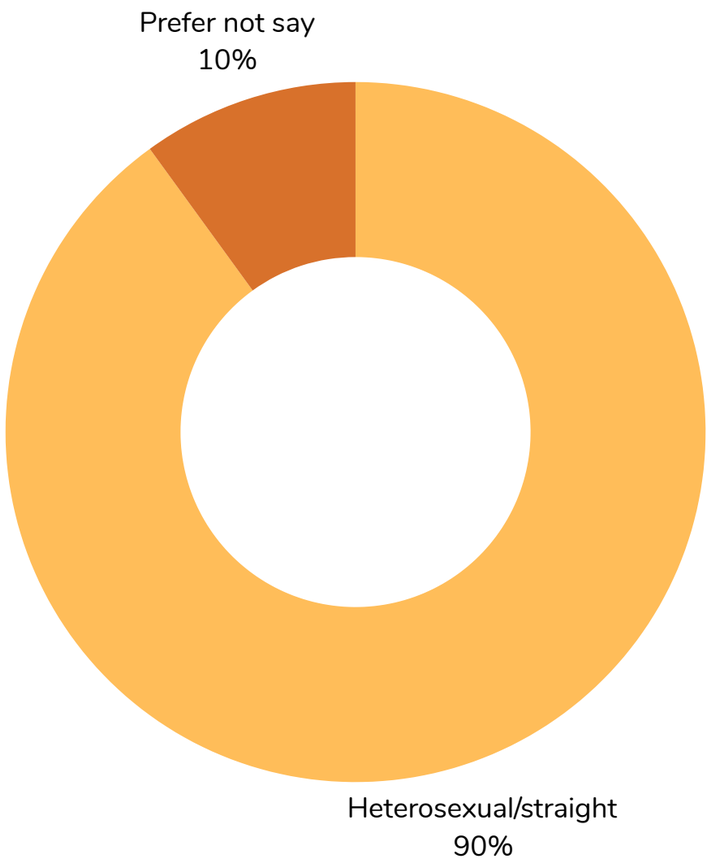




Of our staff participants: 86% did not identify as having a disability; 7% identified as having an emotional disability; 5% identified a having a physical disability; and 2% identified as having a neurological disability. Eighty-seven percent did not identify as neurodiverse, 9% identified as having Attention Deficit Hyperactivity Disorder and 4% identified as autistic.

Stakeholder Participants





Of our stakeholder participants, 70% did not identify as having a disability; 20% identified as having a physical disability and 10% identified as having an emotional disability. Sixty percent were not asked about neurodiversity and 40% did not identify as neurodiverse.

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Study Findings: Causes of Distress

Major Serious Incidents

This included experiencing or witnessing incidents such as assault and aggression, violence targeting protected characteristics, restraints, and deaths on the ward.

Persistent Stressors

Other non-physical incidents happened frequently and built up over to time to impact staff wellbeing. This includes identity-targeted abuse (e.g. racism, homophobia and transphobia), micro- and verbal aggression, near misses, allegations and investigations.

Workforce Issues

Staff and resource shortages increased stress and anxiety. Participants with protected characteristics faced difficulty accessing reasonable adjustments as well as discrimination from colleagues and managers.

These sources of stress impacted multiple areas of participants' lives and were seen as leading to: negative perceptions of work and Trusts; impacts on physical health, personal relationships, anxiety, post-traumatic stress disorder, and burnout. Stressors also affected staff ability to provide a therapeutic environment. In some cases, the impact of stressors led to staff leaving their jobs on inpatient wards entirely.

Nursing Assistant, Black African

> "Sometimes when I think about coming to work and I think they're going to abuse me, I will feel emotional [...] we come here to be receiving all this abuse."

> "Micro things [...] are happening on a daily basis that are building and building and building which means that when something big happens, you're not just experiencing the big thing, you're experiencing the 50 other small things that were in the lead-up."

Psychiatrist, White British

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Study Findings: Current support

High threshold for post-incident support

- Debriefing and referrals to further support were typically only offered for the most extreme incidents such as physical assaults or deaths on the ward.

