"Why keep it all on my shoulders?": Emotional Experiences and Wellbeing of Administrative Staff Working in Forensic Mental Health Services; an Interpretative Phenomenological Analysis

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Title of degree programme	**Professional Doctorate in Clinical Psychology**
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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed: _(signature)_   Date: 30th April 2024

Preface

Table illustrating breakdown of total word count:

Document Name	Word Count
Acknowledgements	258
Thesis Abstract	407
Paper One: Literature Review	7999
Paper Two: Empirical Paper	7997
Paper Three: Executive Summary	2484
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Thesis Abstract

Paper 1 is a literature review of eleven research articles exploring the risk and mitigating factors of secondary traumatic stress (STS), vicarious trauma (VT) and compassion fatigue (CF) in frontline staff working in domestic and sexual violence services. The umbrella term "STS" was utilised. The findings were mixed, but indicated that there were individual and organisational level risk factors of STS. Despite being identified as a risk factor in other systematic reviews, the findings suggested that victim status was not a risk factor of STS in frontline staff, however, the validity of the outcome measures used were questioned. The findings indicated that age strongly predicted STS, with younger frontline staff being at greater risk. Other individual level factors such as ethnicity and education were not sufficiently investigated to draw meaningful conclusions. The findings indicated that organisational factors accounted for the most variation. Across the organisational level factors, direct hours working with victims, workload and a lack of autonomy were predictors of STS. The findings indicated that good quality/ frequent supervision and social support could mitigate STS. Limitations of this review included the methodology and a lack of consistency in defining and operationalising STS, CF and VT across the eleven research articles.

Paper 2 is an empirical study that utilised Interpretative Phenomenological Analysis to explore the wellbeing and emotional experiences of administrative staff who work in Forensic Mental Health Services (FMHS's). Semi-structured interviews were conducted and analysis revealed six Group Experiential Themes and six sub-themes: 'feeling threatened and unsafe', 'vicarious emotional toll', 'deeper empathy and compassion', 'bask in their glory, 'safe and supported', and 'not bottom of the pile'. Findings indicated the importance of a psychologically safe and supportive work environment where administrative staff feel able to share their experiences and feelings without judgement. Administrative staff may benefit from reflective practice, formulation focused sessions, conflict-management training and access to peer support. This is one of the only emerging studies considering the emotional needs and wellbeing of administrative staff, further research is needed in both FMHS's and other healthcare settings.

Paper 3 is an executive summary that provides an accessible version of the empirical study. Four participants provided feedback on the content and design of this executive summary in order to ensure it is accessible and understandable. This paper will be disseminated to the participants, alongside leadership/ management of Forensic Mental Health Services within the NHS. The aims, method, results, implications, limitations and future research are summarised.

Paper 1

What are the risk and mitigating factors of secondary traumatic stress in frontline staff working in domestic and sexual violence services? A literature review

This review has been written in accordance with author guidelines from the *Journal of Occupational Health Sciences* with the intention of publication. A summary of submission guidelines can be found in Appendix 4.

Abstract

Frontline staff who work in domestic and sexual violence services, such as advocates and shelter-workers, are at risk of secondary traumatic stress (STS), compassion fatigue (CF) and vicarious trauma (VT). Despite this, there is limited research exploring the risk and mitigating factors of empathy-based stress in individuals who work in these frontline roles. This review aims to synthesise risk and mitigating factors of STS, CF and VT (STS) in frontline staff. Several databases were searched and studies were selected for inclusion if a quantitative design was utilised, fifty-percent of the sample was frontline staff, and validated measures of STS were used. Eleven studies were identified, critically appraised and synthesised. Individual-level risk factors, including age, were identified. However, organisational-level factors, including direct hours working with victims and workload, accounted for greater variation in STS. Mitigating factors, including supervision and social support were also identified. Domestic and sexual violence services should aim to empower frontline staff, alongside ensuring sufficient and high quality formal and informal support is provided. The rigor of the findings are limited by challenges in how STS, CF and VT are defined and operationalised, in addition to methodological limitations of the included studies.

Key words: Secondary traumatic stress, vicarious trauma, compassion fatigue, domestic and sexual violence, frontline staff

<u>**1.0 Introduction**</u>:

Domestic and sexual violence interventions comprise of various services; including crisis hotline support, emergency shelter provision and advocacy. Services aim to ensure the safety of victims, advocate for their needs, manage distress and support the development of coping strategies (Macy et al., 2018). Experiencing domestic and sexual violence is linked to significant psychological, physical and emotional distress. Sexual and domestic violence is associated with the highest levels of Post Traumatic Stress Disorder (PTSD) (DSM-5; American Psychiatric Association, 2013) compared to other traumas (Kessler, 1995). As such, frontline staff working in domestic and sexual violence services can see people immediately after these traumatic experiences. The negative impacts that are frequently found in professionals working with individuals who have experienced trauma include secondary traumatic stress (STS; Figley, 1995a), vicarious traumatisation (VT; McCann & Pearlman, 1990) and compassion fatigue (CF; Figley, 1995b). Despite the potential traumatic effects on frontline staff, there is currently limited consideration given to these individuals.

STS, VT AND CF

The term STS originated from Figley (1995a), who summarised STS as stress resulting from helping people who have experienced trauma. There is great overlap in symptoms of STS and PTSD, with individuals re-experiencing the client's traumatic events through flashbacks, intrusive thoughts, nightmares, avoidance, hyper-arousal and depression (Bride, 2007). This symptomology is a direct result of the practitioners work with traumatised clients, rather than due to personal traumatic experiences.

CF was also coined by Figley (1995b) and was referred to as "the cost of caring", where a practitioner experiences physical and emotional exhaustion, and feelings of helplessness due to providing care and compassion to individuals who have experienced trauma. CF results in difficulties feeling and conveying consideration, empathy and support to others (Hofmann, 2009). CF is seen as interchangeable with STS in some publications (Robins et al. 2009), whereas others define CF as the combination of STS and symptoms of burnout (Stamm, 2010). Although burnout may also be present in CF/STS (Bride et al., 2007), burnout is an expansive process that

occurs over time due to excessive demands and heightened work stressors, and does not necessarily relate to trauma work (Staudt & Williams-Hayes, 2019).

VT refers to cumulative and longstanding changes in practitioner's cognitive schemas, whereby beliefs about how an individual views themselves, others and the world are negatively impacted. This may present as practitioners feeling powerless, having difficulty trusting others, feeling unsafe and experiencing low self-esteem (Mcann & Pearlman, 1990). Despite discrete differences in symptomology; STS, CF and VT are often used interchangeably to refer to the impact of working with traumatised individuals (Bride et al., 2007). Rauvola et el. (2019) developed the Empathy-based Stress Process model, which refers to the accumulation of STS, CF and VT constructs. The stress process depends on second-hand trauma exposure and the engagement in compassionate practice, but is also impacted by individual (i.e., demographic factors) and contextual factors (i.e., frequency of trauma exposure and available support) that may cause individuals in certain environments to experience empathy-based stress.

The impact of trauma work appears to vary between individuals and literature has explored possible risk and mitigating factors of STS, VT and CF. The existing literature suggests caseload volume, frequent contact with clients who had experienced trauma, personal trauma history (Hensel et al., 2015), having a caseload high in sexual violence (Schauben & Fraizer, 1995), and limited social and supervisory support at work (Choi et al., 2011) are strong predictors of STS, VT and CF in healthcare professionals. Whereas, demographic variables such as age have not been found to be a strong predictor (Hensel et al., 2015). The organisational environment has a profound influence on workforce wellbeing (Handran, 2015). Limited organisational support and trauma informed systems of care have been identified as predictors of STS (Christian-Brandt et al., 2020; Crivatu et al., 2023).

Frontline staff working in Domestic and Sexual Violence Services (frontline staff)

Frontline staff are individuals who have direct contact with victims of domestic and sexual violence. These jobs are often called advocates, shelter/ refuge workers, helpline workers and support workers. These individuals are often the first people victims of sexual and domestic violence meet, and therefore are often placed in high-

stress and crisis situations. This can include hearing the traumatic stories first-hand, seeing victims return to unsafe environments, arranging legal and medical appointments and dealing with hostile perpetrators (Iliffe & Steed, 2000; Hellman & House, 2006; Wegrzyn et al., 2023).

Compared to other human service and health-care roles such as nurses and social workers, frontline staff are often not formally trained, can be unpaid and often work in these roles due to their own experiences of utilising support from domestic and sexual violence services (Baird & Jenkins, 2003; Ullman & Townsend, 2007; Wasco & Campbell, 2002). In addition to partaking in various emotionally demanding activities, frontline staff work in settings that vary immensely in organisational support and workplace standards; including shelters, legal settings, crisis centres and community health centres (Goodman & Epstein, 2008). Research has indicated that advocates have difficulty coping with workplace stressors (Powell-Williams et al., 2013), with Howlett and Collins (2014) identifying that VT was linked to workplace stigma associated with showing vulnerability.

Frontline staff are at risk of developing STS, CF and VT, as they are experiencing daily secondary exposure to their clients' trauma. Despite their central role in supporting victims of domestic and sexual violence, research on risk and mitigating factors of STS, VT and CF is limited compared to healthcare professionals.

1.1 Rationale and aims for review:

This review focuses on research exploring STS, CF and VT within frontline staff. Published research have used the terms STS, VT and CF interchangeably and there are no clear definitions of each. Therefore, although this review recognises their different natures, it will use the umbrella term "secondary traumatic stress" to describe all symptoms, including STS, CF and VT. This is supported by other systematic reviews (Greinacher et al., 2019; Leung et al., 2022). The terminology used in this review can be found in Appendix 2.

The review question was: 'What are the risk and mitigating factors of STS in frontline staff working in domestic and sexual violence services?' Currently, there are no literature reviews conducted within this area. The aim of this review is to provide a greater understanding of the factors that may lead to the development of STS within

frontline staff, alongside factors that can mitigate STS. This is with the aim to identify considerations for practice to prevent the development of STS.

2.0 Method:

2.1 Scoping searches:

Scoping searches were initially undertaken using Google Scholar during January 2023. A search of the Cochrane Database was completed to determine the viability of the review, and to ensure there were no existing reviews on this topic. The searches evidenced the reviews viability, with appropriate literature identified and to the authors knowledge no previous reviews had been published on this topic.

2.2 Search strategy:

A systematic search was completed between February and March 2023. Five databases were used for this review: PsychInfo, Medline, Scopus, Pubmed and Staffordshire University Library database (made up of EBSCOhost, Science Direct, Taylor & Francis, SAGE complete, SpringerLink, Wiley Online Library). Reference lists of selected papers were hand-searched and citation searches of included papers were conducted using Google Scholar. Search results were screened by title and abstract. The search terms (table 1) were grouped into three groups. Group 1 related to STS, group 2 included frontline staff, and group 3 included terms to identify domestic and sexual violence services. Search terms were developed after the scoping exercise through identifying words commonly found in published research and literature, consultation with an academic supervisor and using an online thesaurus.

Table 1: Search terms

Vicarious trauma* OR Secondary traumatic stress OR secondary trauma* OR compassion fatigue	AND	Advocate OR Advoc* OR Sexual Violence Advisers OR Rape Crisis helpline OR Helpline OR Rape Crisis shelter OR Support* OR Refuge OR Outreach Worker OR Crisis House Support Worker OR Shelter	AND	domestic violence OR domestic abuse OR domestic assault OR intimate partner violence OR intra-familial violence OR family violence OR spousal abuse OR rape OR sexual assault OR sexual offence OR sexual violence OR sexual exploitation OR coercive control OR emotional abuse OR physical abuse OR psychological abuse OR abuse* OR physical violence

2.2.1 Eligibility criteria

Table 2 shows the inclusion and exclusion criteria (Cooke et al., 2012).

Table 2: Eligibility criteria

Criteria	Inclusion	Exclusion
Sample	Frontline staff (i.e. advocate) working in domestic and sexual violence services	Studies that solely include participants who are qualified professionals (i.e. therapists)
	At least 50% of sample are in frontline facing roles or the sample can be isolated from other subgroups.	Participants who do not have direct contact with victims of domestic and/or sexual violence
Phenomenon of Interest	Risk and/or mitigating factors of STS, VT and/or CF	
Design	Associations and/or predictors of variables (i.e. correlations or regression)	Qualitative research
Evaluation	Validated measures of STS, VT and CF	
Language	English	

2.3 Publication bias

Publication bias is defined as the failure to publish literature due to the direction or strength of the findings (DeVito & Goldacre, 2018). Grey literature was searched using Proquest and OpenGrey databases. Four unpublished doctoral theses were identified. Studies not written in English were excluded from this review, however, no non-English articles were found to be relevant.

2.4 Search outcome:

The search results and selection process are detailed in Figure 1 (Page et al., 2021). At first, 1144 articles were identified by the databases and other sources. 517 duplicates were removed, leaving 627 articles to be screened by title and abstract. 574 articles were excluded. The remaining 53 articles were fully read, which resulted in 42 being excluded due to not meeting eligibility criteria. Eleven studies were identified to be included in this review.

Fig. 1 *Flow chart demonstrating literature review search strategy*

Identification

Open grey = 6

PsychInfo = 226

Medline = 118

Scopus = 188

Proquest = 250

Staffordshire University Database = 216

Pubmed = 135

Reference searching/ google scholar = 5

Total search results: 1144

517 duplicates removed

Screening

627 articles screened by title and abstract

574 articles excluded by title and abstract

Eligibility

53 full text articles assessed for eligibility

Full text articles excluded:

17 = not investigating STS

5 = Not investigating domestic/sexual violence

11 = qualitative research

4 = frontline staff not part of sample: family/friends (n=2), therapists (n=2)

5 = did not use standardised measure of STS

Included

Articles included meeting inclusion criteria (n=11)

2.5 Critical Appraisal:

The eleven articles were critically appraised to assess methodological quality. This was completed using the Crowe Critical Appraisal Tool v1.4 (CCAT) (Crowe, 2013; Crowe & Sheppard, 2011). This tool is valid and reliable in appraising a variety of research designs, including cross-sectional (Crowe et al., 2011). The tool evaluates eight components of the research; preliminaries, introduction, design, sampling, data-collection, ethical matters, results and discussion. Each area is appraised as either "present", "absent", or "non-applicable", with each component being scored from 0-5. The maximum score is 40, with higher scores indicating greater overall quality of the article. Through using the user-guide each score can be calculated as a percentage, in order to support comparisons across the individual studies.

2.6 Synthesis:

A narrative synthesis was performed to synthesise the findings of the eleven studies. This was chosen due to the range of studies included in this review.

3 Results:

3.1 Overview of studies

All studies utilised a quantitative cross-sectional design, took place in the USA and were published between 2009 and 2022. See table two and appendix three for study summaries. A range of risk and mitigating factors were considered across the eleven studies. Demographic variables included: age, ethnicity, education, years of experience, self-care strategies, burnout, compassion satisfaction, and whether the individual had a personal trauma history (victim status). The following variables were considered for organisational level factors: supervision (type, quality and frequency), caseload, role, hours working with victims, total hours worked, type of victims, tasks performed, workplace support and trauma informed practice.

