## Abstract

Suicide and attempted suicide of people receiving care in Adult Mental Health Inpatient Services (AMHIS) leads to significant emotions amongst mental health professionals, characterised by guilt and shame. A sense of responsibility occurs due to hospital being seen as a safe place. However, little is known about what it is like for ‘non-qualified’ staff. This study explored experiences of suicide and attempted suicide on ‘non-qualified’ staff in AMHIS. Semi-structured interviews explored ten staff’s experiences. Participants were recruited online and transcripts were analysed using Reflexive Thematic Analysis. Four themes were identified; ‘Direct personal impact’, ‘Unrealistic expectations’, ‘Attempting to contain the impact’ and ‘Acclimatisation’. Ten sub-themes outlined; responsibility for assessing risk, shame and protective strategies to aid acceptance. The results provide insight into the unique experience of non-qualified staff in AMHIS experiencing suicidal behaviour.

## Introduction

Suicide constitutes a significant national issue (Royal College of Psychiatrists, 2020). In the decade preceding 2015, 28% of people who died by suicide were in receipt of professional mental health care, of which 9% were receiving inpatient psychiatric care (Burns et al., 2017). Further, incidents of non-fatal suicide attempts are even more common (Beautrais, 2004). Thus, a high proportion of staff working in AMHIS are exposed to working with people who die by suicide (Croft et al., 2022) or make suicide attempts (Takahashi et al., 2011).

### Impact of Suicide on Inpatient Staff

Research exploring the impact of suicide on staff working in AMHIS has found a consistent, strong emotional reaction. From feelings of shock (Bohan & Doyle, 2008), sadness (Wurst et al., 2010) and anger (Hamaoka et al., 2007) to post-traumatic stress disorder (Cabello et al., 2016), the emotional significance is substantial. Staff can experience ‘disenfranchised grief’ (Doka, 1989) as their emotions are less acknowledged, compared to family of the deceased person (Kauffman, 2010), leading to feelings of isolation and shame (Joyce, 2003; Rivett, 2020)

People receiving care in AMHIS are experiencing significant psychological distress, commonly posing a risk of harm to themselves and/or others (Bowers, 2005). As a result, family and friends expect risk to be managed (Sakinofsky, 2014). This leads to feelings of guilt following suicide (Bohan & Doyle, 2008; Joyce, 2003; Rivett, 2020). Feelings of failure may permeate as staff members question their professional competence (Dewar et al., 2000).

Imitative suicides may account for ten percent of suicide deaths by mental health clients (McKenzie et al., 2005). Therefore, AMHIS staff can become fearful of further suicide attempts occurring (Bohan & Doyle, 2008; Bowers et al., 2006). This can lead them to distance themselves from suicidal people (Gibbons et al., 2019) or become more risk-aversive (Sandford et al, 2020).

AMHIS are busy, chaotic environments with high bed occupancy and staff turnover (Cleary, 2011). This leaves inpatient staff little time to process their emotions (Bowers et al., 2006; Hunt et al., 2016) which can lead to more complicated grief (Adwan, 2014).

### Attempted Suicide

Research has not yet explored the impact of working with people who attempt suicide in AMHIS. However, minimal research into the effects of attempted suicide suggests a similar emotional reaction to suicide. Mental health professionals experience shame, loneliness, guilt (Firouz, 2022) and questioning their professional competence following the attempted suicide of a client (Ramsay & Newman, 2005).

Further, Firouz (2022) stated the feelings clinicians experienced after an attempted suicide were not unlike the feelings they felt after a completed suicide. Therefore, the researcher combined these together, to explore the impact of working with people who present with ‘suicidal behaviour’, specifically suicide and attempted suicide.

“Non-qualified” Staff

‘Non-qualified’ refers to those who require no specific training or registration, but play an integral part of the ward team e.g. receptionists, assistants and administration staff (Milne, 2016). They have a key role but receive limited professional support (Sorgaard et al., 2010). Jenkins and Elliot (2004) suggested differences in how AMHIS staff experience stress at work, with non-qualified members being more triggered by client demands.