Limited access to psychological support

- Staff encountered long waiting times or were offered self-help interventions or apps instead, which participants did not feel were sufficient.
- Staff affected by identity-based discrimination or abuse found it difficult to access any specific or suitable support e.g. incidents were not recognised as potentially traumatic, and specialised support like therapy for racial trauma was not available.

Infrequent manager support

- When managers did offer support (e.g. validated difficult experiences or offered breaks) staff felt valued and part of the team.
- However, participants felt support was offered reactively rather than preventatively, and that often managers were not able to prioritise staff support due to pressures on their own time and emotional capacity.

Reliance on peer support

- Colleagues often helped staff to feel supported at work by taking participants to hospital, taking over shifts, care for specific service users and checking-in during shifts and outside of work.
- This was dependent on personal relationships, which could be affected by cultural differences, language barriers, or the amount of time spent with the same colleagues, e.g. bank/agency staff often did not have established relationships with permanent staff.

Overall, staff on inpatient mental health wards did not feel they were sufficiently supported. Some job roles (e.g. bank and agency or non-clinical staff) and minoritised demographic groups were offered less support, or found it even more difficult to access formal and informal support.

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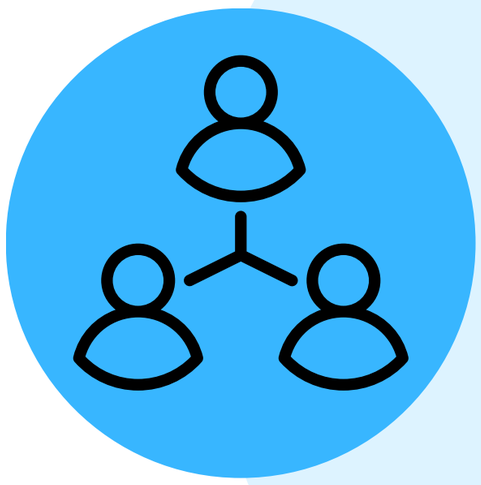
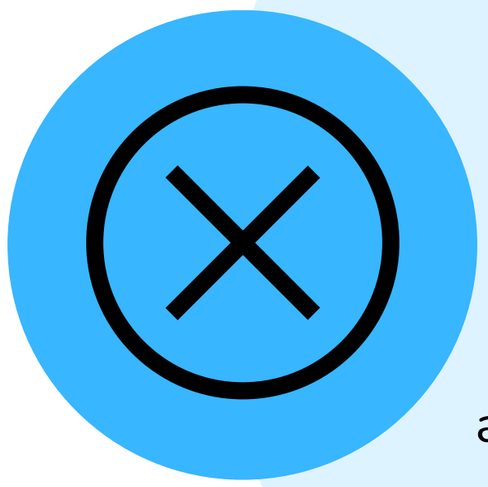
Study Findings: Barriers to accessing support



MANAGEMENT AND LEADERSHIP

Managers felt they had limited capacity, training or confidence to support staff. Senior leadership presence was often perceived negatively or as punitive e.g. perceived as only attending wards following an incident. Managers felt unsupported themselves, and felt pressure to put on a ‘brave face’.



IDENTITY-RELATED ABUSE OFTEN DISMISSED OR MINIMISED

Abuse such as racism and homophobia was often not called out by colleagues and managers, in part due to lack of understanding of its impact. Staff were concerned that service users were impacted by witnessing these incidents. There was a perception that organisations were not doing enough to support staff with protected characteristics and address systemic discrimination. Staff were often unsure about how to support others, and did not want to say the wrong thing.

INEQUITY OF SUPPORT ACCESS

For non-substantiative staff, non-clinical staff (e.g. bank, agency, estates, facilities, domestic staff), and staff working night shifts, support was even more difficult to access. These staff were either not invited to debriefs, or they were held at a time they were unable to attend. Managers outside of the ward were not always notified of incidents, and therefore did not offer support.

LACK OF PROACTIVE SUPPORT

The onus was usually placed on struggling staff members to seek out support. Many found it difficult to find information about support available, or were nervous about reaching out to their managers. Routine support offers were not prioritised on the ward e.g. clinical supervision and reflective practice sessions were often cancelled or rearranged.