Table 2: Table of characteristics

Author & Year	Sample	Methodology	Risk and mitigating factors of STS	Findings	CCAT score (/40) (%)
Benuto et al. (2018)	135 victim advocates	Demographic questionnaire. Secondary Traumatic Stress Scale (STSS) (Bride, 2004)	• Direct hours working with victims • Total hours • Personal history of trauma (victim status) • Years of experience • Services provided • Type of victims	Total hours worked per week (P = 0.02) and direct hours working with victims (P = 0.047) were significant predictors of STS. Victim status was not a significant predictor. Types of services provided by advocates did not predict STS. Only working with adult survivors of childhood sexual abuse was significant predictor of STS (P = 0.008).	29 (73%)
Benuto et al. (2019)	142 victim advocates	Demographic questionnaire Unvalidated self-report questionnaire: Work Support Questionnaire. STSS	• Victim status • Years of experience • Direct hours working with victims • Workplace support	Victim status and years of experience did not relate to STS. Number of direct hours working with victims was associated with higher STS scores (P<0.05) Availability of formal emotional support, educational support or mindfulness-based interventions did not reduce rates of STS.	27 (68%)
Cummings et al. (2021)	132 victim advocates.	Demographic questionnaire	• Burnout • Compassion satisfaction	Burnout accounted for 47.3% of variance in STS (P<0.001), and 45.8% of variance in VT (P<0.001). Compassion	29 (73%)

		Vicarious Trauma Scale (VTS) (Vrklevski & Franklin, 2008). STSS Professional Quality of Life Scale (ProQOL) (Figley, 1995).	22	satisfaction contributed an additional 3.9% variance in STS and 0.6% variance in VT. This indicated that burnout is a strong predictor of VT and STS, but CS may serve as a mitigating factor against experiencing both.	
Dworkin et al. (2016).	164 individuals who work in a rape crisis centre. 36.6 % were advocates. 63.4% were non-advocates.	Demographic questionnaire Posttraumatic Checklist-Civilian Version (PCL-C) (Weathers et al. 1994) Sexual Assault History: Sexual Experiences Survey (Koss et al. 2004)	- Age - Supervision frequency (advocate vs non-advocate) - Caseload - Victim status - Race - Role (advocate vs non advocate)	Individual-level analysis: Race, role and caseload was not significantly associated with STS. Supervision frequency was inversely associated with STS in non-advocates, in comparison to advocates (p<0.05) Age was inversely related to STS (P<0.01) Victim status was associated with higher levels of STS (P<0.01) Setting-level analysis: Higher levels of STS in staff who had less supervision (P<0.01) and larger caseloads (P<0.05).	27 (68%)

Foley (2020)	89 employees from Kentucky's 15 Domestic Crisis Programs 29.3 % advocates (non-residential, residential and child) 9.8% Shelter worker 4.3% Hotline worker	Demographic questionnaire Personal trauma history measured by Life Events Checklist-5 (LEC-5) (Weathers et al., 2013) Ticometer © (Bassuk et al. 2017) STSS	• Trauma history • Organisational Trauma Informed Care (TIC) • Age • Full time status • Length of time in role • Direct hours working with victims	28.8% of the variance in STS was explained by trauma history severity and the perceived level of organizational TIC (P<0.024). For every increase in severity of victim status, STS increases by 0.11 points on STSS. As organisations level of TIC increases by one unit, STS decreases by 0.28 points. 12.6% of variance in STS can be explained by trauma informed delivery domain of Ticometer (P<0.006). STS decreases by 1.07 points on STSS for every one unit increase in trauma informed service delivery. No other variables were significant predictors of STS.	29 (73%)
Hooft & Benuto (2016).	107 victim advocates	Demographic questionnaire STSS VTS ProQOL	• Marital status • Education • Income • Ethnicity • Victim status • Support • Years of experience • Hours worked • Direct hours working with victims • Victim types • No. of tasks performed	Ethnicity (P=0.442), marital status (P=0.402), education level (P=0.608), income (P=0.250), victim status (P=0.785), systems of support (P=0.099), victim types (P=0.06), number of tasks performed (P=0.08) and years of experience were not associated with STS, VT and CF.	28 (70%)

			• Self-care strategies	Hours worked (P=0.001), direct hours with victims (P=0.044) and avoidant self-care strategies was associated with STS (P=0.04).	
Kulkarni et al. (2013).	236 domestic violence service providers. 30.2% advocates. 16.5% shelter workers	Demographic questionnaire Shortened version of Traumatic Life Event Questionnaire (Kubany et al., 2000) The Areas of Worklife Scale (AWS) (Leiter & Maslach, 2006) ProQol.	• Gender • Age • Marital status • Education • Role • Trauma history • Months of experience • Direct hours working with victims • Quality of supervision • Coping strategies • AWS Subscales (workload, control, community, rewards, fairness, values)	Greater time in self-care was associated with lower levels of STS (P<0.05). Greater time in leisure activities was associated with higher levels of STS (P<0.05). AWS subscales was entered into regression. Workload perceptions (P<0.001) and control perceptions (P<0.05) were associated with STS. The final model accounted for 25% variance, with AWS accounting for 17% of total variance (P<0.001). All other variables were not significant predictors of STS.	32 (80%)

Voth-Schrag et al. (2022)	520 employees working in domestic violence and sexual assault organisations. 58.7% advocates (advocate, medical, legal and children's) 5.3% shelter staff	Demographic questionnaire Burnout and STS subscales of the ProQOL, AWS	• Age • Years of experience • Race • Victim status • Recent stress • No. of staff • Direct practice with victims • Supervision • Exposure to micro-aggressions • AWS Subscales	Regression 1 – individual factors: 12% of variance in CF. Age (P<0.001), years of experience (P<0.001), not identifying as Latinx (P<0.001), recent stressors (P<0.00) were significant predictors of CF. Regression 2 - organisational variables: 37% of variance in CF. Age, not identifying as Latinx and recent stressors remained significant. Organisational factors that predicted CF: direct contact with victims (P=0.00), exposure to workplace micro-aggressions (P=0.04) and higher reported workload (P=0.00).	30 (75%)
Slattery & Goodman (2009)	148 female domestic violence workers	Demographic questionnaire PTSD Checklist-Stressor Specific Version (PCL-S) (Weathers et al., 1993) Co-worker Cohesion Subscale of the Work Environment	• Victim status • Direct hours working with victims • Co-worker support • Quality of supervision • Shared power	Correlations: Co-worker support and shared power was negatively correlated with STS (P<0.01), quality of clinical supervision was negatively correlated (P<0.01). Regression: Victim status was the only significant individual variable that	29 (73%)

		Scale (Moos, 1994). Clinical Supervision Quality: mentor subscale of the Relational Health Index (Liang et al. 2002). Unvalidated questionnaire: the Shared Power Scale	26	predicted STS, explaining 8% of variance in the model (P<0.003). Direct hours was non-significant (P=0.178). When workplace factors were entered into the model, shared power was the only workplace factor that predicted STS, explaining 11% of variance in the model (P<0.010). This indicated that advocates who perceived their workplace as empowering were less likely to report symptoms of STS.	
Strange (2014)	164 female rape crisis medical advocates.	Demographic questionnaire Copenhagen Psychosocial Questionnaire (COPSOQ) (Kristensen et al., 2005). The Trauma and Attachment Belief Scale (Pearlman, 2003).	• Age • Education • Experience • Caseload • Individual supervision • Group supervision • Social community at work • Meaning of work • Emotional demands of work	Education (P<0.025), Age (P<0.005), amount of formal group supervision (P<0.005) social community (P<0.025) and meaning of the work (P<0.001) negatively predicted VT, Overall, the variables accounted for 24% of the variance in ratings of VT.	31 (78%)

| Tolerico (2017) | 44 female sexual assault advocates. | Demographic questionnaire

STSS

Inner Strength Scale (Lundman et al., 2011) | • Inner strength
• Victim status
• length of time in role | A significant negative correlation was found between STS and Inner Strength (P=0.001).

There was no significant difference between STSS and ISS scores for victim status (P=0.710).

There was no significant difference between STSS and ISS scores for length of time in role (P=0.628). | 30 (75%) |

3.2 Participants and settings

There was a range of 44-520 participants across the studies. The total number of participants across the 11 studies was 1881. On average 96.3% of the sample were female, with three studies having all female participants (Slattery & Goodman, 2009; Strange, 2014 and Tolerico, 2017). Dworkin et al. (2016) and Voth-Schrag et al. (2022) did not report gender. Participants' average age was 38 years old. Of the seven studies that reported ethnicity, 84.1% of the overall sample identified as White, with the remaining consisting of Latinx, Black/ African American and Asian America. Of the 11 studies, seven had participants in advocate roles (Benuto et al., 2018; Benuto et al., 2019; Cummings et al., 2021; Hooft & Benuto, 2016; Slattery & Goodman, 2009; Strange, 2014; Tolerico, 2017). Of the four studies that had a variety of roles that made up the sample, on average 38.7% of the sample were in advocate roles, with only 11.5% in other frontline facing roles, such as shelter or hotline workers (Dworkin et al., 2016; Foley, 2020; Voth-Schrag et al. 2022[1]; Kulkarni et al., 2013).

Eight studies provided an average for years of experience, which was 6.9 years (Benuto, 2018; Cummings et al., 2021; Dworkin et al., 2016; Foley, 2020; Hooft & Benuto, 2016; Kulkarni et al., 2013; Voth-Schrag et al., 2022; Strange, 2014). Four studies reported average weekly hours working with victims, which was across 25.07 hours (Benuto et al., 2018; Cummings et al., 2021; Hooft & Benuto, 2016; Kulkarni et al., 2013). An average of 58.75% of participants in nine studies had a trauma history (Beunto et al., 2018; Benuto et al., 2019; Cummings et al., 2021; Dworkin et al., 2016; Hooft & Benuto, 2016; Kulkarni et al., 2013; Voth-Schrag et al., 2022; Slattery & Goodman, 2009; Tolerico, 2017).

The staff participating in these studies were employed in various settings, including rape crisis centres (Strange, 2014; Dworkin et al., 2016; Tolerico, 2017) and domestic violence services (Foley, 2020; Kulkarni et al., 2013). Some studies recruited from various services, including dual domestic and sexual violence agencies, social services, legal and medical settings, shelters and hospitals (Benuto et al., 2018; Benuto et al., 2019; Hooft & Benuto, 2016; Cummings et al., 2021; Voth-Schrag et al., 2022[1]; Slattery & Goodman, 2009).

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[1] Sample was isolated by personal communication with author

3.3 Measures

Six self-report measures were used to measure STS across the eleven studies. The Secondary Traumatic Stress Scale (STSS; Bride, 2004) was utilised by Benuto et al. (2018), Benuto et al. (2019), Foley (2020) and Tolerico (2017). The Professional Quality of Life Scale (ProQOL; Figley, 1995; Stamm, 2005) contains subscales that measure CF, CS and burnout. In the current review, the ProQOL was utilised by Voth-Schrag et al. (2022) and Kulkarni et al. (2013). The PTSD Checklist (PCL; Weathers et al., 1994) measures the DSM-IV symptoms of PTSD. Three versions of the PCL exist, a military version (PCL-M), a civilian version (PCL-C) and a specific version (PCL-S). The PCL-S was utilised by Slattery and Goodman (2009) to measure PTSD symptoms linked to stressful experiences regarding specific events. The PCL-C was utilised by Dworkin et al. (2016) to measure PTSD symptoms linked to multiple traumatic experiences. The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003), which measures the effects of VT was utilised by Strange (2014). Cummings et al. (2021) and Hooft & Benuto (2016) utilised three measures of STS, these were STSS, ProQOL and The Vicarious Trauma Scale (VTS; Vrklevski & Franklin, 2008).

All studies utilised valid and reliable measures to assess for STS. The STSS, ProQOL, PCL-S, PCL-C, TABS and VTS all have good psychometric properties (Bride et al., 2004; Hemsworth et al., 2018; Weathers et al., 1993; Pearlman, 2003; Vrklevski & Franklin, 2008). Benuto et al. (2021) completed a confirmatory factor analysis of the STSS on a sample of victim advocates, finding that the STSS did demonstrate high reliability within the population. Cummings et al. (2021) found that within a population of victim advocates the STS subscale of the ProQOL was highly correlated with the STSS, indicating a high concurrent validity between measures. However, Tolerico (2017) adapted the STSS to assess for STS over 30 days rather than the recommended 7 days. Additionally, Dworkin et al. (2016) utilised a 6-point Likert scale, rather than a 5-point Likert scale on the PCL-S. These adaptions from the standardised measures should be considered when comparing results across studies.

3.4 Analysis

The main analysis used was regression, with some studies also utilising correlational analysis and tests of difference such as T-Tests. Regression was utilised by eight studies (Benuto et al., 2019; Benuto et al., 2018; Cummings et al., 2021; Foley, 2020; Kulkarni et al., 2013; Slattery & Goodman, 2009; Strange, 2014; Voth-Schragg et al., 2022). One study utilised multi-level modelling analysis (Dworkin et al., 2016). No studies reported the effect size between variables.

3.4 Critical Appraisal

Appendix 1 provides a summary of the scores given for each sub-section of the CCAT. Of note, four studies are unpublished theses (Strange, 2014; Foley, 2020; Hooft & Benuto, 2016; Tolerico, 2017), and therefore have not been peer reviewed. The CCAT does not provide categorisation of scores, however, as suggested by Singh et al. (2020) the following categorisations were used "poor" (<27), "average" (28-31), "good" (32-35) and "very good" (>35) based on quartile ranks. Two studies were categorised as poor (Benuto et al., 2019; Dworkin et al., 2016), and the remaining nine studies were categorised as average. Reporting ethical issues were omitted from several papers, such as clearly stating how participant confidentiality/ anonymity was ensured (Slattery & Goodman, 2009; Benuto et al., 2019; Benuto et al., 2018; Cummings et al., 2021; Tolerico, 2017 Dworkin et al.,, 2016; Kulkarni et al., 2013). This impacted on the overall CCAT scores.

Transparent and appropriate recruitment procedures were detailed by the majority of studies. However, three studies provided insufficient detail on the settings that participants were recruited from (Benuto et al., 2018; Benuto et al., 2019; Cummings et al., 2021), which limits replicability and generalisability. None of the studies provided information on how many participants withdrew from the research, and therefore the impact of attrition bias could not be considered. A response rate of 50-60% or greater is recommended as a means to control for the impact of non-response bias (Finchman, 2008). None of the studies included in this review reported response rates, which increases sampling bias and limits the representativeness of the studies, although this limitation was acknowledged in some of the papers. In addition, only two studies used a power analysis to detect an effect (Tolerico, 2017; Kulkarni et al., 2013), and therefore it is difficult to determine whether the study

results were genuine or due to chance. Despite the use of valid and reliable measures of the dependent variable, several studies utilised other unstandardised measures which impacted the overall CCAT scores.

3.6 Main findings

Risk factors for STS

This review identified multiple risk factors that may increase the likelihood of frontline staff developing STS. The eleven papers included in this review identified individual and organisational level risk factors.

Overview of individual level factors

Nine studies examined whether victim status was a risk factor for STS. The findings indicated mixed results, with six studies identifying that victim status was not a significant risk factor for STS (Benuto et al., 2018; Benuto et al., 2019; Hooft & Benuto, 2016; Kulkarni et al., 2013; Voth-Schrag et al., 2022; Tolerico, 2017), and three studies identifying that it was (Dworkin et al., 2016; Foley, 2020; Slattery & Goodman, 2009). Voth-Schrag et al. (2022) identified that recent life stressors such as health concerns; alongside experiencing workplace micro-aggressions was a significant predictor of STS.

Four studies explored the age of advocates as a possible risk factor. Three studies found a significant negative relationship between age and STS levels, indicating that younger staff face increased risk of developing STS (Dworkin et al., 2016; Strange, 2014; Voth-Schrag et al., 2022). Foley (2020) identified that age was not a significant risk factor, however, commented that this variable was reaching significance and a larger sample may have been required.

The ethnicity of advocates was examined by three studies. Dworkin et al. (2016) and Hooft and Benuto (2016) identified that ethnicity was not significantly associated with STS. In contrast, Voth-Schrag et al. (2022) found that in comparison to Non-Latinx, Latinx participants were less likely to develop STS. Tolerico (2017) was the only study that explored sexual orientation, finding a significant difference in STSS scores and sexual orientation, with STS being greater in frontline staff who identified as bisexual in comparison to heterosexual. In addition, smoking and alcohol

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consumption (Hooft & Benuto, 2016) and passive/ avoidant leisure time (Kulkarni et al., 2013) were both identified as risk factors for STS.

Years of experience was investigated by seven studies. Six studies identified that amount of years was not a significant risk factor of STS (Benuto et al., 2018; Benuto et al., 2019; Foley, 2020; Hooft & Benuto, Strange, 2014; Tolerico, 2017). Conversely, Voth-Schrag (2022) found that less years of experience was a significant predictor of STS, however, when organisational level factors were entered into the analysis this was no longer significant.

Overview of organisational level factors

Most studies investigated whether amount of hours working as an advocate was a risk factor for STS. Both Benuto et al. (2018) and Hooft and Benuto (2016) found that total hours worked each week was a risk factor for STS. Five studies explored whether direct hours supporting victims was a risk factor for STS. Four studies found that direct service hours was predictive of STS (Benuto et al., 2018; Benuto et al., 2019; Hooft & Benuto, 2016; Voth-Schrag, 2022) and one did not (Slattery & Goodman, 2009). Caseload and workload was investigated. Dworkin et al. (2016) found that larger caseloads was a risk factor for STS, whereas Strange (2014) did not. Both Kulkarni et al. (2013) and Voth-Schrag et al. (2022) found that workload was a significant predictor for STS.

Three studies explored the impact of the role of an advocate on STS. Benuto et al. (2018) separated the role into advocacy services, support services, logistical services and the provision of information; finding that the types of services provided by advocates did not impact STS. Similarly, perceptions of exposure to emotionally demanding work (Strange, 2014) and the number of activity types (Hooft & Benuto, 2016) was not related to STS. In terms of type of victims supported, Hooft and Benuto (2016) found that victim type was not related to STS, whereas Benuto et al. (2018) found that working with adult survivors of childhood sexual assault significantly predicted STS, in comparison to working with child and adult victims of sexual assault and domestic violence.

A lack of work autonomy was investigated as a risk factor for STS. Slattery and Goodman (2009) explored whether access to power, such as being treated fairly, being respected and leadership opportunities, predicted STS in advocates. A

negative relationship was found between access to power and STS, highlighting advocates who identified less access to power in the workplace were more likely to experience symptoms of STS. Similarly, two studies investigated advocates perception of control in the workplace. Kulkarni et al. (2013) found that perceived control was inversely related to STS, with STS being greater in advocates who felt they had less control. However, Voth-Schrag et al. (2022) did not find perceptions of control a significant risk factor of STS. Cummings et al. (2021) identified that burnout was a significant predictor of STS.

Mitigating factors of STS

On an individual level, Tolerico (2017) investigated inner strength (i.e. creativity and flexibility) in advocates, finding a significant negative relationship between inner strength and STS. Strange (2014) found that participants who identified their work as meaningful experienced lower levels of STS. In addition, Kulkarni et al. (2013) identified that greater time spent in self-care activities correlated with lower levels of STS.