Most of the literature concerning the impact of suicide and attempted suicide focuses on qualified staff (Bohan & Doyle, 2008; Bowers et al., 2006; Hunt et al., 2016; Ramsay & Newman, 2005). Some papers included junior staff, but did not draw out the intricacies of their unique experience (Cabello et al., 2016; Rivett, 2020). Awenat et al. (2017) included “junior” staff (nursing assistants and support workers), concluding they avoided discussing suicidality, believing it was beyond their remit, therefore missing opportunities to provide valuable contact with clients.

The experience of non-qualified staff who had been involved in suicide and attempted suicide in AMHIS was not clearly represented in existing studies, despite being a significant part of the workforce. As these staff members have the most direct contact with clients (Bee et al., 2009), it is important to explore the unique needs of their cohort.

### The Current Research

This paper outlines the results of a qualitative study exploring non-qualified staffs’ experiences of inpatient suicidal behaviour.

### Research Question

What is the experience of suicidal behaviour for ‘non-qualified’ staff working in AMHIS?

## Design

### Method

An explorative, qualitative design explored the experience of inpatient suicidal behaviour for “non-qualified” staff working in AMHIS.

A semi-structured interview schedule was developed for data collection. The content was based on previous literature (Rhodes-Kropft et al., 2005). The interview schedule consisted of primarily open-ended questions to allow follow-ups to any divergent information, ensuring the topic was thoroughly explored.

The interview guided participants to focus on one specific incident of inpatient suicide or attempted suicide in an AMHIS setting. It was hoped focusing on one event would elicit a deeper understanding of the experience. The researcher took inspiration from Rhodes-Kropft and colleagues (2005) by asking participants about their “most memorable” experience. This was asked without positive or negative intonation, so the participant produced their own example.

The key topics covered; an introduction to their job and service context, attitudes towards suicide, frequency of suicide and attempted suicide, their “most memorable” experience, their involvement in the incident, their personal reaction and reaction of the wider team, helpful interventions, and learning points.

#### Methodology

The researcher sought to generate rich, explorative data about the experience of suicide and attempted suicide for “non-qualified” AMHIS staff. Qualitative research was selected as it aims to enhance understanding of human processes and experiences and can be used to give voice to marginalised groups (Harper & Thompson, 2012).

Reflexive Thematic Analysis was chosen to guide the research, a process of identifying, analysing, organising, describing and reporting themes found in a dataset (Braun and Clarke 2021).

The researcher’s philosophical position was ‘critical realist’ and they had personal experience of working with suicide and attempted suicide in AMHIS. The researcher saw this as advantageous and aligned with the Reflexive Thematic Analysis process. They utilised a reflective journal and received regular supervision from their research tutor. Further, the researcher utilised Braun and Clarke’s (2022) 15-point checklist for good Reflexive Thematic Analysis to ensure a rigorous, systematic and reflexive analytic process.

### Participants

#### Sample Size

10 participants were included in this study. This may be deemed to be at the lower end of the recommended range for doctoral-level research (Braun & Clarke, 2013) however, the researcher continually reviewed the codes, themes and subthemes and reflected that the participants were providing abundant data, therefore the sample size was deemed to be adequate.

#### Sampling

Purposive sampling was utilised which allows researchers to access a subset of the population that shares a certain characteristic (Palinkas et al., 2015). This was aligned with the Reflexive Thematic Analysis approach as it would allow for patterns to be identified across a subset of data.

Recruitment took place online between April and November 2021 and was promoted on social media platforms, Facebook and Instagram. Prospective participants were asked to contact the researcher directly. At this point, they were provided with an information sheet which outlined the research. Once they confirmed participation and were screened for eligibility, they were reminded their involvement was voluntary and data would remain anonymous.

### Procedure

The researcher arranged a convenient date and time to conduct interviews with each individual. They were emailed a demographic form and consent form and asked to complete and return both prior to interview.