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Study Findings: Barriers to accessing support

PRACTICAL ISSUES

Those who were referred for formal support, through managers or occupational health, encountered long waiting times and limited resources. Support offers on the ward were difficult to attend due to limited time and capacity for staff. Trained support staff could also be hard to access when they did not work permanently on wards (e.g. psychologists).

BARRIERS TO REPORTING

There were perceptions that ‘nothing happens’ after submitting incident reports e.g. no action taken, no feedback given, or no support offered. Limited access to IT reporting systems also acted as a barrier. A high number of incidents often dissuaded staff from reporting due to the extent of paperwork involved or they were actively dissuaded from reporting by senior leadership.

BARRIERS TO SPEAKING UP

Lots of staff were unaware of the process of Freedom to Speak Up and had concerns about confidentiality. Staff feared negative or punitive consequences in response to speaking up, including: impact on relationships with colleagues and managers, bullying and harassment, impact on career progression or job security.

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Study Findings: Ward Culture
‘It’s just part of the job’

A culture of stress and abuse being accepted as ‘part of the job’ further prevented support from being offered and deterred staff from seeking support.

There was a strong and pervasive stigma felt around help-seeking, particularly for persistent stressors such as service pressures, discrimination, micro-aggressions, verbal abuse, staff shortages, and risk.

> I’ve never been part of [post-incident processes], or asked about that, or asked how I feel about something, or if I’m okay after something’s happened. So, it’s just ‘do your shift, suck it up and go home’.

Bank Healthcare Assistant, Identified as having a disability

> [..] the perception of ‘it’s my job, I need to just take it', you know, ‘if you don’t like being thumped and you don’t like being threatened, well, what are you doing working on an acute ward then?’

Psychiatrist, White British

> There was a patient who was extremely aggressive towards me and [...] targeted me [with homophobic abuse], I was new. Everyone liked the patient, so whenever I tried to speak to anybody about it, [...] I would always get, ‘oh but he’s ill. Oh, but he’s such a lovely man’.

Mental Health Nurse, Multiple Protected Characteristics

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Generating Recommendations

Recommendations are primarily based upon our interviews. We also generated some further recommendations at our stakeholder event. Fifty-one staff members attended including representation from:

- NHS England
- Royal College of Nursing
- Royal College of Psychiatrists
- NHS Integrated Care Boards
- EDI Leads
- Staff Wellbeing Leads
- Staff Network Leads
- Frontline Staff
- Service Users

We presented the study and discussed key challenges that were highlighted in the interviews. We asked attendees to help brainstorm ways in which we could overcome these challenges and provide better support to all staff on the wards.

We have separated our recommendations for this document into different audiences so that they may be easily used and employed on the wards.

Please note, these methods have not yet been formally evaluated in practice, but will be a starting point for future research.

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Recommendations for Ward Staff

What can we change now?

Reflection

- Consider the impact of verbal abuse, discrimination, racism, homophobia, abuse targeting disabilities and stress from organisational pressures on yourself and your colleagues.
- Consider what type of support helps you to feel better on the ward, what changes you could make yourself and what you can ask for from senior leadership.

Supporting colleagues

- Always call out and challenge unacceptable behaviour or abuse.
- Check-in with colleagues after incidents of racism, homophobia and abuse targeting protected characteristics. Ask them how they are and how you can help or support them.
- Follow up with colleagues who have been involved in an incident (e.g. in the following shift, or the following week).
- Try to encourage general conversations about wellbeing amongst colleagues.

Explore Trust resources

- Engage in training offers provided by the Trust around Active Bystander Principles, EDI, Trauma and Stress.
- Explore support available at your Trust e.g. occupational health, staff wellbeing teams, and staff networks like Race Equality, LGBTQIA+, Disability Networks.

Team relationships

- Focus on fostering good relationships with colleagues on your ward, including admin, bank, agency, junior doctors and allied health professionals.
- Involve non-clinical staff (including, e.g. domestic staff) in handovers or discussions about risk that may impact their safety.

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Recommendations for Managers

What can we change now?

Identity-based abuse: Monitor & escalate

- Use incident reporting systems to report and label incidents as identity-targeted. Monitor frequency and patterns.
- Ensure that identity-targeted incidents are reported to clinical governance meetings, and escalated to organisation-wide committees/boards.
- Seek advice from EDI teams.