Different kinds of support were investigated as a mitigating factor of STS in numerous studies. Benuto et al. (2019) identified that advocates in their sample were offered workplace support through mindfulness-based interventions and emotional and educational support. However, a significant relationship between workplace support and STS was not found. Foley (2020) investigated trauma- informed practice of services, finding that trauma-informed service delivery was a significant mitigating factor of STS where services supported greater control, predictability and empowerment of staff members.

Social support was also explored. Strange (2014) identified that greater quality of social community at work negatively predicted STS in advocates. Slattery and Goodman (2009) found participants who received higher levels of support from co-workers had lower levels of STS. Conversely, Hooft and Benuto (2016) found that although workplace support was significantly associated with compassion satisfaction, it was not associated with STS. Cummings et al. (2021) identified increased levels of compassion satisfaction decreased levels of burnout and consequently decreased levels of STS.

Supervision was also investigated. Dworkin et al. (2016) found that on an individual level, higher frequency of supervision was not associated with lower levels of STS in advocates, in comparison to non-advocates. However, on an agency-level advocates who received more supervision had lower levels of STS. This was contrasted by Voth-Schrag et al. (2022) who found a significant association with supervision satisfaction and lower levels of STS when completing bivariate analysis, but this did not remain significant when other variables were included in multivariate analysis. Slattery and Goodman (2009) identified that advocates who experienced high quality supervision had lower levels of STS. Strange (2014) identified that although frequency of individual supervision did not predict lower levels of STS, frequency of group supervision did.

Comparison of Individual and Organisational factors

Five studies compared whether individual or organisational level factors explained the most variation in STS. All five studies found that organisational factors accounted for the most variation in comparison to individual level factors (Dworkin et al., 2016; Strange, 2014; Voth-Schrag et al., 2022; Kulkarni et al., 2013). However, Slattery and Goodman (2009) found access to power was the only workplace variable to significantly predict STS above individual factors.

4.0 Discussion

This review aimed to synthesise research on risk and mitigating factors of STS in frontline staff within domestic and sexual violence services. Eleven studies were systematically identified, reviewed and critically appraised. The appraisal demonstrated limitations in research quality, with studies rated as either "poor" or "average", meaning the results should be cautiously interpreted. The results of this review are ambiguous, with some risk and mitigating factors being significant across numerous studies, whereas associations between others are less clear-cut. It is also important to note that of the eight studies that explored which risk and mitigating factors predicted STS, no variables accounted for 100% of explained variance. Therefore, it is likely that other variables or contextual factors will influence STS in frontline staff.

Systematic reviews by Hensel et al. (2015) and Leung et al. (2022) identified that victim status was a significant risk factor for STS in mental health workers. Victim

status increases vulnerability to resource fatigue (Ben-Porat & Itzhaky, 2015) and subsequent exposure to traumatic events can increase the risk of STS through reminders of their own traumatic experiences (Figley, 2002). Fifty-eight percent of participants reported a personal trauma history in the nine studies investigating it as a risk factor. Surprisingly, six of these studies did not find that victim status was a risk factor of STS. It is unclear why this may be; perhaps frontline-staff use their experiences of supporting victims of domestic and sexual violence to heal from their own personal experiences (Michalopulos & Aparcio, 2012). However, another factor to consider is how victim status was ascertained. Four of these studies used a categorical variable, simply asking participants to report yes/no on whether they were a victim of trauma. This measurement is questionable, for example, Jones et al. (2009) reported that victims of sexual assault often do not recognise that they have experienced a trauma. In contrast, two of the studies that found a significant association between victim status and STS utilised a standardised measure that included a list of events. Therefore, as suggested by Armes et al. (2020) and Leung et al. (2022), future research should investigate the role of victim status through providing a list of events with behaviourally defined terms.

This review found that years of experience was not a predictor of STS. However, age appeared to strongly predict STS, with younger staff experiencing greater levels of STS. This is consistent with previous literature (Michalopoulous & Aparicio, 2012; Kadambi & Truscott, 2004; Way et al., 2004), which indicates that newer staff members are at greater risk for STS, whereas older employees may have reached higher positions and established a greater professional identity (Xie et al., 2021).

Some individual level risk factors in this review were not sufficiently investigated to draw meaningful conclusions. More research is required in order to understand whether ethnicity, education, sexual orientation and burnout are risk factors for STS, in addition to the role of compassion satisfaction. Furthermore, research has indicated that avoidant and passive coping strategies (such as alcohol consumption) are a risk factor for STS in roles such as social workers and professionals working with refugees (Gil & Weinberg, 2016; Vukcevic-Markovic & Zivanovic, 2022) and therefore, would benefit from greater research in frontline staff.

While this review highlights individual level risk/mitigating factors of STS, an interesting finding was that organisational factors accounted for the most variation. This finding is also apparent in other research. Hensel et al. (2015) identified that demographic factors did not predict levels of STS in mental health workers. Rakestraw (2021) explored STS in employees working in children's advocacy centres, finding that low organisational support was the largest predictor of STS. Additionally, Brady et al. (2019) suggested that work-related factors primarily predicted STS among forensic interviewers.

Although there were some inconsistencies within the findings, the results indicate that direct hours with victims of sexual and domestic violence, in addition to overall workload is predictive of STS. Whereas the day-to-day activities of frontline staff does not seem to be associated with STS. Additionally, although there were some discrepancies the findings suggest that a lack of autonomy in the workplace may be a risk factor of STS.

Considering mitigating factors, findings were mixed regarding supervision. It can be tentatively suggested that greater frequency and quality of supervision is protective against STS. One interesting finding was that group supervision was associated with lower levels for STS than individual supervision (Strange, 2014). This study also suggested that greater social support mitigates the development of STS, which may explain why group supervision may be beneficial. Houston-Kolnik et al. (2021) identified that although rape crisis advocates found peer support beneficial, they identified numerous barriers to accessing support, including fear of burdening others and not connecting with others due to cultural differences. Therefore, greater organisational commitment to encouraging culturally sensitive social support between colleagues could reduce STS levels within frontline staff.

Although research was limited, findings suggest that formal provision of training and interventions may not protect advocates against the development of STS. However, services offering trauma-informed delivery where choice, collaboration and empowerment are routinely available may mitigate the risk of STS. These findings are supported by Choi et al. (2011) who found that social support within the work environment was significantly related to lower levels of STS, whereas access to resources was not significant. Furthermore, Choi et al. (2017) demonstrated that

higher levels of psychological empowerment was related to lower levels of STS in social workers who assist with sexual assault. Psychological empowerment is defined in the literature as having autonomy, choice, self-determination and involvement in decision-making within an organisation (Spreitzer et al., 1995). Empowerment is a key principle of a trauma informed delivery (Elliot, 2005) and it has been identified that a trauma-informed organisational culture can decrease severity of STS (Hales et al., 2019; Handran; 2015; Keesler, 2020; Wolf et al., 2014). Sprang et al. (2021) identified through longitudinal investigation that organisational commitment toward becoming trauma-informed can reduce workforce STS levels.

4.1 Considerations for practice and future directions

Theories exploring the development of STS, for example the Empathy Based Stress model (Rauvola et al., 2019), identify the development and maintenance of STS as underpinned by both individual and organisational factors. Preliminary findings from this review suggest that although individual factors such as age can be predictive of STS, organisational factors may account for a greater variation in STS in frontline staff. This suggests that organisational practices are critical to reducing STS, and this review has tentatively indicated that creating and sustaining trauma-informed services may be key in mitigating STS.

A number of considerations for practice have been identified. Domestic and sexual violence services should consider approaches to empower staff through increasing autonomy, choice and shared decision-making. Services should also be aware of the potential for younger staff to face increased risk of developing STS, in addition to staff who have a trauma history and who work with childhood sexual trauma. Additionally, encouraging social and peer support may be beneficial, for example, through the option of group supervision alongside individual supervision. Services should also consider opportunities to maintain balanced work duties and workload when working with trauma, and endorse self-care within staff.

Research in this area is still in its infancy, as most studies have focused on STS in healthcare professionals. Greater high-quality research should be conducted that investigates risk and mitigating factors of STS in frontline staff, in addition to the relationship between trauma informed service delivery and STS. This may be aided through the use of a standardised measure such as Secondary Traumatic Stress

Informed – Organisational Assessment (STSI-OA) (Sprang et al., 2017), which assesses an organisations approach to the prevention and intervention of STS. Additionally, this study has highlighted a lack of research on what individual level interventions would mitigate STS, and therefore greater research would be beneficial.

4.2 Limitations of included studies

A challenge of this review was clearly defining the dependent variable, STS. In order to be included in this review studies had to quantitatively assess STS. Conceptual definitions of STS, VT and CF are not precise in the literature, with some publications using them interchangeably and others differentiating between them. For this review STS, VT and CF were referred to as "STS". Similarities have been drawn between STS and CF, with symptoms reflecting the DSM-IV criteria of PTSD. However, there is evidence that indicate they differ regarding their content validity (Jenkins & Baird, 2002), whereas VT has been conceptually linked to long-term changes in worldview.

Across the studies reviewed there seemed to be an absence in conceptual clearness regarding trauma-related symptoms and equivalent measures. For example, STS was measured by the PCL-C and PCL-S, which are measures of primary trauma (Dworkin et al., 2016; Slattery & Goodman, 2009). Likewise, the burnout, VT and STS subscales of the ProQOL were used to measure STS in one study (Kulkarni, 2013), whereas burnout and STS subscales of the ProQOL was used to measure CF in another (Voth-Schrag et al., 2022). Furthermore, two studies utilised the ProQOL, VTS and STSS to measure STS, VT, CF and burnout. Cummings et al. (2021) found that burnout, VT and STS were co-occurring within their sample. Whereas, Hooft & Benuto (2016) identified differences in findings for STS and VT. The use of measurements without considering the different underlying definitions of STS related symptoms makes the interpretation of the results challenging. Although there is great overlap in STS, VT and CF symptoms (Sprang et al., 2019; Newell & MacNeil, 2010); more research is required to explore potential differences in STS/ CF and VT in frontline staff. As recommended by Molnar et al. (2017) future research should aim to operationalise the concepts of VT, STS and CF in order to aid development of tailored outcome measures.

Although numerous risk and mitigating factors were identified, it is important to consider that all studies used a cross-sectional design. Therefore, cautious interpretation of results is required due to the possible impact of extraneous variables. Longitudinal studies are required in order to better understand this. This limitation was strengthened by the insufficient reporting of response rates and power-analysis, which made it difficult to establish if the sample included in this review are representative and whether the results were powered enough to detect a true significant effect.

It is important to note that despite the inclusion criteria for this study being a minimum of 50% of the sample being in frontline-facing roles, three studies had a slightly smaller sample (Foley, 2020; Dworkin et al., 2016; Kulkarni et al., 2013), with advocates making up on average 32% of the sample, and other roles making up on average 15%. Due to the limited number of relevant studies in this review, it was deemed important to include these findings. Therefore, it is likely that the results may be impacted by the experiences of other professions such as counsellors. It is also important to note that the searches utilised for this review were for a variety of frontline staff, including shelter, helpline and outreach workers. The sample of these workers in this review are minimal, highlighting a need for research on STS in these roles.

Although the inclusion of unpublished theses may be seen as advantageous regarding limiting publication bias, it is important to consider that four papers in this review were not peer reviewed. Four of the eleven articles being unpublished theses highlights the lack of research in this area. Additionally, all included studies were from the USA. There will be differences in domestic and sexual violence services from country-to-country and possible differences in staff roles, and therefore this needs to be considered when interpreting the results. Furthermore, three studies referenced their participant recruitment was from 75 agencies in the USA, and therefore there is likely overlap in samples. This limitation is further amplified due to establishing that findings from Cummings et al. (2021) and Benuto et al. (2019) were from the same data collection set.

4.3 Limitations of review

The Crowe Critical Appraisal Tool v1.4 (CCAT) was used to appraise the quality of the eleven studies, which allowed for consistency across the studies and a straightforward and replicable means of reporting and interpreting overall study quality. The CCAT does not provide a cut-off range, with Crowe (2013) indicating that each paper should be appraised on its own qualities and not due to any predetermined notions of a high-quality paper. Therefore, in order to aid transparency this review utilised cut off scores constructed by Singh et al. (2020), however this deviates from the original tool. Additionally, inter-rater reliability was compromised as only author EB appraised study quality. Furthermore, this review was also unable to determine the strength/ magnitude of the results, this is a limitation as although a significance level indicates whether an effect exists, it is unable to reveal the size of the effect (Sullivan & Fein, 2012).

5.0 Conclusion

The findings from this review highlighted several risk and mitigating factors for STS for frontline staff working in domestic and sexual violence services. This review has indicated that organisational factors may account for larger variation in STS, in contrast to individual-level factors, and some implications for practice have been suggested. Despite this, the rigor of these conclusions is limited by current challenges in terms of how STS, CF and VT are defined and operationalised in measures. Future research should put greater focus on STS in these roles, ensuring high quality and longitudinal designs as well as investigating preventive interventions at an organisational and individual level.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). American Psychiatric Publishing.

Armes, S. E., Lee, J. J., Bride, B. E., & Seponski, D. M. (2020). Secondary trauma and impairment in clinical social workers. *Child abuse & neglect*, *110*, 104540. https://doi.org/10.1016/j.chiabu.2020.104540

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and victims*, *18*(1), 71-86. DOI: 10.1891/vivi.2003.18.1.71

Bassuk, E., Unick, G., Paquette, K., & Richard, M. (2017). Developing an instrument to measure organizational trauma-informed care in human services: The TICOMETER. Psychology of Violence, 7(1), 150-157. http://dx.doi.org/10.1037/vio0000030

Ben-Porat, A., & Itzhaky, H. (2015). Burnout among trauma social workers: The contribution of personal and environmental resources. *Journal of Social Work*, *15*(6), 606-620. https://doi.org/10.1177/1468017314552158

Benuto, L. T., Newlands, R., Ruork, A., Hooft, S., & Ahrendt, A. (2018). Secondary traumatic stress among victim advocates: Prevalence and correlates. *Journal of evidence-informed social work*, *15*(5), 494-509. https://doi.org/10.1080/23761407.2018.1474825

Benuto, L. T., Singer, J., Gonzalez, F., Newlands, R., & Hooft, S. (2019). Supporting those who provide support: Work-related resources and secondary traumatic stress among victim advocates. *Safety and health at work*, *10*(3), 336-340. https://doi.org/10.1016/j.shaw.2019.04.001

Benuto, L. T., Yang, Y., Ahrendt, A., & Cummings, C. (2021). The secondary traumatic stress scale: confirmatory factor analyses with a national sample of victim advocates. *Journal of interpersonal violence*, *36*(5-6), 2572-2591. https://doi.org/10.1177/0886260518759657

Brady, P. Q., Fansher, A. K., & Zedaker, S. B. (2019). Are parents at a higher risk for secondary traumatic stress?: How interviewing child victims impacts relationships with forensic interviewer's friends and family. *Child Abuse & Neglect*, *88*, 275-287. https://doi.org/10.1016/j.chiabu.2018.11.017

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social work*, *52*(1), 63-70. https://doi.org/10.1093/sw/52.1.63

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on social work practice*, *14*(1), 27-35. https://doi.org/10.1177/1049731503254106

Choi, G. Y. (2011). Organizational impacts on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in social work*, *35*(3), 225-242. https://doi.org/10.1080/03643107.2011.575333

Choi, G. Y. (2017). Secondary traumatic stress and empowerment among social workers working with family violence or sexual assault survivors. *Journal of Social Work*, *17*(3), 358-378. https://doi.org/10.1177/1468017316640194

Christian-Brandt, A. S., Santacrose, D. E., & Barnett, M. L. (2020). In the trauma-informed care trenches: Teacher compassion satisfaction, secondary traumatic stress, burnout, and intent to leave education within underserved elementary schools. *Child abuse & neglect*, *110*, 104437. https://doi.org/10.1016/j.chiabu.2020.104437

Crivatu, I. M., Horvath, M. A., & Massey, K. (2023). The impacts of working with victims of sexual violence: a rapid evidence assessment. *Trauma, Violence, & Abuse*, *24*(1), 56-71. DOI: 10.1177/15248380211016024

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER Tool for Qualitative Evidence Synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Crowe, M. (2013). Crowe critical appraisal tool (CCAT) user guide. *Conchra House.*

Crowe, M., & Sheppard, L. (2011). A general critical appraisal tool: an evaluation of construct validity. *International journal of nursing studies*, *48*(12), 1505-1516. https://doi.org/10.1016/j.ijnurstu.2011.06.004

Crowe, M., Sheppard, L., & Campbell, A. (2011). Comparison of the effects of using the Crowe Critical Appraisal Tool versus informal appraisal in assessing health research: a randomised trial. *International Journal of Evidence‐Based Healthcare*, *9*(4), 444-449. https://doi.org/10.1111/j.1744-1609.2011.00237.x

Cummings, C., Singer, J., Hisaka, R., & Benuto, L. T. (2021). Compassion satisfaction to combat work-related burnout, vicarious trauma, and secondary traumatic stress. *Journal of interpersonal violence*, *36*(9-10), NP5304-NP5319. https://doi.org/10.1177/0886260518799502

DeVito, N. J., & Goldacre, B. (2018). Catalogue of bias: publication bias. *BMJ Evidence-Based Medicine*, *24*(2), 53–54. https://doi.org/10.1136/bmjebm-2018-111107

Dworkin, E. R., Sorell, N. R., & Allen, N. E. (2016). Individual-and setting-level correlates of secondary traumatic stress in rape crisis center staff. *Journal of Interpersonal Violence*, *31*(4), 743-752. https://doi.org/10.1177/0886260514556111

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of community psychology*, *33*(4), 461-477. https://doi.org/10.1002/jcop.20063

Figley, C. R. (1995a). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). Brunner/Mazel.