All interviews took place remotely to comply with Covid-19 restrictions. They were conducted in the researcher’s home, in a private study via Zoom (n=8) or Microsoft Teams (n=2). All but one participant opted to have both video and audio on, whereas one person chose to just use the audio facility. No other people were present in the vicinity to ensure privacy and confidentiality. Prior to interview, the researcher checked consent forms had been received. At the beginning of the interview, participants were provided the opportunity to ask questions and consent verbally.

Interviews were conducted using the interview schedule and audio-recorded using a Dictaphone. They ranged between 47 and 87 minutes, with a mean length of 58.7 minutes.

Interviews were transcribed verbatim by the researcher. Each audio was listened to twice and compared to the text. The researcher transcribed pauses, laughter, tears and noticeable changes in pitch/volume to provide a full overview of the data. Any identifiable data shared in the interview was omitted from transcription.

### Data Analysis

Each transcript was analysed following the six stages of Reflexive Thematic Analysis (Braun & Clarke, 2022). The researcher referred back to their reflective journal to remind them of thoughts and feelings they had during interviews and initial coding, ensuring all data was taken into account. Themes, subthemes and codes continued to be reviewed, redefined and abandoned during write up.

#### Ethics

Full ethical approval was granted by Staffordshire University’s Ethics Committee. Guidance for completing ethical human research was followed (British Psychological Society, 2021).

It was acknowledged that suicidal behaviour is a sensitive topic. Participants were assured they could decline any questions, take breaks or end the interview if they wished. Three participants became visibly upset during their interviews and were offered breaks, but they declined. No participants declined questions, took a break or requested to end their interview.

### Service User Involvement

The researcher consulted with a member of the target demographic (a healthcare support worker who had experienced suicidal behaviour in AMHIS) through the development of the interview schedule. This ensured questions asked were appropriate and understandable. Further, a potential participant who had been unable to take part in the research offered to help by reading the themes and executive summary. They fed back that the themes reflected their experience and felt the executive summary was accessible. Neither of these people were offered any remuneration for their contribution to the research.

## Findings

This section outlines the results; themes and subthemes are introduced with supporting quotations.

### Participant Demographics

All participants described their gender as female. The majority (n=5) were aged 25-34 years. Nine were ‘white’ and one ‘mixed ethnicity’. Two participants were Christian and eight had ‘no religion’. Each was assigned a pseudonym to maintain anonymity. Job-role has been omitted from the table to promote anonymity: healthcare assistant (n=7), benefits advisor (n=1), occupational therapy assistant (n=1) and student nurse (n=1). Participants were permanent (n=7), flexible worker (n=2) and students (n=1). Six shared examples of completed suicides and four attempted suicides. Some participants were involved in the incident (n=7), whereas others found out about it later (n=3).

### Themes and Subthemes

Four themes and 10 subthemes were developed through Reflexive Thematic Analysis (Braun & Clarke, 2021), displayed in Table 1.

**Table 1**

|  |  |
| --- | --- |
| Theme | Subtheme |
| Direct Personal Impact | Feeling Emotionally Overwhelmed |
|  | Attempting to Find Meaning |
|  | Heightened Threat System |
| Unrealistic Expectations | Responsibility for Managing Risk |
|  | Unrelenting Nature of Risk |
|  | Unprepared for the Role |
| Attempting to Contain the Impact | Just Carrying On |
|  | Wearing a Professional Mask |
| Acclimatisation | Leaning on Colleagues |
|  | The Inevitability of Suicide |

*Themes and Subthemes Derived from the Data*

#### Theme One: Direct Personal Impact

This theme encompasses the impacts experienced directly by staff after their exposure to suicidal behaviour. ‘Feeling emotionally overwhelmed’ describes how participants felt emotionally and how this was related to staff sickness absence. ‘Attempting to find meaning’ refers to staff trying to identify a cause for the incident by blaming themselves or others. Finally, ‘heightened threat system’ describes how staff became extra vigilant after a suicidal behaviour event, to prevent it happening again.