Identity-based abuse: Support staff

- Always call out unacceptable behaviour; check in with all staff and offer support, e.g. breaks, sick-leave, chaperone for future interactions, reporting to police, psychological support.
- Discuss at Multi-Disciplinary Team (MDT) meetings and consider appropriate action. Do not automatically move a staff member to another ward.
- Encourage staff to talk about the distressing impact of racism, homophobia/ transphobia, and abuse targeting disabilities.

Post-incidents

- Implement immediate huddles to check-in on the same shift and note who was present for the incident.
- Include all affected staff in debriefs/other support offers, including bank & agency, estates, domestic, and non-clinical staff.
- Ask staff what they need to feel supported e.g. going home, taking a paid break, psychological support.
- Co-ordinate with ward psychologists to offer timely support to staff on the wards e.g. debriefs.
- Explore preceding factors of violence and aggression to work towards prevention of future incidents.
- Follow up with staff after debriefs to ask if they need more support.
- Offer the opportunity for gradual reintroduction to the ward or support returning to work.
- Seek support from Trust security and incident response teams.
- Reach out to offer support when incidents are reported.

Allegations and investigations

- Handle investigations with confidentiality and consideration for the impact on a staff member.
- Offer or arrange support (including psychological, financial, legal or union support). Developing or helping staff to access existing peer/mentor schemes could be beneficial.
- Offer opportunities to move into a different role if possible.
- Involve the staff member in as much communication as possible or explain why you can't feedback on certain parts of the investigation.
- Support staff during interviews with the police or coroner's court.

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Staff Wellbeing and Routine Practice

- Contribute to creating an open culture: acknowledging when shifts are difficult and sharing when personally affected with your team.
- Role model accessing support offers, taking care of yourself and share regular information about support in team meetings.
- Raise staff wellbeing and EDI in MDTs and Senior Leadership Teams (SLTs).
- Pursue reasonable adjustments in a timely fashion, seek support from EDI Teams for further information and signposting. Offer flexibility in shift patterns or lengths for staff when required.
- Celebrate good practice in patient care and staff support, and celebrating individuals on the ward (e.g. employee of the month).
- Consider implementing ‘pre-briefs’ on the ward when admitting service users with complex needs.
- Involve frontline staff in decision-making and consider the impact of all changes on staff wellbeing.
- Be conscious that new starters and students may need more frequent support and check-ins.
- Prioritise clinical supervision and protect time for staff support. Seek further training to improve support e.g. EDI, cultural awareness,

Auxiliary and Bank & Agency Staff

- Reach out and include non-clinical and non-permanent staff in debriefs, handovers and risk assessments where suitable.
- Inform auxiliary managers when their staff member is involved in an incident.
- Make effort to include these staff members as part of the team e.g. involving in away days and social plans.

What should you aim to implement long-term?

- Release people during work hours to attend training or access support.
- Arrange weekly reflective practice and request cover for the ward during this period.
- Regular team away days to foster and strengthen team relationships with all staff including regular bank, agency and non-nursing staff.
- Offer flexibility or reduced hours for those who need it.
- Improve staff working conditions and causes of persistent distress e.g. access to breaks, food, resources.

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Recommendations for Organisations

What can we change now?

SLTs should ensure a consistent and structured approach to improving staff support across their organisations. A dedicated team can help to bring together the various services outlined below and adopt a preventative approach.