Figley, C. R. (1995b). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm, *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3–28). The Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of clinical psychology*, *58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Fincham, J. E. (2018). Response Rates and Responsiveness for Surveys, Standards, and the Journal. *American Journal of Pharmaceutical Education*, *72*(2), 43. https://doi.org/10.5688/aj720243

Foley, M. E. (2020). *The Relationship Between Organizational Trauma-Informed Care and Secondary Trauma Symptoms in Staff Members of Kentucky Domestic Violence Programs* (Doctoral dissertation, Western Kentucky University).

Gil, S., & Weinberg, M. (2015). Secondary trauma among social workers treating trauma clients: The role of coping strategies and internal resources. *International Social Work*, *58*(4), 551-561. https://doi.org/10.1177/0020872814564705

Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice.* American Psychological Association. https://doi.org/10.1037/11651-000

Greinacher, A., Derezza-Greeven, C., Herzog, W., & Nikendei, C. (2019). Secondary traumatization in first responders: a systematic review. *European journal of psychotraumatology*, *10*(1), 1562840. https://doi.org/10.1080/20008198.2018.1562840

Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2019). Trauma-informed care outcome study. *Research on Social Work Practice*, *29*(5), 529-539. https://doi.org/10.1177/1049731518766618

Handran, J. (2015). Trauma-informed systems of care: The role of organizational culture in the development of burnout, secondary traumatic stress, and compassion satisfaction. *Journal of Social Welfare and Human Rights*, *3*(2), 1-22. DOI: 10.15640/10.15640/jswhr.v3n2a1

Hellman, C. M., & House, D. (2006). Volunteers serving victims of sexual assault. *The Journal of social psychology*, *146*(1), 117-123. https://doi.org/10.3200/SOCP.146.1.117-123

Hemsworth, D., Baregheh, A., Aoun, S., & Kazanjian, A. (2018). A critical enquiry into the psychometric properties of the professional quality of life scale (ProQol-5) instrument. *Applied Nursing Research*, *39*, 81-88. https://doi.org/10.1016/j.apnr.2017.09.006

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of traumatic stress*, *28*(2), 83-91. https://doi.org/10.1002/jts.21998

Hofmann, P. B. (2009). Addressing compassion fatigue. The problem is not new, but it requires more urgent attention. *Healthcare Executive*, *24*(5), 40-42.

Home Office (2012). *New Definition of domestic violence* https://www.gov.uk/government/news/new-definition-of-domestic-violence

Home Office (2017). *The role of the Independent Sexual Violence Adviser: Essential Elements.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647112/The_Role_of_the_Independent_Sexual_Violence_Adviser_-_Essential_Elements_September_2017_Final.pdf

Hooft, S. & Benuto, L. T (2016). *Secondary traumatic stress, vicarious trauma, and compassion fatigue among victim advocates* (Doctoral dissertation, University of Nevada).

Houston-Kolnik, J. D., Odahl-Ruan, C. A., & Greeson, M. R. (2021). Who helps the helpers? Social support for rape crisis advocates. *Journal of interpersonal violence*, *36*(1-2), 406-427. https://doi.org/10.1177/0886260517726970

Howlett, S. L., & Collins, A. (2014). Vicarious traumatisation: Risk and resilience among crisis support volunteers in a community organisation. *South African Journal of Psychology*, *44*(2), 180-190. https://hdl.handle.net/10520/EJC153403

Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of interpersonal violence*, *15*(4), 393-412. https://doi.org/10.1177/088626000015004004

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *15*(5), 423-432. DOI: 10.1891/vivi.2003.18.1.71

Jones, J. S., Alexander, C., Wynn, B. N., Rossman, L., & Dunnuck, C. (2009). Why women don't report sexual assault to the police: The influence of psychosocial variables and traumatic injury. *The Journal of emergency medicine*, *36*(4), 417-424. https://doi.org/10.1016/j.jemermed.2007.10.077

Kadambi, M. A., & Truscott, D. (2004). Vicarious Trauma Among Therapists Working with Sexual Violence, Cancer, and General Practice. *Canadian Journal of Counselling, 38*(4), 260–276. https://doi.org/10.1177/153476560300900404

Keesler, J. M. (2020). Promoting satisfaction and reducing fatigue: Understanding the impact of trauma-informed organizational culture on psychological wellness among Direct Service Providers. *Journal of Applied Research in Intellectual Disabilities*, *33*(5), 939-949. https://doi.org/10.1111/jar.12715

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of general psychiatry*, *52*(12), 1048-1060. https://doi.org/10.1001/archpsyc.1995.03950240066012

Koss, M. P., Bachar, K. J., & The SES Collaborative (2004). Sexual Experiences Survey—Long Form Victimisation (SES-LFV). *University of Arizona*.

Kristensen, T. S., Hannerz, H., Høgh, A., & Borg, V. (2005). The Copenhagen Psychosocial Questionnaire-a tool for the assessment and improvement of the psychosocial work environment. *Scandinavian journal of work, environment & health*, *31*(6), 438-449. https://www.jstor.org/stable/40967527

Kubany, E. S., Leisen, M. B., Kaplan, A. S., Watson, S. B., Haynes, S. N., Owens, J. A., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: the Traumatic Life Events Questionnaire. *Psychological assessment*, *12*(2), 210. https://psycnet.apa.org/doi/10.1037/1040-3590.12.2.210

Kulkarni, S., Bell, H., Hartman, J. L., & Herman-Smith, R. L. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research*, *4*(2), 114-130. DOI:10.5243/jsswr.2013.8

Leiter, M. P., & Maslach, C. (1999). Six areas of worklife: A model of the organizational context of burnout. Journal of Health and Human Services Administration, 21, 472-489. Retrieved from http://www.jstor.org/stable/25780925

Leung, T., Schmidt, F., & Mushquash, C. (2022). A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: A systematic literature review. *Psychological trauma: theory, research, practice, and policy*. https://psycnet.apa.org/doi/10.1037/tra0001277

Liang, B., Tracy, A., Taylor, C. A., Williams, L. M., Jordan, J. V., & Miller, J. B. (2002). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly*, *26*(1), 25-35. https://doi.org/10.1111/1471-6402.00040

Lundman, B., Viglund, K., Aléx, L., Jonsén, E., Norberg, A., Fischer, R. S., ... & Nygren, B. (2011). Development and psychometric properties of the Inner Strength Scale. *International journal of nursing studies*, *48*(10), 1266-1274. https://doi.org/10.1016/j.ijnurstu.2011.03.006

Macy, R. J., Martin, S. L., Nwabuzor Ogbonnaya, I., & Rizo, C. F. (2018). What do domestic violence and sexual assault service providers need to know about survivors to deliver services?. *Violence against women*, *24*(1), 28-44. DOI: 10.1177/1077801216671222

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, *3*, 131-149.

Michalopoulos, L. M., & Aparicio, E. (2012). Vicarious trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment & Trauma*, *21*(6), 646-664. https://doi.org/10.1080/10926771.2012.689422

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, *23*(2), 129. http://dx.doi.org/10.1037/trm0000122

Moos, R. H. (1994). *Work environment scale manual: Development, applications, research: A social climate scale*. Consulting Psychologists Press.

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best practices in mental health*, *6*(2), 57-68.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, 105906.

Pearlman, L. A. (2003). *Trauma and attachment belief scale (TABS)*. Western Psychological Services.

Powell-Williams, M., White, S. D., & Powell-Williams, T. (2013). "I help the ones that want help": Emotion work and the victim advocate role. *Sociological Spectrum*, *33*(3), 258-275. https://doi.org/10.1080/02732173.2013.732904

Rakestraw, D. (2021). *Assessing the level of secondary traumatic stress experienced by children's advocacy center employees* (Doctoral dissertation, Wichita State University).

Rauvola, R. S., Vega, D. M., & Lavigne, K. N. (2019). Compassion fatigue, secondary traumatic stress, and vicarious traumatization: A qualitative review and research agenda. *Occupational Health Science*, *3*, 297-336. https://doi.org/10.1007/s41542-019-00045-1

Robins, P. M., Meltzer, L., & Zelikovsky, N. (2009). The experience of secondary traumatic stress upon care providers working within a children's hospital. *Journal of Pediatric Nursing*, *24*(4), 270-279. https://doi.org/10.1016/j.pedn.2008.03.007

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma the effects on female counselors of working with sexual violence survivors. *Psychology of women quarterly*, *19*(1), 49-64. https://doi.org/10.1111/j.1471-6402.1995.tb00278.x

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health*, *17*(19), 6987. doi:10.3390/ijerph17196987

Slattery, S. M., & Goodman, L. A. (2009). Secondary traumatic stress among domestic violence advocates: Workplace risk and protective factors. *Violence against women*, *15*(11), 1358-1379. DOI: 10.1177/1077801209347469

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2019). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research

and leading experts. *Traumatology*, *25*(2), 72. https://psycnet.apa.org/doi/10.1037/trm0000180

Sprang, G., Lei, F., & Bush, H. (2021). Can organizational efforts lead to less secondary traumatic stress? A longitudinal investigation of change. *American Journal of Orthopsychiatry*, *91*(4), 443. https://psycnet.apa.org/doi/10.1037/ort0000546

Sprang, G., Ross, L., Miller, B. C., Blackshear, K., & Ascienzo, S. (2017). Psychometric properties of the Secondary Traumatic Stress–Informed Organizational Assessment. *Traumatology*, *23*(2), 165 - 71 https://doi.org/10.1037/trm0000108.

Spreitzer, G. M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of management Journal*, *38*(5), 1442-1465. https://doi.org/10.5465/256865

Stamm, B. H. (2010). The concise ProQOL manual (2nd Ed.). https://programs. caringsafely.org/wpcontent/uploads/2018/01/ProQOL_Concise_2ndEd_12- 2010.pdf

Staudt, M., & Williams-Hayes, M. (2019). Secondary traumatic stress, burnout, and compassion satisfaction among child advocacy interdisciplinary team members. *Advances in Social Work*, *19*(2), 416-429. https://doi.org/10.18060/22957

Strange, C. N. (2014). "You can stay if you want" Women's experiences providing rape crisis medical advocacy. (Doctoral dissertation, University of Kentucky).

Sullivan, G. M., & Feinn, R. (2012). Using effect size—or why the P value is not enough. *Journal of graduate medical education*, *4*(3), 279-282. https://doi.org/10.4300/JGME-D-12-00156.1

Tolerico, A. M (2017). The effects of vicarious traumatisation and inner strength among sexual assault advocates. (Doctoral Dissertation, Alliant International University).

Ullman, S. E., & Townsend, S. M. (2007). Barriers to working with sexual assault survivors: A qualitative study of rape crisis center workers. *Violence against women*, *13*(4), 412-443. 10.1177/1077801207299191

Voth Schrag, R. J., Wood, L. G., Wachter, K., & Kulkarni, S. (2022). Compassion fatigue among the intimate partner violence and sexual assault workforce: Enhancing organizational practice. *Violence against women*, *28*(1), 277-297. https://doi.org/10.1177/1077801220988351

Vrklevski, L. P., & Franklin, J. (2008). Vicarious Trauma Scale. *Traumatology*. https://psycnet.apa.org/doi/10.1037/t03119-000

Vukčević Marković, M., & Živanović, M. (2022). Coping with secondary traumatic stress. *International Journal of Environmental Research and Public Health*, *19*(19), 12881. https://doi.org/10.3390/ijerph191912881

Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly*, *26*(2), 120-130. https://doi.org/10.1111/1471-6402.00050

Way, I., VanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of interpersonal violence*, *19*(1), 49-71. https://doi.org/10.1177/0886260503259050

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). The Life Events Checklist for DSM-5 (LEC-5). Instrument available from the National Center for PTSD at www.ptsd.va.gov

Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993, October). The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility. In *annual convention of the international society for traumatic stress studies.* (Vol. 462).

Weathers, F. W., Litz, B., Herman, D., Juska, J., & Keane, T. (1993). *PTSD Checklist— Civilian Version (PCL-C)* [Database record]. APA PsycTests. https://doi.org/10.1037/t02622-000

Wegrzyn, A., Tull, P., Greeson, M. R., Pierre-Louis, C., Patton, E., & Shaw, J. (2023). Rape crisis victim advocacy: A systematic review. *Trauma, Violence, & Abuse*, *24*(3), 1966-1985. https://doi.org/10.1177/15248380221082089

Wolf, M. R., Green, S. A., Nochajski, T. H., Mendel, W. E., & Kusmaul, N. S. (2014). 'We're civil servants': The status of trauma-informed care in the community. *Journal of Social Service Research*, *40*(1), 111-120. https://doi.org/10.1080/01488376.2013.845131

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. World Health Organization. https://www.who.int/publications/i/item/WHO-RHR-13.10

Xie, W., Wang, J., Zhang, Y., Zuo, M., Kang, H., Tang, P., ... & Ma, C. (2021). The levels, prevalence and related factors of compassion fatigue among oncology nurses: a systematic review and meta-analysis. *Journal of clinical nursing*, *30*(5-6), 615-632. https://doi.org/10.1111/jocn.15565

Appendix 1: CCAT Table of Results

Author and year	Preliminaries	Introduction	Design	Sampling	Data collection	Ethical matters	Results	Discussion	Total (/40)	%
Benuto et al. (2018)	4	5	3	3	4	2	4	4	29	73
Benuto et al. (2019)	3	5	2	3	4	3	3	4	27	68
Cummings et al. (2021)	4	5	3	3	3	3	4	4	29	73
Dworkin et al. (2016)	4	5	2	3	3	3	3	4	27	68
Foley (2020)	4	5	3	4	3	3	3	4	29	73
Hooft & Benuto (2016)	4	5	3	3	3	2	4	4	28	70
Kulkarni et al. (2013)	5	5	3	5	4	2	4	3	32	80
Voth-Schrag et al. (2022)	3	5	3	4	4	4	3	4	30	75

Slattery & Goodman (2009)	4	5	3	3	4	3	3	3	29	73
Strange (2014)	3	5	2	5	4	3	4	5	31	78
Tolerico (2017)	4	5	4	4	4	3	2	4	30	75

Appendix 2: Terminology

Domestic violence:

This review has conceptualised domestic violence as "any incident or pattern of controlling, coercive or threatening behaviour, violence or abuse between those aged sixteen years or over who are or have been intimate partners or family members regardless of gender or sexuality" (Home Office, 2012).

Sexual Violence:

This review has conceptualised sexual violence as "any sexual act or attempt to obtain a sexual act by violence or coercion, act to traffic a person, regardless of the relationship to the victim" (World Health Organisation, 2013).

Role of frontline staff:

For the purpose of this review, the responsibilities of frontline staff members has been summarised as: ensuring the safety of victims and their dependents when in crisis, acting as a single point of contact, providing emotional and practical support that is tailored to the individual, provision of accurate and unbiased information, providing support before, during and after legal proceedings and providing a professional service (Home Office, 2017).

Secondary Traumatic Stress

For the purpose of this review an umbrella term of "secondary traumatic stress" was used to represent STS, CF and VT. Vicarious Trauma is defined as cumulative effect of working with survivors of trauma where one's worldview and beliefs are impacted (Mcann & Pearlman, 1990). Secondary traumatic stress is a collection of symptoms that are identical to those of PTSD, including intrusion, avoidance and arousal (Figley, 1995). Compassion Fatigue is defined as a diminished ability to do one's role due to feelings of helplessness and exhaustion, as a result of providing care and compassion to individuals who have experienced trauma (Figley, 1995).