##### ***Feeling Emotionally Overwhelmed***

Participants shared a range of emotions including ‘shock’, ‘sadness’ and ‘feeling upset’ after their experience with suicidal behaviour. Often, this was difficult to contain and they cried whilst at work. Sydney, Liz and Katie also cried during their interviews when recounting their experience, further reflecting the emotional impact. This often had an intrusive effect affecting the person physically too. “It is a bit like you’re going in a fight and you have a punch. You’re a bit groggy afterwards” (Laurie). This experience of physical tiredness was reported more by those directly involved in incidents, however those who found out about it later shared the overwhelming emotional experience.

Staff described feeling ‘traumatised’ which crossed over into their home lives, having; ‘nightmares’, becoming ‘withdrawn’ and ‘not being able to sleep’. These symptoms built up to where staff felt unable to continue providing high quality care. This led to discussions around sickness levels. “Something like that happens and sickness peaks because people just burn out” (Ellen).

Some participants also shared fears for their emotional wellbeing in the future; “it’s trauma after trauma after trauma that’s getting piled on. At some point, I’m sure I will just break” (Katie).

##### ***Attempting to Find Meaning***

Most participants shared how their suicidal behaviour incident was a ‘shock’. Therefore, in an attempt to make sense of the event, they analysed the information they had. Often, scrutiny was directed inwards, where staff would blame themselves; “you naturally feel guilt because you think “what if?”” (Christie).

Staff would question whether they had missed something and would berate themselves. This guilt also made staff imagine worst-case scenarios. In Rachel’s case, the person made a suicide attempt when Rachel was late to check on them. She blamed herself, comparing the guilt to how she would have felt if the person had died; “I was blaming myself for something that hadn’t even happened” which highlights the self-critical questioning. Participants who were not directly involved in the incident, but found out about it later, reported the same feelings of guilt and failure, suggesting that they did not need to be present during the suicidal behaviour event to experience the emotional toll.

Another avenue for finding meaning was to scrutinise and blame others; “I didn’t understand how they could have discharged him” (Regan). Staff questioned the events surrounding the incident. The interviewer interpreted this as an attempt to mitigate their personal guilt. This process of scrutinising could cause ruptures in teams as everyone was ‘analysing everything’.

##### ***Heightened Threat System***

Staff described feeling ‘on edge’, ‘more wary’ and ‘more cautious’ after a suicidal behaviour event, anticipating a further incident; “brace yourself. You just kind of armour-plate yourself a little bit ready for when it happens again” (Sydney).

Some participants shared how ‘copy-cat’ incidents could make this anxiety more intense; “it did escalate those behaviours on the ward; that she managed to complete it when they had thought of it” (Amy). Staff did not have the opportunity to recover from the event as they were immediately expecting the next one to happen.

Participants distanced themselves from people receiving care on the ward; “I was a bit wary to approach the patient after” (Laurie). This caution was viewed by the researcher as an internal mechanism to avoid becoming too emotionally overwhelmed.

#### Theme Two: Unrealistic Expectations

This theme describes being a non-qualified ‘frontline’ worker and how this influenced their experiences of suicidal behaviour. ‘Responsibilities for managing risk” explains how non-qualified staff completed the most observations and were responsible for monitoring risk status. ‘Unrelenting nature of risk’ refers to risk incidents taking place regularly on the wards. ‘Not adequately trained’ then describes how staff felt unprepared to manage the risks associated with their job.

##### ***Responsibility for Managing Risk***

Non-qualified AMHIS staff made up the majority of the workforce. As they had the most direct contact with clients, they had the responsibility to oversee and report back any issues to their qualified colleagues. They referred to this as being ‘on the frontline’; “we’re doing the groundwork, we’re on the floor every day, we’re the ones building up those really close relationships” (Regan).

Therefore, staff felt they had to be vigilant and “be the eyes and ears” of the nurses. With that came the responsibility to assess suicide risk. Participants expressed how hospital is supposed to be a ‘safe space’ and that it was their job to ‘prevent harm’. Therefore, they felt like they had failed when a suicidal behaviour incident occurred; “we were supposed to look after her. It was literally our jobs to make sure she didn’t manage to kill herself and we failed” (Liz). This was communicated as an intense responsibility that they felt solely responsible for due to their increased direct activity with the people.