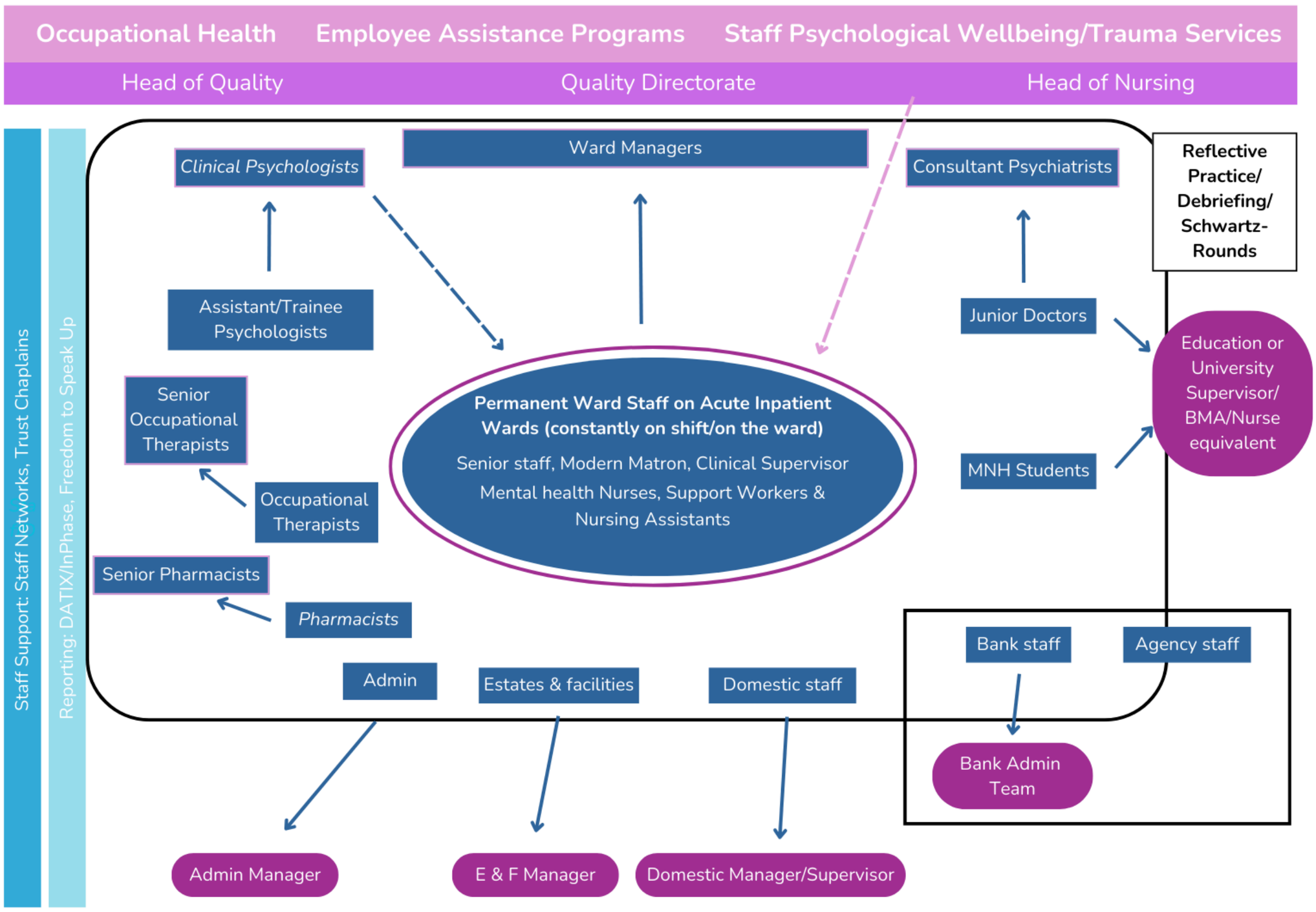

Figure 1. Diagram of staff and some support available on the wards.

Prioritise and invest in staff wellbeing

- SLTs should designate a member for reporting and addressing staff experience and report to a nominated member of the board and executives.
- Create changes in routine practice to reduce the impact of workplace stressors (e.g. reducing inequalities; staff support structures), rather than only reacting after incidents have occurred.
- Run awareness campaigns to encourage teams to routinely support each other and access support.
- Work proactively to identify problem areas on the ward (e.g. patterns of racist abuse), and develop ward-specific strategies to address problems and support staff.
- Engage in the continual promotion of staff support and wellbeing training.
- Ensure there is a system in place (e.g. ward level; Trust level) for monitoring and responding to identity-based incidents.
- Monitor and evaluate the impact of changes (e.g. the recommendations in this report) including financial costs, impacts on clinical work (e.g. on frequency of incidents of violence and aggression) and staff retention.