Appendix 3:   Extended table of characteristics

Author & Year	Aims	Sample	Methodology	Risk and mitigating factors	Analysis	Findings	Limitations	CCAT score (/40) (%)
Benuto et al. (2018)	To identify the prevalence of STS among victim advocates. To identify the risk factors in the development of STS among victim advocates.	135 victim advocates	Recruitment: Purposive sampling: victim advocacy agencies identified through internet search Data collection: Demographic questionnaire Dependent variable: Secondary Traumatic Stress Scale (STSS) (Bride, 2004)	• Direct hours working with victims • Total hours • Personal history of trauma (victim status) • Years of experience • Services provided • Type of victims	Three linear regressions	Total hours worked per week (P = 0.02) and direct hours working with victims (P = 0.047) were significant predictors of STS. Victim status was not a significant predictor. Types of services provided by advocates did not predict STS. Only working with adult survivors of childhood sexual abuse was significant predictor of STS (P = 0.008)..	Limited generalisability to wider victim advocate population due to recruitment bias. Response rate of survey is unknown	29 (73%)

Benuto et al. (2019)	Examined how organisational factors may act as protective or risk factors against the development of STS among primarily victim advocates	142 victim advocates	Recruitment: Purposive sampling: victim advocacy agencies identified through internet search Data collection: Demographic questionnaire Unvalidated self-report questionnaire: Work Support Questionnaire. STSS	• Victim status • Years of experience • Direct hours working with victims • Workplace support	Independent Sample T-Tests, descriptive statistics, Pearson's Correlation Coefficient, multiple regressions	Victim status and years of experience did not relate to STS. Number of direct hours working with victims was associated with higher STS scores (P<0.05) Availability of formal emotional support, educational support or mindfulness-based interventions did not reduce rates of STS.	Recruitment bias – participants self-selected to be in the study Educational support was trending toward significant, which may indicate that a larger sample size was required Did not examine naturalistic forms of support i.e. family, friends.	27 (68%)
Cummings et al. (2021)	To examine which predictor (burnout and victim of a trauma) accounted for the most variation in	132 victim advocates	Recruitment: Purposive sampling: victim advocacy agencies identified through internet search	• Burnout • Compassion satisfaction	Pearson correlations and hierarchical regression.	Burnout accounted for 47.3% of variance in STS (P<0.001), and 45.8% of variance in VT (P<0.001). Compassion satisfaction contributed an additional 3.9% variance in STS and 0.6% variance in VT.	External validity of study limited due to the sample consisting of mostly white females. The study may be subject to	29 (73%)

victim advocates experiencing STS and VT and whether compassion satisfaction influenced the relationship.			Data collection: Demographic questionnaire Vicarious Trauma Scale (VTS) (Vrklevski & Franklin, 2008). STSS Professional Quality of Life Scale (ProQOL) (Figley, 1995).			This indicated that burnout is a strong predictor of VT and STS, but CS may serve as a mitigating factor against experiencing both.	volunteer bias and the response rate is unknown.	
Dworkin et al. (2016)	To understand the correlates of STS among rape crisis centre staff members at the individual and setting level	164 individuals who work in a rape crisis centre. 36.6 % of sample were advocates. 63.4% non advocate.	Recruitment: Purposive sampling Data collection: Demographic questionnaire Posttraumatic Checklist- Civilian	Risk and mitigating factors of STS • Age • Supervision frequency (advocate vs non-advocate) • Caseload • Victim status • Race	Multilevel modelling in SAS 9.4 to account for dependency in the data and separate variance at the level of the individual and setting	Individual-level analysis: Race, role and caseload was not significantly associated with STS. Supervision frequency was inversely associated with STS in non-advocates, in comparison to advocates (p<0.05) Age was inversely related to STS (P<0.01)	Clerical error on STSS, an incorrect response scale was used with a 6 point Likert scale. Missing data on some key variables.	27 (68%)

| | | | Version (PCL-C) (Weathers et al. 1994)

Sexual Assault History: Sexual Experiences Survey (Koss et al. 2004) | • Role (advocate vs non advocate) | | Victim status was associated with higher levels of STS (P<0.01)

Setting-level analysis:

Higher levels of STS in staff who had less supervision (P<0.01) and larger caseloads (P<0.05). | | |
| Foley (2020) | What factors (including trauma informed care) predict and reduce levels of secondary trauma symptoms in organisation employees? | 89 employees

from Kentucky's 15 regional Domestic Crisis Programs

29.3 % advocates (non-residential | Recruitment:

Purposive sampling. An email was sent to Executive Directors of the 15 KCADV, who provided a list of staff contact details.

Data collection:

Demographic questionnaire

Personal trauma history measured by Life | • Trauma history
• Organisational trauma informed care (TIC)
• Age
• Full time status
• Length of time in role
• Direct hours working with victims | Descriptive statistics and Multiple regression analyses | 28.8% of the variance in STS was explained by trauma history severity and the perceived level of organizational TIC (P<0.024).

For every increase in severity of victim status, STS increases by 0.11 points on STSS. As organisations level of TIC increases by one unit, STS decreases by 0.28 points. | External validity of study, the findings reflect participants from one geographical region. The sample was also predominantly female.

Age was captured as a categorical variable.

The use of LEC-5 deviated from its original | 29 (73%) |

		residential and child) 9.8% Shelter worker 4.3% Hotline worker	Events Checklist-5 (LEC-5) (Weathers et al., 2013) Ticometer © (Bassuk et al. 2017) STSS			12.6% of variance in STS can be explained by trauma informed delivery domain of Ticometer (P<0.006). STS decreases by 1.07 points on STSS for every one unit increase in trauma informed service delivery. Age, full time status and direct hours working with victims were not significant predictors of STS.	intention, it was applied to measure personal trauma history rather than whether the individual met diagnostic criteria for PTSD.	
Hooft & Benuto (2016)	To identify risk factors that predict the development of STS, VT and CF.	107 victim advocates	Recruitment: Purposive sampling: victim advocacy agencies identified through internet search Data collection: Demographic questionnaire STSS	• Marital status • Education • Income • Ethnicity • Victim status • Support • Years of experience • Hours worked • Direct hours working with victims • Victim types • No. of tasks performed	One way ANOVAs and correlational analyses	Ethnicity (P=0.442), marital status (P=0.402), education level (P=0.608), income (P=0.250), victim status (P=0.785), systems of support (P=0.099), victim types (P=0.06), number of tasks performed (P=0.08) and years of experience were not associated with STS, VT and CF. Hours worked (P=0.001), direct hours with victims (P=0.044) and avoidant	Where an advocate works was not included in the analysis. Also unable to determine geographic regions. Did not report on response rate.	28 (70%)

			VTS ProQOL	• Self-care strategies		self-care strategies was associated with STS (P=0.04).		
Kulkarni et al. (2013)	To examine perceived fit between employee abilities and work demands on domestic violence services providers' experiences of burnout, secondary traumatic stress, and compassion satisfaction after adjusting for other individual, employment,	236 domestic violence service providers. 30.2% of sample were advocates. 16.5% shelter workers	Recruitment: Purposive and snowball sampling. Participants were recruited from two statewide domestic violence coalitions in South and Southwest regions of the US. Data collection: Demographic questionnaire Shortened version of Traumatic Life Event Questionnaire (Kubany et al., 2000)	• Gender • Age • Marital status • Education • Role • Trauma history • Months of experience • Direct hours working with victims • Quality of supervision • Coping strategies • AWS Subscales (workload, control, community, rewards, fairness, values)	Series of two step hierarchical regressions.	Greater time in self-care was associated with lower levels of STS (P<0.05). Greater time in leisure activities was associated with higher levels of STS (P<0.05). AWS subscales was entered into regression. Workload perceptions (P<0.001) and control perceptions (P<0.05) were associated with STS. The final model accounted for 25% variance, with AWS accounting for 17%	Workplace was not identified and therefore individual workplaces may be over represented Did not differentiate hours worked in terms of full time and part time staff	32 (80%)

and coping factors			The Areas of Worklife Scale (AWS) (Leiter & Maslach, 2006) ProQol.			of total variance (P<0.001). All other variables were not significant predictors of STS.		
Voth-Schrag et al. (2022)	What personal and organizational factors contribute to compassion fatigue among intimate partner violence and sexual assault employees?	520 employees working in intimate partner violence and sexual assault organisations. 58.7% advocates (advocate, medical, legal and children's)	Recruitment: Purposive sampling Data collection: Demographic questionnaire Burnout and STS subscales of the ProQOL, AWS	• Age • Years of experience • Race • Victim status • Recent stress • No. of staff • Direct practice with victims • Supervision • Exposure to micro-aggressions • AWS Subscales	T-test, ANOVA, Pearson Correlation Analyses and Hierarchical Regressions. .	Regression 1 – individual factors: 12% of variance in CF. Age (P<0.001), years of experience (P<0.001), identifying as Latinx (P<0.001), recent stressors (P<0.00) were significant predictors of CF. Regression 2 - organisational variables: 37% of variance in CF. Age, identifying as Latinx and recent stressors remained significant. Organisational factors that predicted CF: direct contact with victims (P=0.00), exposure to	External validity of study, the findings reflect participants from one geographical region of the USA. The ProQOL is used as a measure of the construct of compassion fatigue, although it is developed to discriminate between burnout and STS.	30 (75%)

		5.3% shelter staff					workplace micro-aggressions (P=0.04) and higher reported workload (P=0.00).		
Slattery & Goodman (2009)	To identify organisational risk and protective factors of secondary traumatic stress among domestic violence advocates	148 female domestic violence workers	Recruitment: Purposive sampling was used. A convenience sample of domestic violence advocates working across Massachusetts. Data collection: Demographic questionnaire PTSD Checklist-Stressor Specific Version (PCL-S) (Weathers et al., 1993) Coworker Cohesion Subscale of the Work	• Victim status • Direct hours working with victims • Co-worker support • Quality of supervision • Shared power	Correlational analysis and Hierarchical regression analysis	Correlations: Co-worker support and shared power was inversely correlated with STS (P<0.01), quality of clinical supervision was negatively associated (P<0.01) Regression: Victim status was the only significant individual variable that predicted STS, explaining 8% of variance in the model (P<0.003). Direct hours was non significant (P=0.178)	Language used had an emphasis on services for women in abusive relationships with men, this may have excluded advocates working with homosexual victims. Use of PCL-S may not be able to effectively separate out the differences in PTSD and	26 (65%)

			Environment Scale (Moos, 1994). Clinical Supervision Quality: measured by the mentor subscale of the Relational Health Index (Liang et al. 2002). Unvalidated questionnaire: the Shared Power Scale			When workplace factors were entered into the model, shared power was the only workplace factor that predicted STS, explaining 11% of variance in the model (P<0.010). This indicated that advocates who perceived their workplace as empowering were less likely to report symptoms of STS.	secondary traumatic stress.	
Strange (2014)	Do individual and systemic variables predict ratings of vicarious trauma (VT) and vicarious post-traumatic growth?	164 female rape crisis medical advocates	Recruitment: Purposive and snowball sampling utilised. Rape crisis services in the USA were identified via an internet search. Data collection: Demographic questionnaire	• Age • Education • Experience • Caseload • Individual supervision • Group supervision • Social community at work • Meaning of work	Hierarchical regression	Education (P<0.025), age (P<0.005), amount of formal group supervision (P<0.005) social community (P<0.025) and meaning of the work (P<0.001) negatively predicted VT, Overall, the variables accounted for 24% of the variance in ratings of VT.	A small sample size and possible lack of power as indicated by post-hoc power analysis Social community at work and meaning of the work were not transformed	31 (78%)

							resulting in leptokurtic distribution of scores.	
			Copenhagen Psychosocial Questionnaire (COPSOQ) (Kristensen et al. 2005). The Trauma and Attachment Belief Scale (Pearlman, 2003).	• Emotional demands of work				
Tolerico (2017)	To identify risk factors of STS in sexual assault advocates. To investigate a presence of inner strength among sexual assault advocates.	44 female sexual assault advocates.	Recruitment: Purposive sampling. Study materials emailed to coordinator at the community-based crisis centres in Minnesota, USA. Data collection: Demographic questionnaire STSS	• Inner strength • Victim status • length of time in role	Pearson correlation and Independent T-Tests	A significant negative correlation was found between STS and Inner Strength (P=0.001). There was no significant difference between STSS and ISS scores and victim status (P=0.710). There was no significant difference between STSS and ISS scores for length of time in role (P=0.628).	External validity of study, the findings reflect participants from one geographical region of the USA and only female participants. Advocates in the study had limited long-term advocate experience.	30 (75%)

			Inner Strength Scale (Lundman et al., 2011)				The Inner Strength Scale is a relatively new measure and the authors have not determined cut off scores.	

Note: **STSS =** Secondary Traumatic Stress Scale, **AWS =** The Areas of Worklife Scale, **ProQoL** = Professional Quality of Life Scale, **VTS** = Vicarious Trauma Scale

Appendix 4: Author guidelines

Author guidelines for the Journal of Occupational Health Science can be accessed here: https://link.springer.com/journal/41542/submission-guidelines

Paper 2

"Why keep it all on my shoulders?": Emotional Experiences and Wellbeing of Administrative Staff Working in Forensic Mental Health Services; an Interpretative Phenomenological Analysis

This review has been written in accordance with author guidelines from the *Journal of Occupational Health Sciences* with the intention of publication. A summary of submission guidelines can be found in Appendix 14.

Abstract

Administrative staff working in Forensic Mental Health Services (FMHS's) may be exposed to verbal abuse, intimidation and distressing information. However, to date, there has not been any research exploring the wellbeing of administrative staff working in FMHS's. This qualitative study explores the emotional experiences and wellbeing of administrative staff working in FMHS's, in order to better understand the demands of their role and whether there are any unmet support needs. Semi-structured interviews were completed with seven administrators. Interpretative Phenomenological Analysis (IPA) was used. Six Group Experiential Themes were identified: 'feeling threatened and unsafe', 'vicarious emotional toll', 'deeper empathy and compassion', 'bask in their glory, 'safe and supported', and 'not bottom of the pile'. Some administrative staff experienced incidents where they felt fearful and vigilant, in addition to the vicarious impact of being exposed to service-user index offences. Some stressors were mitigated by teams offering a safe and supportive environment. Additionally, administrative staff shared having greater empathy and compassion towards service-users through working in a FMHS. Findings indicated the importance of a psychologically safe work environment. Administrative staff may benefit from reflective practice, formulation-focused sessions, conflict-management training and access to peer support.

Key words: Administrative staff, Staff Wellbeing, NHS, Forensic Mental Health Services

Introduction

Staff that work in Forensic Mental Health Services (FMHS's) are especially vulnerable to job-related stress, due to the enduring and complex difficulties experienced by this client group (Ewers et al., 2002). This includes non-clinical staff, such as administrators. FMH service-users are individuals who have a mental health illness and have offended or are at risk of offending (Mullen, 2000). Administrative staff may be exposed to distressing incidents and material within their role, such as receiving verbal abuse from service-users or reading service-user index offences (Twigg et al., 2020). Despite this, there is currently limited research exploring the wellbeing of administrative staff in the NHS and no existing research on the wellbeing of administrative staff who work in FMHS's.

Non-clinical staff, including administration, make up 47% of NHS roles and are integral to the effective running of NHS services (NHS England, 2023). The 2023 NHS staff survey indicated that 70% of administrative staff reported frequently having contact with service-users. The NHS is working on improving the health and wellbeing of their workforce as part of their Long-Term Plan (NHS, 2019) and the People Plan (NHS England, 2020). Since the Covid-19 pandemic, there has been greater focus on the role of psychology in staff support, through the formulation of wider systemic issues, consultation, whole team initiatives, supervision and reflective practice (Conniff, 2022).

A notable construct of wellbeing is 'subjective wellbeing'. Diener (2000, p.34) defined subjective wellbeing as "people's cognitive and affective evaluations of their lives". Individual wellbeing is based upon having frequent positive emotions, infrequent negative emotions and an overall evaluation of life satisfaction (Diener, 1984). Staff wellbeing is imperative, with good wellbeing being linked to increased job satisfaction, morale, performance and retention (Powell et al., 2014). There are direct negative correlations between workplace wellbeing and staff sickness absence, work-place errors and service-user outcomes (Malik, Blake & Batt, 2011; Quirk et al., 2018).

Research has shown that nurses that work in FMHS's may be exposed to violence from service-users, with verbal aggression being the most prevalent, followed by physical violence and observing violence (Newman, Roche & Elliott, 2023).

Administrative staff working in FMHS's may experience verbal abuse or intimidation from service-users (Chambers & Kelly, 2006) and experience incidents where service-users or colleagues may have been harmed (O'Beirne et al., 2012). It is likely that administrative staff would be routinely exposed to distressing material, such as when typing dictated tribunal reports (Twigg et al., 2020). This exposure can have a detrimental impact on psychological and physical wellbeing (Ireland et al., 2021; Newman et al., 2021).

Frequent exposure to distressing material and narratives can negatively affect an individual's mental health, and can lead to the development of symptoms related to Secondary Traumatic Stress (STS) (Figley, 1995a). This can include re-experiencing the event through flashbacks, nightmares, hypervigilance and avoidance (American Psychiatric Association, 2013). This can lead to depression, difficulty separating work and home life, lower levels of distress tolerance, negative self-soothing behaviours and decreased every-day functioning (Pirelli, Formon & Maloney, 2020). One group who are routinely exposed to distressing material are investigators of child internet exploitation. Research has shown that this exposure can lead to intrusive thoughts, protectiveness of family and general distrust (Morabito, Pattavina & Williams, 2020; Perez et al., 2010).

Building a positive relationship with service-users can facilitate feeling safer at work (Marshall, Adams & Stuckey, 2019). Feeling at risk of harm can limit staff-service user relationships, with over 30% of violent incidents being triggered by negative staff-service user interactions (Papadopoulos et al., 2012). Despite this, there is a large discrepancy in support received for administrative staff in comparison to clinical staff. Training for administrative staff focuses more on clerical responsibilities than enhancing knowledge and confidence to work in a clinical environment (Ward & Wood, 2001). Moreover, administrative staff do not routinely receive clinical supervision or reflective practice (Martin, 2022). Twigg et al. (2020) conducted a pilot service initiative that trialled group clinical supervision for administrative staff working in an NHS neuropsychology department. The findings indicated that the opportunity for clinical supervision supported wellbeing, improved assertiveness and the frequency of self-care.