It appeared non-qualified staff in AMHIS experienced a double exposure to suicidal behaviour. Firstly, through the constant responsibility of risk-assessing and secondly, as they are most likely to be physically present when suicidal behaviour has taken place.

##### ***Unrelenting Nature of Risk***

Participants shared dealing with suicidal behaviour was ‘daily’ and a ‘normal’ part of the job. Staff had to deal with one incident after another, often ‘juggling’ multiple risk scenarios at once; “I just don’t think your brain has time to take a breath” (Regan). Each incident had a profound and cumulative effect. They had little time or opportunity to recover from one thing before another incident occurred, and over time this became ‘too much’.

Participants also shared how suicide risk was unpredictable which meant they had to remain hyper-vigilant to risk at all times. Even when not dealing with an actual suicidal behaviour event, they had to scan for the next one as suicide risk can fluctuate so rapidly; “It’s just because of the type of patients. It is that unpredictability. It’s not like working on a general ward where their observations start going down or there are tell-tale signs that they’re progressively getting worse” (Katie).

Some staff referenced socio-political factors regarding suicide risk, such as recruitment issues leaving mental health services under strain, leading to more severe risk presentations in AMHIS; “our admissions have been riskier the last year” (Regan). This added to the constant risk workload for the staff.

##### ***Unprepared for the Role***

Non-qualified staff reported feeling unprepared to manage the demands of their role. There was no official education or training required prior to working on the ward and specific suicide training was lacking. Of those that had attended suicide training, many described it as being an online e-learning module that was not robust enough for working with real-life risk; “I wasn’t trained to use restraint techniques before I started working on the wards” (Rachel).

Non-qualified staff are expected to monitor risk and intervene when incidents occur. However, lack of training left them feeling ‘unprepared’. Therefore, when faced with suicidal behaviour incidents, they ‘froze’ and felt ‘unsure of what to do’. This feeling abated after being exposed to a few suicidal behaviour events and participants shared they mostly learned how to do their job through their non-qualified colleagues.

Some participants also felt their organisations did not invest in non-qualified staff’s professional development. They stated training had been more aimed towards qualified staff’s role in suicide prevention, such as completing risk assessments and making decisions about observation levels; “training was not aimed at unqualified” (Ellen).

#### Theme Three: Attempting to Contain the Impact

Theme three describes staff’s attempts to control the personal impact of the suicidal behaviour event. ‘Just carrying on’ explains how staff went into an auto-pilot mode focusing on work tasks instead of their emotions. ‘Wearing a professional mask’ explains how staff attempted to minimise their emotions.

##### ***Just Carrying On***

After suicidal behaviour, participants explained they avoided focusing on their emotional experience. Instead, they focused their energy on completing work tasks and many described this as going into ‘auto-pilot’ mode; “I remember thinking “I’m not going to process this now, I need to just carry on with work”” (Amy). The researcher interpreted this as a controlling mechanism to avoid becoming emotionally overwhelmed whilst at work.

An additional factor with this was the environment was not conducive for therapeutic support; “It would have been nice to have a moment. But where would I have gone? You can’t even go in the toilet, you need a key or a code. There’s nowhere to literally go” (Sydney). Having constant work demands and no safe space to go meant staff had no option but to compartmentalise and save the emotion for later. Going into ‘auto-pilot’ allowed them to complete their shift until they were in a safer place to process what they had experienced.

##### ***Wearing a Professional Mask***

There was a message amongst participants that expressing emotions on the ward was shameful and undermined their professionalism. This was further highlighted by Sydney, Liz and Katie apologising after crying in their interviews. Therefore, when dealing with a suicidal behaviour incident which was distressing, staff had to hide their emotions in order to be respected. They believed that as mental health workers, they could not show any emotional vulnerabilities themselves, as that could undermine the advice they offer; “You wouldn’t get mortgage advice off somebody who was in debt” (Regan). As a result, staff hid their emotions, putting a ‘professional mask’ on to cover their raw, human self.