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Senior Leadership

- Increase visibility of senior leadership in clinical areas.
- Celebrate good practice (e.g. newsletters, annual staff awards)
- Prioritise staff wellbeing after incidents.
- Tackle defensive practice and culture of blame by adopting open culture of admitting mistakes or facing issues within the Trust.
- Involve frontline staff in decision making, communicate explanations for changes and choices. Consider the impact of decisions on staff wellbeing.
- Invest in staff wellbeing - fund cover for the wards, provide payment for out of hours staff or non-permanent staff to attend support and debriefs on non-working days.
- Encourage networking between managers and senior leadership to reduce isolation, e.g. networking events, mentor schemes.
- Provide separate support offers or groups for managers and senior leadership.
- Role model accessing support and regularly discussing the impact of work.

Organisational approaches to discrimination

- Recognise and acknowledge the impact of structural discrimination and previous failures of the organisation.
- Increase conversations between senior leadership and staff with protected characteristics e.g. listening events, reverse mentoring scheme.
- Ensure all panels (e.g. interview, disciplinary) are diverse to reduce unconscious bias and help increase diversity of senior leadership.
- Implement a mentor and coaching scheme for staff with protected characteristics.
- Ensure EDI is prioritised on care group and senior leadership agendas and members are accountable for orchestrating change (e.g. implementing anti-racism policies; sharing challenges and good practice).
- Engage with staff networks to tackle cultural barriers and stigma to accessing support.
- Engage with the Trust EDI team to help facilitate reporting and access to support. Ensure EDI team members attend the wards and consider the use of EDI champions in each service.

Communicating support offers

- Information about support offers should be regularly shared through various avenues: auxiliary staff managers, bank and agency texts/emails, screensavers, posters, ward managers and meetings, handovers, debriefs, newsletters, and during inductions. Ensure comms are short and accessible.
- Focus on the impact on staff instead of using overly psychological language e.g. instead of providing support for ‘trauma’ or ‘anxiety’, instead focus on the impact such as finding work ‘difficult’ or ‘stressful’.
- Provide easy to use guidance documents on how to support staff and support offers available for managers and ward staff.

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Freedom to Speak Up

- Reassure and emphasise that speaking up is confidential, particularly when staff are reporting discrimination, bullying and harassment from colleagues.
- Advertise in various areas (online, in person, word of mouth) and send information directly to bank and agency staff.
- Provide clarity and a written example of the process of speaking up.
- Publicise issues that have been resolved including examples of actions that were taken.

Staff Networks

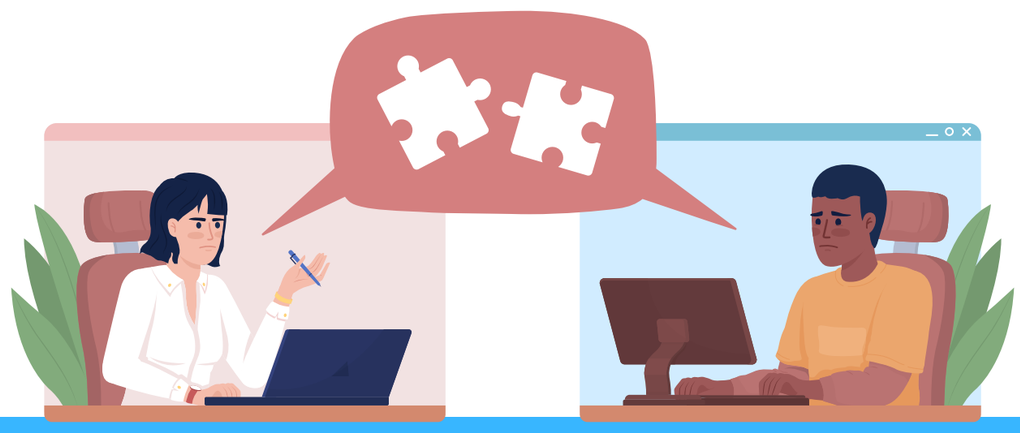
- Invest in staff networks to support those with protected characteristics. Including training, linking with senior leadership and care groups, and protected time for leaders. Ensure leaders of networks are also supported.
- Meetings should be a mix of timings, locations and events to improve access for inpatient staff.
- A network representative could come to wards to talk to staff and check-in on those with protected characteristics (including chaplaincy and spiritual networks).