With stressors on NHS staff becoming greater, a number of support initiatives have been developed (Schneider, Hobson & Shelton, 2021). These include Psychologically Informed Environments (PIEs) (Haigh et al., 2012; Keats et al., 2012) and Trauma-Informed Care (TIC) (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). PIEs aim to understand and effectively respond to challenges faced in services through enhancing staff and service-user wellbeing. The principles of PIEs are to develop staff skills, knowledge, motivation and job satisfaction through creating an environment that is reflective, attentive and compassionate (Against Violence and Abuse, 2017; Keats et al., 2012; Schneider et al., 2021). One framework of PIEs is TIC. TIC follows six principles; ensuring staff feel physically and psychologically safe, trust is promoted through transparent organisational decisions, access to peer support is offered, staff are treated equally and are empowered, and individual differences are respected (SAMHSA, 2014). A TIC initiative was implemented in a FMHS and evaluated through a quality improvement project on all staff. Results indicated that job satisfaction increased and sickness rates decreased through the implication of the TIC principles (Hearn, 2023). Organisational policies and cultures that promote safe and supportive work environments are vital for staff to feel psychologically and physically well at work, which ultimately supports good service-user care and outcomes (Procter et al., 2017).

Study Rationale

There is an incremental number of published studies exploring the impact of working in FMHS's on mental health professionals (Cramer et al., 2020; Mullholland, 2015; Rodrigues et al., 2021). Verstegen et al. (2024) explored the experiences of FMHS professionals who were exposed to service-user aggression. In response to service-user aggression, professionals experienced feelings of anger and fear that affected them both personally and professionally. Despite this, there is limited research that explores the wellbeing of administrative staff working in healthcare settings or FMHS's specifically, despite administrators often having limited training, clinical knowledge and support in comparison to mental health professionals.

The purpose of the current study is to understand the emotional experiences and wellbeing of administrative members of staff who work in FMHS's, to better

understand the demands of their role and whether there are any unmet support needs. This is in line with the NHS Long Term Plan and the People Plan.

Research Question

What are the emotional experiences of administrative staff who work in Forensic Mental Health Services, and what are the implications for wellbeing?

Method

Ethics

Ethical approval for this study was granted by Staffordshire University Research Ethics Committee in January 2023 (Appendix 1) and the Health Research Authority in June 2023 (Appendix 2). All participants provided informed consent. Due to the potentially emotive topic, participants were provided a debrief form (Appendix 6), which signposted to numerous services that could offer additional support. No participants indicated signs of distress during the interview.

Design

A qualitative design was chosen as it aligns to the aims of this research, which seeks to understand the meaning of human experiences (Schwandt, 2000). Semi-structured interviews were used. Guidance and feedback on the interview schedule was gained from the researchers' clinical and academic supervisors in order to ensure that the interview schedule was appropriate and accessible. In addition, an administrative manager was consulted to understand the role, training and formal/ informal support of an administrator, due to the researcher having limited knowledge of working in a FMHS and the role of an administrator. Four participants provided feedback on the executive summary of this research. Interpretative Phenomenological Analysis (IPA) was identified as the most appropriate methodology, as it provides in-depth individual accounts of a particular phenomenon (Smith, Flowers & Larkin, 2021). IPA studies provide a detailed account of how participants make sense of their individual and social world. IPA is a particularly useful methodology for examining topics which are emotionally laden and complex (Smith & Osborn, 2015), and therefore relevant to the emotional experiences and wellbeing of administrative staff. IPA's exploratory nature is valuable when examining novel and under-researched ideas (Smith, Flowers & Larkin, 2021).

IPA draws upon theoretical principles of 'phenomenology', 'hermeneutics' and 'idiography'. Phenomenology explores the components of individual lived experiences, and how these are unique in comparison to others (Pietkiewicz & Smith, 2014). Hermeneutics focuses on the interpretation of an individual's beliefs and language to understand their world experiences and translate the meaning of their experiences (Freeman, 2008). IPA relies on idiography, which is an in-depth analysis of individual cases in their unique contexts before producing any general statements from collective participants (Smith, Harre & Van Langenhove, 1995). IPA was chosen over other phenomenological approaches, such as Thematic Analysis (Braun & Clark, 2006), due to the research question being under-researched and its focus being on a deeper understanding of administrators unique lived experiences and individual voices, rather than their collective accounts and patterns. IPA encourages this through its idiographic and double-hermeneutic approach.

Recruitment and Participants

Purposive sampling was used and based on the inclusion and exclusion criteria populated in table 1.

Table 1: Participant eligibility criteria

Inclusion criteria	Exclusion criteria
Staff that currently work in FMHS's in an administrative role.	Staff that have worked in an administrative role in FMHS's for less than six months. If a participant has worked in the role for less than six months they may have limited in-depth experience to reflect on during the interview

IPA research requires a homogenous sample through purposive sampling, due to the focus being on the shared experiences of the phenomenon. Typically, small sample sizes are utilised in IPA to ensure the study captures personal significance and richness of each participants' experiences. Due to IPA favouring depth over

breadth, Smith et al. (2021) broadly recommend between six to ten interviews for professional doctorate research using IPA methodology.

Administrative managers and team leaders working in six different FMHS's in two NHS trusts in the West Midlands consented to support the participant recruitment for this study. The administrative managers and team leaders shared a flyer (Appendix 3) with the study information and researcher contact details with administrative staff and asked them to contact the researcher if they were interested in taking part in the study. In addition, the researcher attended a team meeting with one administrative team in order to share the study details. Nine participants expressed their interest, with two choosing not to participate after the information sheet was shared.

Seven participants were recruited in total. All participants were female, 71 percent of participants were White British and 29 percent were Asian/ Asian British. One participant was aged between 25-34 years old, and six participants were aged between 45-64 years old. The amount of years participants had worked as an administrator in a FMHS ranged from one year to ten years, with the average being five. The FMHS's ranged from secure services for men and women and outpatient services.

Procedure

Potential participants could choose to contact the researcher through email. Individuals who met the inclusion criteria and conveyed an interest in participating were emailed an information sheet (Appendix 4) and were provided an opportunity to ask any questions. Participants who wished to take part in the study signed and returned an electronic consent form (Appendix 5).

Interviews were offered remotely via Microsoft Teams or in-person at the participants' place of work. All participants wished to be interviewed remotely. An interview schedule was utilised (Appendix 7) and interviews were audio/video recorded and transcribed verbatim using Microsoft Teams. Interviews were on average 75 minutes long. All personal information was redacted during the transcription process and pseudonyms were allocated to each participant to ensure participant anonymity and confidentiality.

No financial compensation was provided to participants. After the interview the researcher emailed a debrief form with signposting information regarding whistleblowing where wrongdoing at work was disclosed and additional wellbeing support, in addition to a demographic form (Appendix 8) that the participants returned.

Data Analysis

Interview recordings were transcribed verbatim using Microsoft Teams. Due to IPA being idiographic, each case was individually examined in-depth. The researcher followed Smith et al. (2021) guidance on conducting IPA analysis. The researcher immersed themselves in the data through watching the video recordings and reading the transcripts several times. Exploratory notes were created which summarised areas of semantic interest of the full transcript. Experiential statements were then created, articulating the most important features of the exploratory notes, whilst directly relating to the experiences of the participant and considering the researchers' interpretation (Appendix 9).

The next step was to search for connections across the experiential statements, which supported the naming of personal experiential themes (PETs). The experiential statements were listed in chronological order in a Microsoft Word document and the researcher began to identify themes through colour coding (Appendix 10 and 11). This process was completed for each of the seven cases individually. The final step was to identify patterns of similarity and difference across the PETs to create a set of group experiential themes (GETs) (Appendix 12 and 13). This aimed to highlight the shared and distinctive features of the experiences across the participants. As recommended by Smith et al. (2021), for a GET to be included in this research it had to be present in at least one third or half of the participants, in addition to capturing the specific experiences of working in a FMHS.

Epistemology and Reflexivity

Due to utilising a qualitative design, it is important to consider the researcher's ontological and epistemological position. The researcher's ontological position was interpretivist, which recognises that there are multiple realities that are socially constructed (Hiller, 2016). A social constructivist epistemological position guided this research, where events, realities, meanings, and experiences are understood and

shaped through the interaction of individual discourses. Social constructivist theory identifies that there is no single truth and one's reality, such as working in an administrative role in a FMHS, is developed through the interactions had with colleagues, service-users and their environment (Crotty, 1998).

Reflexivity is imperative in IPA, in order to raise awareness to the influence of the researcher on the research process. Reflexivity ensures that the researcher's interpretation remains faithful to the participants' interpretations through attempting to manage bias (Engward & Goldspink, 2020). Therefore, a reflexive diary was kept throughout the data-collection and analysis process to capture researchers' thoughts, emotions and understanding, and how this may have impacted the analysis process (Appendix 13). By completing a reflexive diary, the researchers own beliefs and assumptions were bracketed as a means to limit the researcher's bias (Schwandt, 2014).

The researcher had no prior experience of working in a FMHS, but had worked with administrative colleagues in other services and consequently had heard first-hand accounts of their experiences. Therefore, the researcher had acknowledged that their own beliefs and experiences could have influenced the interpretation of the data, for example, acknowledging the belief that some administrators can be overworked and underappreciated. Research supervision and IPA group workshops were also utilised to support the researcher's awareness of these potential biases. The credibility and rigour of the analysis were sustained by ensuring that themes were supported by relevant quotes. A clear audit trail of the analysis process and how emerging themes were ascertained from transcripts was kept by the researcher to establish trustworthiness and transparency.

Results

Analysis of the interview transcripts revealed six GETs and six subthemes. The GETs were as follows: 'Feeling threatened and unsafe', 'Vicarious emotional toll, 'Deeper empathy and compassion', 'Bask in their glory', 'Safe and supported', and 'Not bottom of the pile' (Table 2). Although all participants worked as an administrator in a FMHS, two participants worked in a different work environment and had some different experiences. This influenced how they engaged with the

interview schedule and subsequently impacted on how their voice was represented across the GETs.

Table 2: Group Experiential Themes (GETs) and subthemes

GETs and sub-themes	Participants
1. **Feeling threatened and unsafe**	
Fear, wariness and vigilance	*Louise, Mary, Amy, Lucy*
Building confidence and ease	*Louise, Mary, Lucy*
2. **Vicarious emotional toll**	
'It really brings you down'	*Louise, Mary, Lucy, Sandra*
Choice and control affects wellbeing	*Louise, Mary, Lucy*
3. **Deeper empathy and compassion**	*Louise, Mary, Amy, Lucy, Abigail, Molly, Sandra*
4. **'Bask in their glory'**	*Mary, Lucy, Abigail, Molly, Sandra*
5. **Safe and supported**	
'You do not feel on your own'	*Louise, Mary, Amy, Lucy, Abigail, Molly*
'Talking to someone helps clear your mind'	*Mary, Lucy, Abigail, Sandra*
6. **'Not bottom of the pile'**	*Louise, Mary, Amy, Lucy, Abigail*

1. Feeling threatened and unsafe

This theme reflected the experiences of four participants who shared incidents whilst working as an administrator in a FMHS that led to them feeling fearful, wary and vigilant. Participants reflected that through the support of their colleagues they felt more confident and at ease around service-users.

Fear, wariness and vigilance

Four participants described a time where they felt fearful, wary and vigilant. Mary directly witnessed a violent incident between a service-user and staff member that created a sense of preoccupation and anticipation that other service-users could act violently.

> *"I used to think God I hope he doesn't kick off like that other lad." (Mary, p. 31)*

Louise also shared a sense of anticipation and trepidation towards male service-users making inappropriate comments and gestures towards her when she was on the wards.

> *"You'll just feel like eyes like staring at you and I think sometimes that can be quite scary." (Louise, p. 40)*

Similarly, Amy shared feeling intimidated and anxious after a violent incident at work, reflecting some preoccupation over her colleague's wellbeing when she was on leave.

> *"I'll never forget that people were scared to just even go to the car to go home. So I did worry while I was off about people at work." (Amy, p. 27)*

Some participants shared how safety concerns were present outside of work, with some struggling to switch off, for example, through re-experiencing the incident.

> *"And I said I just get real bad heart palpitations and I'd had a dream about him kicking off and stuff." (Mary p. 34)*

Lucy shared how seeing a discharged service-user in her hometown made her feel on-edge and worried about her family's safety. There was a sense that this felt unforeseen and invasive.

> *"I'll admit for a few weeks I was looking out for her but not really wanting to see her… I wouldn't want the service-user to have seen my family." (Lucy, p. 28)*

Building confidence and ease

Participants spoke about ways they had grown in confidence in managing service-user related challenges. There were reflections on the positive impact their colleagues had in increasing their confidence through offering practical advice and validation.

Louise and Mary spoke about how their fear reduced when they were offered practical advice from clinical staff on how to effectively communicate with service-users, and how they consequently felt greater reassurance and confidence.

> *"My ward manager said, 'so what you need to do is when you see him is instead of freezing, you walk past him and say hello to him'. I've learned, now I can have a full-blown conversation with him and I do not feel threatened." (Mary, p. 34)*

There was a sense from Lucy of feeling ashamed and confused over feeling vigilant after seeing a service-user in her hometown.

> *"I said I can't understand why I'm feeling on-edge because of the crime that that person had committed." (Lucy, p.29)*

Lucy shared these feelings with her manager, who consequently offered validation and allowed her to see that there was not a correct way to feel. This helped to alleviate the sense of shame and confusion she was feeling.

> *"And it helped just talking and for somebody with all that experience being able to say to me, 'no, that's fine, you're not a bad person because you're thinking this'." (Lucy, p. 33)*

Despite fear, wariness and vigilance reducing, there was a reflection from Louise, Mary and Lucy that there was still a gap in training that would be beneficial. They spoke about still feeling unconfident in managing escalations with service-users due to not having sufficient training when they started their role.

"Like we all know what to do when there's a fire. But what do you do when a service-user kicks off?" (Mary, p. 46)

2. Vicarious emotional toll

This theme reflected the experiences of four participants who spoke about the vicarious impact of reading and hearing distressing information within their role. Participants shared individual differences in their preference of knowing about service-user index offences, and the helpfulness of managers in scaffolding this exposure.

'It really brings you down'

Four participants spoke about the vicarious stress they had experienced within their role. There was a sense of distress and despair when reading about service-users' index offences, three participants shared that as mothers they found it especially challenging to read about crimes against children. In addition to feelings of worry and sadness when seeing colleagues upset after a challenging day.

Sandra shared feeling saddened and needing to take some time to decompress after hearing about crimes against children.

> *"I had to step away from the dictation for an hour just to gather my thoughts, I think I even had a little cry." (Sandra, p. 29)*

Additionally, Lucy spoke about how she can feel worried outside of work about her colleague's wellbeing if they have had an especially challenging day, which can lead to feelings of sadness.

> *"When it's something bad that's happened and if it's a colleague that you know really well, you take it home with you... it just really brings you down" (Lucy, p. 76)*

Choice and control affects wellbeing

Three participants shared having choice and control in how much information they read about service-users index offences. There were individual differences in their preference in reading about and having an awareness of service-user index offences, which helped them to manage the emotional demands of the role. Louise reflected that her wellbeing was protected in her role due to only learning about service-user forensic history on an ad-hoc basis.

> *"If I heard a service-user's story from the beginning to the end it would be a lot harder for me because you learn everything." (Louise, p. 33)*

Mary described how she found it beneficial to read service-user's forensic history in advance, in order to reduce the distress she would feel if the information came as a surprise.

> *"It really freaked me out because I wasn't prepared. Whereas if you read up, you're prepared and I think that that just helps me." (Mary, p. 67)*

Lucy shared that her preference was to not know about service-user index offences. She shared concern that it would change her perception of service-users, and this could upset them if they were to sense a change in warmth towards them.

> *"If I knew what they did, I think it would show on my face whilst talking to them. I'd feel awful if something I said or did would set back a patient." (Lucy, p. 20)*

Louise, Mary and Lucy all shared a sense of choice and control from management in how much information they knew about service-user index offences.

> *"(The manager said) do you feel that you don't want to be involved in that side, finding out about patients? If that's the case, you know we'll make sure that you don't have anything to do with that." (Lucy, p. 12)*

3. Deeper empathy and compassion

This theme is based on participants' perceptions of service-users. Some participants shared that they developed a more holistic and person-centred view of service-users, through being able to apply a more empathetic and compassionate lens to their offences. For some, this was supported through their team sharing their understanding of service-user's crimes in the context of their mental health difficulties and early experiences.

Five participants shared that they have developed a more holistic perception of service-users through working in a FMHS. Sandra shared how when she was new in her role she categorically viewed people as either good or bad, but through experience this view became more integrated.

> *"It's probably just experience over time because obviously when I started a baddy was a baddy and a goody was a goody." (Sandra, p. 35)*

Mary, Amy, and Sandra shared that they had a deeper empathy and understanding towards service-users since working in a FMHS, reflecting a greater awareness of how adverse early experiences can be linked to mental health difficulties.

> *"Sometimes it is quite heart-breaking to see what some of these have been through in the past you know, it's quite difficult." (Amy, p. 33)*

> *"The majority of these people were abused, which really gets me because I think that they've grown up thinking that that's the right way to be." (Mary, p.57)*

Not all participants developed a holistic view through working in a FMHS. Molly shared how she came into her role with a non-judgemental and unprejudiced view of service-users due to her own personal experiences of a family member with mental health difficulties.