When new members of staff joined the ward, they therefore had no one modelling healthy emotional expression and this perpetuated the culture of minimalizing emotional impact; “when I first encountered it, I was quite stressed and worried about it and other staff seemed to see it as more of a self-harm behaviour. They’re dealing with this so often I got the impression some of those responses might make it easier to cope with it” (Rachel).

#### Theme Four: Acclimatisation

This theme describes ways in which staff adapted their working practices in order to deal with the demands of working with suicidal behaviour. ‘Leaning on colleagues’ describes how staff sought support from their team as a way to cope and ‘the inevitability of suicide’ explains how staff accepted suicide as an unavoidable aspect of working in AMHIS.

##### ***Leaning on Colleagues***

Participants shared support from their organisations was lacking, therefore in order to continue working in AMHIS, they valued support from colleagues; “the Trust I work for are absolutely shocking for debriefs, so it’s just support from your colleagues really” (Katie). This allowed them to share the physical load of risk assessing and the emotional load after suicidal behaviour events.

Developing strong bonds helped staff feel less alone in the aftermath of suicidal behaviour. There was a shared understanding of the non-qualified role and its stresses; “there is something more supportive about an inpatient unit. It’s almost a real appreciation for each other” (Ellen). The researcher interpreted that strong team bonds had developed as there were no other outlets for emotional expression, therefore banding together helped them to manage with the many stresses of their role, which was less isolating.

##### ***Accepting the Inevitability of Suicide***

Staff dealt with the impact of suicidal behaviour by leaning into acceptance; “if somebody is hell-bent on attempting or doing actual suicide, they’re going to do it and you can’t stop that” (Julie). This is likely influenced by the high prevalence of suicidal behaviour in AMHIS. It is happening so often that staff have become somewhat acclimatised to it. This process of acceptance may be a protective mechanism to negate the feelings of personal guilt and emotional exhaustion. This allows staff to place suicide in an external context and allow them to continue working without becoming overwhelmed.

## Discussion

The aim of this research was to explore the experience of working with suicidal behaviour for non-qualified staff working in AMHIS. Reflexive Thematic Analysis was used to analyse interview transcripts from a purposive sample of 10 participants who had experienced this phenomenon. Four themes were identified; ‘Direct personal impact’, ‘Unrealistic expectations’, ‘Attempting to contain the impact’ and ‘Acclimatisation’. This section will discuss the main findings and their implications, both clinical and for future research.

Non-qualified staff found themselves in a paradoxical position, as the least trained members of staff but most likely to intervene when suicidal behaviour occurred. Further, they were navigating their experiences within an environment where emotional expression was seen as shameful. Non-qualified staff tend to not access wider professional networks such as registration with professional bodies (Sorgaard et al., 2020), which can help to mitigate some of these cultural ‘norms’. These processes interweaved leading to non-qualified staff experiencing notable emotional impacts. This led them to develop a number of defence mechanisms, which were not always helpful.

The emotional reaction of non-qualified staff following a suicidal behaviour event was substantial, similar to qualified staff (Cabello et al., 2016; Firouz, 2022). Staff expressed emotional exhaustion likened to having a “fight”. Typically, when faced with threats, one responds with fight, flight or freeze activating adrenaline production in the body (Donahue, 2020). When the threat subsides, people experience a slump in energy (Donahue, 2020) which may account for staff feeling tired or “groggy” after a suicidal behaviour event. However, AMHIS staff were not always able to respond in the ‘typical’ way. Fight, flight and freeze are not easily activated for staff working in AMHIS as they cannot leave the ward. Therefore, non-qualified staff experienced an atypical way of dealing with threats, developing alternative ways of coping, such as distancing themselves, going into auto-pilot, minimalising their emotions and becoming desensitised to suicide.

Additionally, staff likely did not experience the typical peak and fall of adrenaline as the threat of suicide never abated. When faced with repeated threats, the cycles of fluctuating adrenaline can lead to ‘adrenaline fatigue’ (Wilson, 2013). Persistent stress can lead to burn-out of the adrenal glands due to prolonged production of cortisol and can eventually lead to difficulties with completing everyday tasks (Wilson, 2013). Non-qualified staff in AMHIS are faced with high-stress situations daily as outlined in the subtheme ‘unrelenting nature of risk’. Aside from physically responding in-the-moment, they are further plagued by internal cognitions such as personal guilt, blame and trying to make sense of the situation, as well as navigating this within a context of emotional expression being shameful. This was similar to emotional processes described by qualified staff in AMHIS after suicidal behaviour (Bohan & Doyle, 2008; Joyce, 2003; Firouz, 2022).