Connections with third party organisations

- Improve Trust relationships with outside agencies who provide psychological support to implement a cohesive support process.
- Improve relationships with the police with a liaison in each ward or designated service/individual.
- Implement community contracts with external partners (like Employee Assistance Programmes) to hold them accountable to supporting staff.

Mandatory Training

- All staff should have further training on workplace trauma and stress, how to support others, preventing discrimination and racism, cultural awareness, neurodiversity, disability, and Active Bystander Principles.
- Managers and senior leadership require training on how to support others, how to manage teams (and why this is important), and how to pursue reasonable adjustments.
- International staff may need a longer onboarding process and support and training on the structure of the NHS and the UK mental health system.



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What should you aim to implement long-term?

Staff Support Service

- A fully funded and fully staffed in-house dedicated service for staff support and wellbeing should aim to provide a broad range of confidential and flexible support following a tiered support structure (e.g. including universal training and psychoeducation, team-based support, and 1:1 psychological interventions).
- Multiple referral options should be offered, including self-referral, manager referral, drop-in, and anonymous options.
- The service should be set up and designed with the input of frontline staff with lived experience of inpatient wards and protected characteristics.
- Services should offer 1:1 confidential support, including interventions for trauma, such as eye movement desensitization and reprocessing (EMDR) therapy.
- Ensure support providers are trained to support staff from minoritised groups, are culturally informed, and able to recognise the impact of systemic and organisational pressures.
- Ensure support providers have regular clinical supervision and access to their own support.
- There should be a designated team to support the global majority, including support with approaching Workforce/Organisational Development, speaking up and offering a choice of specialised support e.g. racial trauma support.
- Each ward should have a designated staff psychologist embedded within the team, to facilitate conversations on the ward, support manager training, attend auxiliary staff meeting to encourage staff support, and provide support to out-of-hours staff if possible.
- Support staff should attend wards to give post-incident support and provide necessary follow ups.
- Support services should offer assessments to ensure staff are ready to return to the ward after time off/sick leave.

Improve working conditions

- Fund and train more permanent staff for the wards to ensure safe staffing levels.
- Increase flexibility of shifts, working patterns and career development opportunities for staff.
- Address basic needs e.g. heating, air conditioning, functioning IT equipment, access to tea, coffee, nutritional/discounted food offers.
- Implement Quality Improvement programmes for staff wellbeing.

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Further Resources: Policies and Avenues for Change

Due to the broad spectrum of incidents, stressors and types of support involved in this work, there are several teams and members who should be concerned with staff wellbeing and be accountable for making changes. The below diagram gives a sense of some of the Trust, NHS and Third Sector Organisations who could be involved in pursuing structural change.