"I believe that people deserve a second chance…I do think that this understanding of mental health has obviously been there from a little girl." (Molly, p. 13)

Some of the participants shared that their clinical team have helped them to develop a more holistic view of service-users through sharing their therapeutic work, in order to help them to broaden their understanding of mental health. Mary spoke about how although it was difficult to understand why offences occurred, it became easier through her team offering a compassionate perspective that took service-user's early experiences into consideration.

"It's hard for me to understand why they've done it…but for me it's the background thing. You can go into more depth, especially with the psychology team." (Mary, p.56)

Conversely, Lucy shared experiencing disbelief and confusion after building a positive relationship with a service-user and subsequently learning about their index offence. There was a sense that for Lucy building a positive relationship with the service-user acted as a barrier to being able to separate the service-user from their crime.

"When I found out what she'd actually done my view of her did change because I couldn't put the patient and the crime together and I was very, very surprised." (Lucy, p.22)

4. 'Bask in their glory'

This theme related to participants experiences of feeling pride, reward and satisfaction in not only witnessing a service-user's journey to rehabilitation, but helping service-users reach discharge through their administrative role.

Five participants shared a sense of pride, reward and satisfaction in getting to witness service-users progress first hand within their role. Sandra shared feeling

deeply joyous and optimistic over service-users having new opportunities after discharge.

> *"Like I said you shared a tear but they were happy tears because you can see that he could turn his life around." (Sandra, p. 35)*

Molly spoke about having the opportunity to be part of and allied with service-users' journey to rehabilitation.

> *"So it's like a journey that you take with them, you know I get to go with them and the rest of my team on their journey." (Molly, p.4)*

Participants also spoke about a sense of job satisfaction that they have helped to make a difference to service-users lives. Abigail shared a sense of reward in helping service-users from admission through to being discharged.

> *"I suppose knowing that we're helping in a way the patients…it's nice to see them progress through to discharge." (Abigail, p.45)*

5. Safe and supported

This theme is related to the importance of a safe and supportive environment and team culture as a way to protect participant's wellbeing when working in a FMHS. Participants shared how safety was created through their team and manager being approachable and available, and some reflections were offered on the importance of talking to colleagues to help switch off from work.

You do not feel on your own

Five participants spoke about how safety is created through not feeling alone, with their team members being approachable and non-judgmental to any questions or concerns that are brought to them. Amy and Abigail shared comfort in knowing that their colleagues would support any issue that they faced.

> *"You just know that you can come in with any issue that can be helped or spoke about." (Amy, p. 72)*

Amy, Lucy and Abigail spoke about feeling part of a team who genuinely cared for each other's wellbeing. Lucy reflected feeling fortunate to be in a team who are emotionally intelligent to how others are feeling and who offer support when a team member is struggling.

> *"So we're very open about our feelings, if one person comes in really down we're all there asking "are you OK?"... I think that's what makes me feel very lucky." (Lucy, p. 69)*

Participants also spoke about how relational safety was created by their manager. Louise reflected on how management style directly impacts on administrator's wellbeing, with it being important to feel considered and advocated for.

> *"Some managers are dictators and actually don't have that soft side to know how to support. I think management styles can be make or break for admin staff, I feel supported, cared for and appreciated." (Louise, p. 73)*

Molly's experiences amplified the importance of a safe and supportive environment and team culture. Molly was in a unique and different work context to the other participants. Due to this difference, despite support offered by the NHS trust, the work environment felt unpredictable and hostile.

> *"Like I say it affects my mood and wellbeing because I don't feel welcome." (Molly, p. 56)*

This experience contrasted to Louise's, who shared an appreciation of being part of a community who built strong connections as a service through celebrations and events.

"When teams all come together in one place and it is really nice to build those relationships between people that wouldn't normally work together." (Louise, p. 27)

Molly also spoke about feeling confused and let down over the inconsistent and unpredictable support she was offered over various challenges she had faced in her role.

"I was able to cope with it because of the way people looked after me…whereas when you look back at the time last year, they weren't supportive." (Molly, p. 33)

Molly reflected that, consequently, feeling unsafe to raise any issues with her team led to her being physically and psychologically unwell.

"They watched me then go downhill…I've had two significant issues, one with my mental health and one with my physical health." (Molly p. 25)

'Talking to someone helps clear your mind'

Participants described the importance of sharing their feelings with their colleagues to help clear their mind and switch off from work.

"Being able to talk to someone helps clears your mind." (Mary, p.65)

Lucy shared how by expressing how she was feeling to her manager; it allowed her switch off from any issues.

"I can just phone my manager and have a quick five minute chat and have a little whinge…and before you know it I'm fine." (Lucy, p.56)

Some participants shared concern over breaching confidentiality. Mary described how she felt unable to disclose her in-depth work experiences to her loved ones, and therefore ensured she talked to her team in order to protect her wellbeing.

> *"The psychiatrist will say "if you need to chat just give me a call" and that's really important to me as if I'm really upset, I can't share that with my family." (Mary p. 59)*

Abigail shared a sense of having to conceal her feelings from her family after a difficult day due to confidentiality limits, and therefore ensured she voiced her feelings to another administrative colleague, who was able to understand and empathise with her experiences due to being in the same role.

> *"We tend to meet up and go for a coffee and have a moan about things, get things off your chest." (Abigail, p.84)*

The value of shared experiences of administrative colleagues was also spoken about by Sandra, who was in a team where she was the only administrator. Sandra shared that despite enjoying her role, she felt more isolated and missed having the support network of administrative colleagues.

> *"I don't feel like I've got the support network as a whole… I do feel a bit more isolated." (Sandra, p.5)*

6. 'Not bottom of the pile'

This theme is related to participants' experiences of being treated equally and their hard work being recognised and appreciated. Participants shared the positive implications this had on their wellbeing and work ethic.

Happiness in the role of all participants seemed to be directly linked to feeling respected, appreciated and valued. Some participants spoke about the impact of feeling underappreciated in previous roles and there was a sense of being made to feel unimportant and inferior.

> *"I feel like I'm on the same level with the psychiatrist and the team. I don't feel like I'm down the bottom of the pile, which is what I felt in other roles." (Abigail, p. 27)*

Participants shared acts of appreciation and respect that have helped them to feel valued. These included the receipt of kind gestures and having flexibility and autonomy. In terms of working in a FMHS, Mary shared how a sense of belonging and feeling valued is created through her team being inclusive, for example, being included in updates on service-users progress.

> *"Every time someone sends an email about one of the lads, I get copied into it… So it's really nice because I feel like I'm part of the team." (Mary, p. 83)*

Lucy shared feeling valued and respected through her team taking into consideration her views in clinical meetings, sharing that she can offer her administrative expertise and a "layman's point of view".

> *"It's not 'you are admin and we are the psychologists' it's 'we are the psychological therapies team' and it makes me feel good." (Lucy p. 56)*

Participants reflected that feeling appreciated, valued and respected increased their motivation and contentment within their role.

> *"I think if you feel supported, cared for and appreciated by your manager it really comes out in the quality of your work and how you feel." (Louise, p. 72)*

Discussion

The study was the first to explore the emotional experiences and wellbeing of administrative staff who work in FMHS's. Additionally, this research is one of the only emerging studies that has considered the emotional needs of administrative staff working in mental-health settings. Seven participants were recruited and took part in semi-structured interviews. Overall, all participants shared having a high job

satisfaction within their role. Six GETs were constructed: 'Feeling threatened and unsafe', 'Vicarious emotional toll', 'Deeper empathy and compassion', 'Bask in their glory', 'Safe and supported', and 'Not bottom of the pile'. This section will provide an overview of key findings, implications for practice, future research and methodological strengths and limitations.

Feeling threatened and unsafe

The findings reflected that some participants shared feeling threatened and unsafe after experiencing incidents directly linked to service-users. This, therefore, indicates that similar to clinical staff, administrative staff are also at risk of direct exposure to distressing incidents and the subsequent fear, wariness and vigilance.

Participants spoke about ways they managed their feelings of fear, wariness and vigilance around service-users. There was a sense that participants felt more comfortable around service-users the longer they worked in their role. Support from their team directly after the incident seemed to be beneficial, with some participants reflecting on the helpfulness of debriefing and having a non-judgmental and safe space to talk about their feelings. Mangaoil et al. (2020) completed a scoping review on the use of staff debriefing, finding that it was an effective intervention to allow staff to emotionally and psychologically support each other. Similarly, a study found an improvement in FMH clinician's confidence levels and team morale after participating in a reflective practice group, and this was especially noted in early career staff (Aurora, Mawren & Fullam, 2023). Therefore, administrative staff may benefit from post-incident debriefing and allocated reflective spaces facilitated by clinical staff, where they have the opportunity to explore their feelings, receive validation and learn new skills. This may be especially helpful for newly appointed administrative staff.

Additionally, participants spoke about the helpfulness of practical solution-focused advice from their clinical team on how to manage conflict and effectively communicate with service-users. Some participants reflected that they would have benefited from training on conflict resolution and communication when they were new in their role. This is in line with research that explored the experiences of newly employed FMH nurses. The transition and introductory period was seen as imperative, with those who had not had training on conflict management and de-escalation feeling ill equipped to manage staff-service-user conflict and less safe in

their role (Sørensen et al., 2018). Offering training during the induction period on conflict resolution could help administrative staff to feel better equipped to manage violent incidents and consequently feel safer at work.

Vicarious emotional toll

Alongside the direct exposure to distressing incidents, administrative staff are also at risk of indirect exposure. As part of their role, many administrative staff are exposed to in-depth written and auditory accounts of violent crimes. Some participants spoke about the challenge of reading about service-user index offences, with crimes against children being especially distressing for participants who were mothers. One participant reflected feeling despondent when seeing her colleagues in distress after a challenging experience. Similar findings were found by Burns et al. (2008) who explored the emotional impact of investigators of internet child exploitation. Participants reported feeling concerned when their colleagues were in distress, and participants who were parents reported feeling more concerned and protective over their children. There is growing evidence of the impact of repeated and cumulative exposure to distressing details of traumatic events in FMH professionals (Newman et al., 2019; Newman et al., 2021; Newman et al., 2022), and these results indicate that forensic administrative staff are also at risk of vicarious stress.

The amount of information known about service-user index offences seemed to act as a protective factor against vicarious stress. Similar findings have been shown, with one study identifying that exposure to service-users' forensic history led to negative reactions in FMH nurses (Jacob & Holmes, 2011). Some participants described a sense of choice and control over this, which was linked to management being flexible and person-centred. It is apparent that preference of knowing about service-user index offences will differ for each administrator. Therefore, a person-centred and flexible approach from management is required to support administrator's wellbeing, where they are offered choice based on their individual needs.

 Deeper empathy and compassion

A holistic and trauma-informed view of service-users developed through working in FMHS's for many participants. Considering service-user's offences in the context of their mental health and adverse early experiences helped to develop a deeper

understanding, empathy and compassion towards service-users. Similar themes have been found in other qualitative research, with one study finding that FMH nurses "made sense by understanding why" (Beryl, Davies & Völlm, 2018). Some participants shared that this holistic understanding was developed through their clinical team sharing service-user formulations. Clinical staff are able to share how unhelpful coping mechanisms may have been adaptive in a service-user's earlier life (Barrera, Attard & Chaplin, 2019). Developing a trauma-informed view of service-users can support administrative staff to feel safer at work (Simjouw, Vogel & de Ruiter, 2024). Therefore, providing administrative staff allocated time for formulation and reflection may serve to proactively limit the impact of vicarious stress and support their wellbeing (Beryl et al., 2018; Davies et al., 2013).

'Bask in their glory'

Pride, reward and satisfaction in having the opportunity to both witness and help service-users journey to rehabilitation was described by participants, with many reflecting that this was the most satisfying part of their role. There was a sense from participants that they felt embedded into the team celebrations and a collective sense of accomplishment when a service-user had been discharged, with their role being part of the process that helped them rehabilitate. This is in line with literature on compassion satisfaction, which describes the sense of fulfilment and gratification that therapists develop from doing their work well (Stamm, 2002). Compassion satisfaction is greater when there is more control over the traumatic information they are exposed to and when there is sufficient emotional and social support provided (Stamm, 2002; Koutra, Mavroeides & Triliva, 2022). The findings suggest that compassion satisfaction in administrators could be important in protecting their wellbeing and overall job satisfaction. This link with compassion satisfaction may reinforce the importance of safe reflective spaces and a person-centred approach to traumatic material that was suggested in earlier themes.

Safe and supported

A key experience across all participants was the importance of a safe and supportive work environment. Participants reflected that psychological safety was created through colleagues being empathetic, approachable and non-judgmental. If a work environment is psychologically safe, employees feel able to ask questions,

voice their concerns, and seek feedback without fear of ridicule (Edmondson, 1999). This promotes greater wellbeing, job satisfaction and performance (Clark et al., 2024; Frazier et al., 2017; Hirak et al., 2012). The impact of a psychologically unsafe environment was shown by one participant, who shared how feeling unsafe to ask for help consequently led to being psychologically and physically unwell. Psychological safety is crucial for all staff, and therefore it is important for FMHS's to prioritise creating psychological safety within their work culture.

Participants in this study valued having the opportunity to share their feelings with colleagues, and having a support network of other administrative colleagues who can relate and empathise with each other's experiences. This is in line with a systematic review exploring enabling factors of psychological safety in healthcare teams, which identified that leaders being physically present and peer support were important for creating psychological safety (O'Donovan & Mcauliffe, 2020). Therefore, services should ensure that administrative staff are not working in isolation and have opportunities to regularly connect with colleagues, for example, through peer mentoring.

'Not bottom of the pile'

Feeling respected, valued and appreciated played a key role in participants' happiness and morale at work. Participants shared the importance of feeling like an equal team member and not feeling at the bottom of a hierarchy. Literature has indicated that staff groups that have 'lower professional status' regard their work to be invisible (Hersh, 2023) and under-appreciated (Hewko et al., 2015), despite having a high workload and important responsibilities (Hennekam, Ladge & Shymko, 2020; Jones et al., 2015). Literature has explored leadership styles that promote respect and appreciation (Korkmaz et al., 2022). Inclusive and autonomy supportive leadership where leaders' words and actions show appreciation of efforts made by employees (Carmeli, Reiter-Palmon & Ziv, 2010; Hirak et al., 2012; Nembhard & Edmonson, 2006; O'Donovan & Mcauliffe, 2020), in addition to offering choice and flexibility (Slemp et al., 2018), can reduce these hierarchal differences and support wellbeing and overall work performance. Therefore, administrators may thrive best at work through leadership that focuses on inclusivity and autonomy.

Theoretical Implications

Organisational staff support approaches, such as PIEs (Haigh et al., 2012; Keats et al., 2012) and TIC (SAMHSA, 2014) aim to improve the psychological and emotional wellbeing of both staff and service-users (Homeless Link, 2024). There are six principles of TIC; safety, trust, peer support, collaboration, empowerment and cultural sensitivity (SAMHSA, 2014). Additionally, two key principles of PIEs are supporting staff-service-user relationships and the provision of staff training (Homeless Link, 2024). The findings of this study largely corresponds to these principles, and may explain why participants had a high overall job satisfaction. For example, teams created physical and psychological safety for many participants through offering a safe space to talk and providing practical advice and validation. Moreover, participants were empowered through their management offering choice and control within their role. Therefore, FMHS's should focus on a commitment through system-level policies and practice to creating psychologically and trauma informed organisations to support the wellbeing of all staff, including administrators (Emsley et al., 2022). It is hopeful that psychologists working in leadership roles in FMHS's can play a key role in supporting administrators wellbeing, for example, through using their knowledge and skillset to offer training, reflective practice groups and supervision (Conniff, 2022).

Strengths and limitations

This study is original and clinically relevant, providing valuable insights into the experiences and wellbeing of administrators working in FMHS's. This is in line with the NHS Long-Term Plan (2019) and People Plan (2020) and it is hopeful that this research will add to the literature on improving staff wellbeing in the NHS. However, a limitation of this research is that it only captured the voices of administrative staff who overall were satisfied in their role. Participants in this study had been in their role for at least one year, with the majority working in a FMHS for three years and more. Administrative staff who had less job satisfaction may not have felt comfortable or safe to share their experiences. In addition, the inclusion criteria for this study meant that the voices of previously employed administrators were not included, meaning that their experiences and reason for leaving was not captured. Furthermore, transferability may be impacted by all participants being female and 71% being White British.

Future research

Despite there being expanding research on the experiences and wellbeing of mental health professionals, there is currently limited research on administrative staff. Future research should continue to understand the experiences of FMH administrators. Recruiting from NHS trusts in a larger geographic area may assist with capturing a variety of experiences, with this study including two NHS trusts both located in the Midlands of the UK. In addition, future research should aim to include greater participant representation and include administrators who had left their role. Further research is required to explore the experiences and wellbeing of administrators working in other NHS services, such as secondary care mental health. Additionally, the findings indicated that compassion satisfaction could be important in protecting administrator's wellbeing and job satisfaction. To the authors knowledge there is no current research on compassion satisfaction in administrative/ non-clinical roles, therefore, research on the role of compassion satisfaction in wellbeing for non-clinical roles would be valuable.