Further, the threat of imitative incidents means they are continually scanning for risks, as highlighted in the subtheme ‘heightened threat response’. When staff described being “burnt out”, they may have been experiencing adrenaline fatigue. Long-term heightened stress is associated with physical, biological and psychological changes (Yaribeygi et al., 2017).Therefore, prolonged stress could lead to more serious complications for staff and an increase in sickness rates. Thus, organisations should prioritise adequate support following distressing incidents to improve staff retention.

Non-qualified staff outnumber qualified in AMHIS, as outlined in the subtheme ‘responsibility for managing risk’. They act as the “eyes and ears” for the qualified team and report back any concerns. An AMHIS admission is a last resort for people in crisis (Zeigenbein et al., 2006) and many participants described hospital as a “safe space”. As a result, non-qualified staff placed high expectations on themselves to prevent risk. This could contribute to feelings of guilt when suicidal behaviour did occur. This finding is similar to the literature on qualified staff in AMHIS, who experience self-blame and a sense of responsibility for the suicidal behaviour (Bohan & Doyle, 2008; Joyce, 2003; Rivett, 2020). Slade and Scowcroft (2019) found inpatient staff experienced a ‘crisis of confidence’ questioning their professional competence following suicidal behaviour. This was also communicated by the participants in this research with “if only I had…” type statements, suggesting a similarity between qualified and non-qualified staff in how they appraise their professional competence following a suicidal behaviour event. Organisations should ensure clear guidance is in place so staff are aware of their role expectations and responsibilities in suicidal behaviour events.

The researcher sensed a divide between non-qualified and qualified staff. Participants noted that qualified staff’s professional development was prioritised and they would approach fellow non-qualified staff for support following a suicidal behaviour event rather than qualified. This was not explored in this study, but future research could explore the power dynamics between qualified and non-qualified staff following suicidal behaviour.

Despite being the most present on the ward, participants received little to no training. This left them feeling ill-equipped, as noted in the subtheme ‘unprepared for the role’, and they may make decisions in-the-moment that they later experience guilt over. Staff’s understanding of their responsibilities following suicidal behaviour was not explored in this research, however future projects could inquire whether non-qualified staff are clear in their duties and how this impacts them when faced with suicidal behaviour.

Participation in suicide prevention training can increase self-perceived competence in working with suicidal behaviour (Solin, Tamminen and Partonen, 2021), therefore lack of training may have influenced the participants’ feelings of professional failure. Lees (2011) suggested training as a core procedural requirement to support ‘unqualified’ staff to complete observation work in AMHIS. Therefore, specific training on practical interventions when faced with suicidal behaviour may improve non-qualified staff’s confidence.

The data suggested a cultural ‘norm’ where emotions were hidden at work by ‘wearing a professional mask’. Participants did not reflect too deeply, despite prompts, instead pushing the focus onto others. This finding was in alignment with other literature exploring the impact of suicide on inpatient staff (Joyce, 2003; Rivett, 2020). This suggests shame is not profession-specific, but rather a generic aspect of ward culture. The researcher interpreted this as a way of staff protecting themselves from being vulnerable and maintaining their professional identity. Concealing distress may also be linked to ‘professional anxiety’ where staff question their competencies (Slade, & Scowcroft, 2019). Wearing a mask allows one to conceal their identity so they can continue to play the part of a competent mental health worker. However, masking distress in this way can lead to more complicated forms of grief (Wagner & Maercker, 2010). As this is the subtle culture in which staff are working, it is learnt by new members that join the team and so the cycle perpetuates.