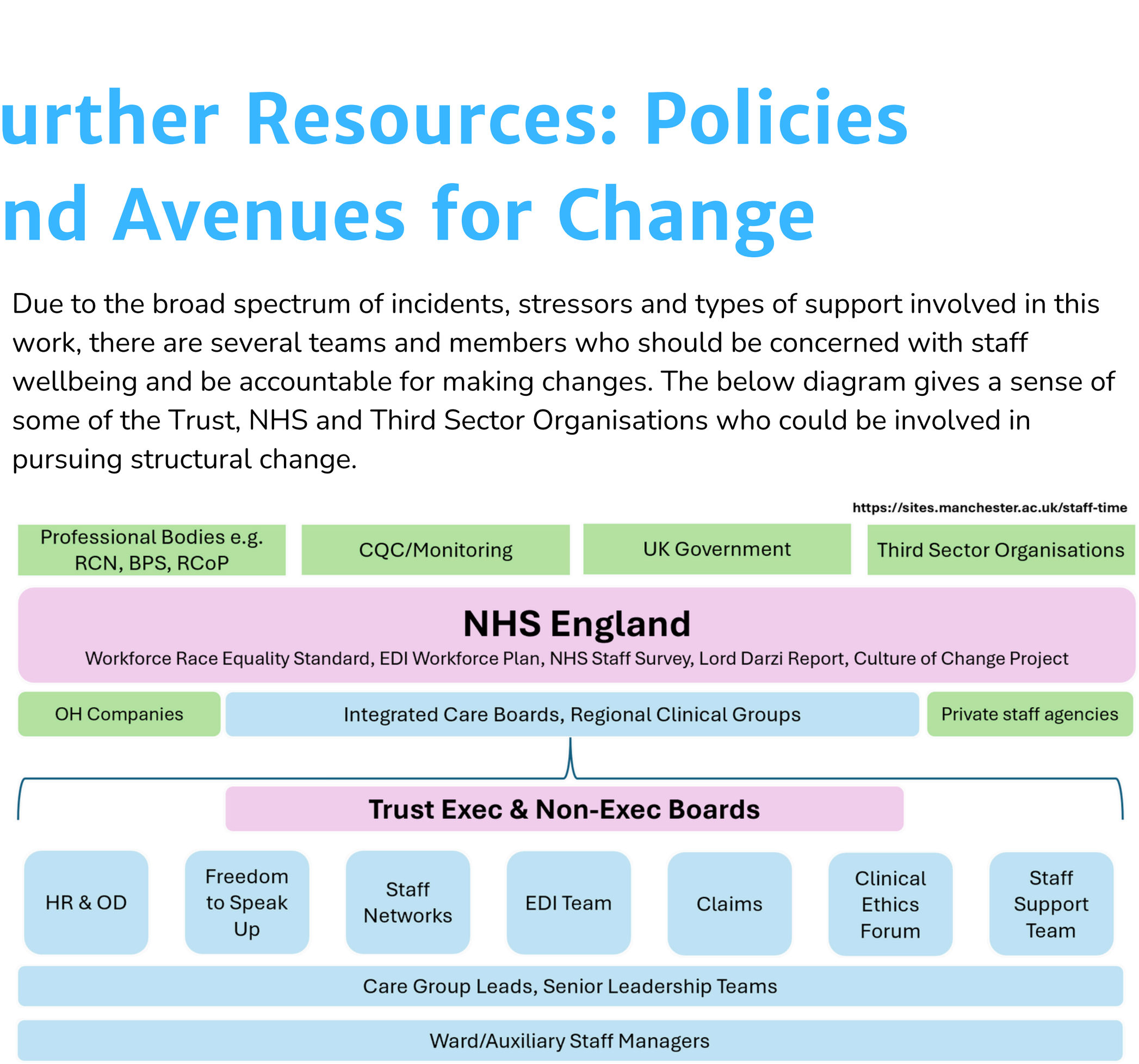

Figure 2. Diagram of NHS & External Organisations involved in supporting staff

At a Trust level, policies relating to this work could potentially include:

Allegations and Investigations

Staff Health and Wellbeing

Equity, Diversity and Inclusion

Incident Reporting and Management

Anti-Racism

Hate Crime

Bullying and Harassment

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Further Resources: Recommended Reading

Reports

- British Psychological Society - Learning From NHS Staff Mental Health and Wellbeing Hubs. Principles for staff mental health provision.
- Roger Kline - 'Too Hot to Handle? Why concerns about racism are not heard.. or acted on.'
- Roger Kline - The "snowy white peaks" of the NHS
- NHS Staff Survey findings
- Royal College of Nursing - Violence and Aggression in the NHS
- NHS Providers and Hempsons - Closing the Gap: A Guide to Addressing Racial Discrimination in Disciplinaries
- NHS Staff and Learners' Mental Wellbeing Commission (2019). Health Education England

Guidance

- Association of Clinical Psychologists - Group Psychological 'Debriefs'. Guidance for Post-event team reflection (PETR) following distressing events at work
- Conniff, H. (Ed.). (2022). *Psychological staff support in healthcare: Thinking and Practice*. ACP-UK Book Series.

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NHS Resources

- Lancashire and South Cumbria NHS Foundation Trust - Workplace Trauma Support Model and Traumatic Stress Service
- Lancashire and South Cumbria NHS Foundation Trust - 'I want you to know' video of staff experiences of racism at work
- Mersey Care NHS Foundation Trust - Restorative, Just and Learning Culture

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Thank you for supporting our work. Please feel free to get in touch with any feedback or to be involved in future projects.

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