Organisations should ensure both formal and informal support is offered to mitigate this high-stress work. Clinical supervision improves professional practice and reflection, and improves wellbeing by providing opportunity to explore practice (HCPC, 2019). Clinical supervision should be offered to all AMHIS staff, not just those with professional status. This would provide an opportunity to model emotional reflection after difficult incidents. Additionally, opportunities to learn how suicidal behaviour can impact staff would be valuable. For example, an understanding of their heightened threat system from a Compassion Focused Therapy approach could help destigmatise the distress and reduce shame (Gilbert, 2010).

Non-qualified staff felt unsupported by management. A change in leadership style in AMHIS, to one where managers/clinicians are more visible, available and supportive may help staff feel better able to manage the risks. One way to achieve this is through ‘Schwartz rounds’; group reflective practice for all staff to reflect on the emotional and social aspects of their role (General Medical Council, 2019). Maben (2018) outlined Schwartz rounds provide opportunity to mentally process work challenges.

Finally, some participants shared thoughts around suicidal behaviour being an inevitable product of working with people in mental distress. By externalising the phenomena as just part of the job, staff distanced themselves from it and hence guilt was minimised. As suicidal behaviour was so prevalent, the researcher interpreted that staff developed this new narrative as a way to be able to cope with the gravity of suicidal behaviour. Links can be made to compassion fatigue, whereby staff can become “too tired to care and having to forgo compassion in an effort to protect oneself from despair” (Kleiner & Wallace, 2017, p.18). Desensitisation and compassion fatigue merit further research as they were not probed in this study.

The specific experiences of “non-qualified” AMHIS staff working with suicidal behaviour was previously unexplored. Therefore, a key strength of this research is it provided an opportunity for a historically underrepresented group to have their voices heard. The researcher had personal experience of working in AMHIS with people who present with suicidal behaviour. This was advantageous as they were able to provide reflexive insights and understand the intricacies of the phenomenon. Further, conducting interviews remotely added an additional layer of anonymity. When considering emotional expression in this group is often concealed, any opportunity to increase anonymity likely improved participation.

There was not much variance in the sample in terms of job role. The majority of participants (n=7) were healthcare assistants so the analysis was heavily led by these participants. Future research could attempt to capture a wider range of non-qualified staff such as admin workers, reception and domestic staff. It is possible these groups were missed due to the recruitment method. Advertising in groups designed for mental health workers may not be accessed by staff in non-frontline roles.

Similarly, the demographics of participants were limited, for example all identified as female. Sex role theories argue that expressing emotions opposes male role expectations (Wester et al., 2007; Hill & Donatelle, 2005) which may have played a factor in dissuading males from participating. Further, lack of diversity in religion and ethnicity of the sample meant it was not possible to distinguish whether cultural or religious contexts influenced the experience. Research indicates cultural beliefs can affect how one experiences emotions (Nangyeon, 2016), therefore future research could consider the role of culture in emotional expression within the workplace.

It is acknowledged that the use of the term ‘suicidal behaviour’ to encompass attempted and completed suicide is not in line with national UK guidance and may cause some confusion when read alongside other literature. NICE guidelines (National Institute for Health and Care Excellence, 2022) suggest the term ‘self-harm’ to encompass intentional self-poisoning or injury, rather than ‘attempted suicide’ as the purpose of behaviour is not always possible to determine. However, the researcher was interested in the participants’ interpretation of the event, rather than the person’s intention. Future research should be mindful of use of language regarding suicidal behaviour.

Suicidal behaviour had a significant emotional impact on staff and the high-risk nature of AMHIS meant repeated experiences had a cumulative effect. As a protective strategy, staff attempted to distance themselves from their distress, but this makes the healing process more complex (Wager & Maercker, 2010). Non-qualified frontline staff are often the first to notice a change in risk status, but it is their qualified counterparts who are responsible for making decisions regarding risk management. With little training, non-qualified staff were often left unsure of how to respond to suicidal behaviour which could lead them to questioning their professional competence.

These findings have been considered in terms of their clinical implications and recommendations have been suggested. This research will be of interest to staff working in AMHIS and healthcare management, as well as Clinical Psychologists offering support to staff in AMHIS.

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