Conclusion

This research aimed to explore the emotional experiences and wellbeing of administrative staff working in FMHS's. Findings indicated the importance of administrators having emotional support and psychological safety. Administrative managers should ensure safe and reflective spaces are available, where staff feel able to share their feelings without judgement. Administrative staff should be equipped and empowered with skills and knowledge to feel safe in the presence of service-users through training on conflict management and understanding service-user presentations through formulation. It is hopeful that these recommendations would create an environment where administrators feel supported, valued and appreciated. This research is one of few studies exploring the wellbeing of administrative staff working in mental health settings and greater research is needed in this area to continue supporting the wellbeing of all NHS staff.

References

Against Violence & Abuse (2017). *Good Practice Briefing, Psychologically Informed Environments*. Against Violence & Abuse. https://avaproject.org.uk/wp-content/uploads/2017/09/PIE-Ascent-good-practice-briefing1.pdf

American Psychiatric Association, D. S. M. T. F., & American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5, No. 5). American Psychiatric Association.

Aurora, M., Mawren, D., & Fullam, R. (2023). An Exploratory Evaluation of the Impact and Acceptability of a Structured Reflective Practice Program Piloted with Staff in a Forensic Mental Health Setting. *International Journal of Forensic Mental Health*, 1–12. https://doi.org/10.1080/14999013.2023.2174213

Barrera, A., Attard, C., & Chaplin, R. (Eds.). (2019). *Oxford textbook of inpatient psychiatry*. Oxford University Press.

Beryl, R., Davies, J., & Völlm, B. (2018). Lived experience of working with female patients in a high-secure mental health setting. *International journal of mental health nursing*, *27*(1), 82-91. https://doi.org/10.1111/inm.12297

Boyland, J. R. (2019). A social constructivist approach to the gathering of empirical data. *Australian counselling research journal*, *13*(2), 30-34.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Burns, C. M., Morley, J., Bradshaw, R., & Domene, J. (2008). The emotional impact on and coping strategies employed by police teams investigating internet child exploitation. *Traumatology, 14*(2), 20–31. https://doi.org/10.1177/1534765608319082

Carmeli, A., Reiter-Palmon, R., & Ziv, E. (2010). Inclusive leadership and employee involvement in creative tasks in the workplace: The mediating role of psychological safety. *Creativity Research Journal*, *22*(3), 250-260. https://doi.org/10.1080/10400419.2010.504654

Chambers, F., & Kelly, M. (2006). Violence at work: the experience of general practice receptionists. *Irish medical journal*, *99*(6), 169-171.

Clark, S. L., Miller, B., Akin, B. A., Byers, K., Wright, K., Carr, K., & Hunt, M. K. (2024). Exploring the relationships between self-care and well-being outcomes among child welfare professionals. *Journal of Public Child Welfare*, 1-31. https://doi.org/10.1080/15548732.2024.2306151

Conniff, H. (2022, November 24). *The Changing Profile of Staff Support*. The British Psychological Society. https://www.bps.org.uk/psychologist/changing-profile-staff-support

Cramer, R. J., Ireland, J. L., Hartley, V., Long, M. M., Ireland, C. A., & Wilkins, T. (2020). Coping, mental health, and subjective well-being among mental health staff working

in secure forensic psychiatric settings: Results from a workplace health assessment. *Psychological Services, 17*(2), 160–169. https://doi.org/10.1037/ser0000354

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process*. Sage Publications.

Davies, J., Black, S., Bentley, N., & Nagi, C. (2013). Forensic case formulation: Theoretical, ethical and practical issues. *Criminal Behaviour and Mental Health*, *23*(4), 304-314. https://doi.org/10.1002/cbm.1882

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, *95*(3), 542–575. https://doi.org/10.1037/0033-2909.95.3.542

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist*, *55*(1), 34–43. https://doi.org/10.1037/0003-066x.55.1.34

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative science quarterly*, *44*(2), 350-383. https://doi.org/10.2307/2666999

Emsley, E., Smith, J., Martin, D., & Lewis, N. V. (2022). Trauma-informed Care in the UK: Where Are we? A Qualitative Study of Health Policies and Professional Perspectives. *BMC Health Services Research*, *22*(1), 1-12. https://doi.org/10.1186/s12913-022-08461-w

Engward, H., & Goldspink, S. (2020). Lodgers in the house: Living with the data in interpretive phenomenological analysis research. *Reflective Practice*, *21*(1), 41-53. https://doi.org/10.1080/14623943.2019.1708305

Ewers, P., Bradshaw, T., McGovern, J., & Ewers, B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of advanced nursing*, *37*(5), 470-476. https://doi.org/10.1046/j.1365-2648.2002.02115.x

Figley, C. R. (1995a). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). Brunner/Mazel

Frazier, M. L., Fainshmidt, S., Klinger, R. L., Pezeshkan, A., & Vracheva, V. (2017). Psychological safety: A meta-analytic review and extension. *Personnel psychology*, *70*(1), 113-165. https://doi.org/10.1111/peps.12183

Freeman, M. (2008). Hermeneutics. *The Sage encyclopaedia of qualitative research methods*, *1*, 385-388.

Haigh, R., Harrison, T., Johnson, R., Paget, S., & Williams, S. (2012). Psychologically informed environments and the "Enabling Environments" initiative. *Housing, Care and Support*, *15*(1), 34–42. https://doi.org/10.1108/14608791211238412

Hearn, E. B. (2023, November 20). *Trauma-informed care at a forensic mental health ward*. Nursing Times. https://www.nursingtimes.net/roles/mental-health-nurses/trauma-informed-care-at-a-forensic-mental-health-ward-20-11-2023/

Hennekam, S., Ladge, J., & Shymko, Y. (2020). From zero to hero: An exploratory study examining sudden hero status among nonphysician health care workers during the COVID-19 pandemic. *Journal of Applied Psychology*, *105*(10), 1088. https://doi.org/10.1037/apl0000832

Hersh, U. (2023). Underappreciated and undervalued: nurse dissatisfaction and the COVID-19 pandemic. In *Handbook of Research on Transforming Government, Nonprofits, and Healthcare in a Post-Pandemic Era* (pp. 234-272). IGI Global. DOI: 10.4018/978-1-6684-2314-1.ch014

Hewko, S. J., Cooper, S. L., Huynh, H., Spiwek, T. L., Carleton, H. L., Reid, S., & Cummings, G. G. (2015). Invisible no more: a scoping review of the health care aide workforce literature. *BMC Nursing*, *14*(1). 1-17. https://doi.org/10.1186/s12912-015-0090-x

Hiller, J. (2016). *Epistemological foundations of objectivist and interpretivist research*. Barcelona Publishers.

Hirak, R., Peng, A. C., Carmeli, A., & Schaubroeck, J. M. (2012). Linking leader inclusiveness to work unit performance: The importance of psychological safety and learning from failures. *The Leadership Quarterly*, *23*(1), 107-117. https://doi.org/10.1016/j.leaqua.2011.11.009

Homeless Link. (2024). *Trauma Informed Care and Psychologically Informed Environments.* Homeless Link. Trauma-Informed Care and Psychologically Informed Environments | Homeless Link

Ireland, C. A., Chu, S., Ireland, J. L., Hartley, V., Ozanne, R., & Lewis, M. (2021). Extreme stress events in a forensic hospital setting: Prevalence, impact, and protective factors in staff. *Issues in Mental Health Nursing*, *43*(5), 418–433. https://doi.org/10.1080/01612840.2021.2003492

Jacob, J. D., & Holmes, D. (2011). The culture of fear: Expanding the concept of risk in forensic psychiatric nursing. *International Journal of Culture and Mental Health*, *4*(2), 106-115. https://doi.org/10.1080/17542863.2010.519123

Jones, G., Hocine, M., Salomon, J., Dab, W., & Temime, L. (2015). Demographic and occupational predictors of stress and fatigue in French intensive-care registered nurses and nurses' aides: a cross-sectional study. *International journal of nursing studies*, *52*(1), 250-259. https://doi.org/10.1016/j.ijnurstu.2014.07.015

Keats, H., Maguire, N., Johnson, R., & Cockersall, P. (2012). *Psychologically informed services for homeless people. Good practice guide.* Department for Communities and Local Government. Good%20practice%20guide%20-%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf (soton.ac.uk)

Korkmaz, A. V., Van Engen, M. L., Knappert, L., & Schalk, R. (2022). About and beyond leading uniqueness and belongingness: A systematic review of inclusive leadership research. *Human Resource Management Review*, *32*(4), 100894. https://doi.org/10.1016/j.hrmr.2022.100894

Koutra, K., Mavroeides, G., & Triliva, S. (2022). Mental Health Professionals' Attitudes Towards People with Severe Mental Illness: Are they Related to Professional Quality of Life? *Community Mental Health Journal*, 1-12. https://doi.org/10.1007/s10597-021-00874-x

Malik, S., Blake, H., & Batt, M. (2011). How healthy are our nurses? New and registered nurses compared. *British Journal of Nursing*, *20*(8), 489–496. https://doi.org/10.12968/bjon.2011.20.8.489

Mangaoil, R. A., Cleverley, K., & Peter, E. (2020). Immediate staff debriefing following seclusion or restraint use in inpatient mental health settings: a scoping review. *Clinical nursing research*, *29*(7), 479-495. https://doi.org/10.1177/1054773818791085

Marshall, L. A., Adams, E. A., & Stuckey, M. I. (2019). Relationships, experience, and support: staff perception of safety in a forensic mental health facility. *The Journal of Forensic Psychiatry & Psychology*, *30*(5), 824–835. https://doi.org/10.1080/14789949.2019.1642368

Martin, S. (2022, Jan 22). *Supervision Policy.* Midlands Partnership NHS Foundation Trust. https://c9online.sharepoint.com/sites/MPFT/library/docs/Supervision%20Policy.pdf#search= supervision%20standards

Morabito, M. S., Pattavina, A., & Williams, L. M. (2020). Vicarious trauma, secondary traumatic stress or burnout? An exploratory study of the effects of investigating sexual assault cases on detectives. *Policing: An International Journal*, *44*(1), 77–92. https://doi.org/10.1108/pijpsm-07-2020-0123

Mullen, P. E. (2000). Forensic mental health. *The British journal of psychiatry*, *176*(4), 307-311. https://doi.org/10.1192/bjp.176.4.307

Mullholland, R. (2015). Resilience, burnout and psychological well-being in forensic health care professionals working in a secure setting. In *20th NAPICU Annual Conference. University of Warwick*.

Nembhard, I. M., & Edmondson, A. C. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, *27*(7), 941-966. https://doi.org/10.1002/job.413

Newman, C., Eason, M., & Kinghorn, G. (2019). Incidence of vicarious trauma in correctional health and forensic mental health staff in New South Wales, Australia. *Journal of Forensic Nursing*, *15*(3), 183-192. *DOI:* 10.1097/JFN.0000000000000245

Newman, C., Roche, M., & Elliott, D. (2021). Exposure to workplace trauma for forensic mental health nurses: A scoping review. *International journal of nursing studies*, *117*, 103897. https://doi.org/10.1016/j.ijnurstu.2021.103897

Newman, C., Roche, M., & Elliott, D. (2022). Vicarious trauma and health outcomes in forensic mental health nurses. *Journal of forensic nursing*, 10-1097. *DOI:* 10.1097/JFN.0000000000000450

Newman, C., Roche, M., & Elliott, D. (2023). Exposure to patient aggression and health outcomes for forensic mental health nurses: A cross-sectional survey. *Journal of Advanced Nursing*, *80*(3), 1201-1211.https://doi.org/10.1111/jan.15885

NHS England. (2020). *NHS People Plan for 2020/2021 – action for us all.* NHS England. https://www.england.nhs.uk/ournhspeople/

NHS England. (2023). *Consolidated NHS Provider Accounts 2021/22.* NHS England. consolidated-provider-accounts-21-22-final.pdf (england.nhs.uk)

NHS Staff Survey Results. (2023). *2023 National NHS Staff Survey.* NHS Staff Survey. https://www.nhsstaffsurveys.com/results/national-results/

NHS. (2019). *NHS Long Term Plan*. NHS. https://www.longtermplan.nhs.uk/

O'Donovan, R., & McAuliffe, E. (2020). A systematic review exploring the content and outcomes of interventions to improve psychological safety, speaking up and voice behaviour. *BMC health services research*, *20*(1), 1-11. https://doi.org/10.1186/s12913-020-4931-2

O'Beirne, M., Sterling, P., Palacios-Derflingher, L., Hohman, S., & Zwicker, K. (2012). Emotional impact of patient safety incidents on family physicians and their office staff. *The Journal of the American Board of Family Medicine*, *25*(2), 177-183. DOI: https://doi.org/10.3122/jabfm.2012.02.110166

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. (2012). The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica*, *125*(6), 425–439. https://doi.org/10.1111/j.1600-0447.2012.01827.x

Perez, L. M., Jones, J., Englert, D. R., & Sachau, D. (2010). Secondary Traumatic Stress and Burnout among Law Enforcement Investigators Exposed to Disturbing Media Images. *Journal of Police and Criminal Psychology*, *25*(2), 113–124. https://doi.org/10.1007/s11896-010-9066-7

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14. DOI: 10.14691/CPPJ.20.1.7

Pirelli, G., Formon, D. L., & Maloney, K. (2020). Preventing vicarious trauma (VT), compassion fatigue (CF), and burnout (BO) in forensic mental health: Forensic psychology as exemplar. *Professional Psychology: Research and Practice*, *51*(5) 454-466. https://doi.org/10.1037/pro0000293

Powell, M., Dawson, J., Topakas, A., Durose, J., & Fewtrell, C. (2014). Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data. *Health Services and Delivery Research*, *2*(50), 1–306. https://doi.org/10.3310/hsdr02500

Procter, N., Ayling, B., Croft, L., Degaris, P., Devine, M., Dimanic, A., Fiore, L., Eaton, H., Edwards, M., Ferguson, M., Lang, S., Rebellato, A., Shaw, K., Sullivan, R., Procter, N., & Fiore, D. (2017). *Trauma-informed approaches in mental health: A practical resource for health professionals*. University of South Australia. https://www.unisa.edu.au/siteassets/episerver-6-files/global/research/mhsp/trauma-informed-approaches-in-forensic-mental-health-resource.pdf

Quirk, H., Crank, H., Carter, A., Leahy, H., & Copeland, R. J. (2018). Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study. *BMC Public Health*, *18*(1), 1-14. https://doi.org/10.1186/s12889-018-6283-y

Rodrigues, N. C., Ham, E., Kirsh, B., Seto, M. C., & Hilton, N. Z. (2021). Mental health workers' experiences of support and help-seeking following workplace violence: A qualitative study. *Nursing & Health Sciences*, *23*(2), 381-388. https://doi.org/10.1111/nhs.12816

Schneider, C., Hobson, C. W., & Shelton, K. H. (2021). "Grounding a PIE in the sky": Laying empirical foundations for a psychologically informed environment (PIE) to enhance well-being and practice in a homeless organisation. *Health & Social Care in the Community*, *30*(3), e657-e667. https://doi.org/10.1111/hsc.13435

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In *Handbook of qualitative research* (pp. 189-213). SAGE Publishing.

Schwandt, T. A. (2014). *The Sage dictionary of qualitative inquiry*. Sage publications.

Simjouw, A., de Vogel, V., & de Ruiter, C. (2024). Trauma-Informed Care Training in Forensic Mental Health Services: A Scoping Review. *International Journal of Forensic Mental Health*, 1-15. https://doi.org/10.1080/14999013.2024.2323934

Slemp, G. R., Kern, M. L., Patrick, K. J., & Ryan, R. M. (2018). Leader autonomy support in the workplace: A meta-analytic review. *Motivation and Emotion, 42*(5), 706–724. https://doi.org/10.1007/s11031-018-9698-y

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods*. Sage Publications, Inc.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain*, *9*(1), 41-42. Doi: 10.1177/2049463714541642

Smith, J. A., Flowers, P., Larkin, M. (2021). *Interpretative Phenomenological Analysis: Theory, Method and Research* (2nd ed.). Sage Publications.

Smith, J. A., Harré, R., & Van Langenhove, L. (Eds.). (1995). *Rethinking psychology* (Vol. 3). Sage.

Sørensen, T., Tingleff, E. B., & Gildberg, F. A. (2018). Feeling safe and taking on responsibilities: Newly graduated nurses' perceptions and evaluations of their transition into a forensic mental health inpatient setting. *Journal of Forensic Nursing*, *14*(3), 126-134. *DOI:* 10.1097/JFN.0000000000000190

Stamm, B. H. (2002). *Professional quality of life: Compassion satisfaction and fatigue subscales-III, 1995-2002*. Retrieved January, 4, 2019, from http://www.isu.edu/~bhstamm

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* SAMHSA. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Twigg, J., Methley, A., Leighton, Z., Meehan, R., & Kirkby, A. (2020). Using supervision to improve the wellbeing of administrative staff in a busy Neuropsychology department: A pilot service initiative. *Clinical Psychology Forum*, *1*(334), 39–44. https://doi.org/10.53841/bpscpf.2020.1.334.39

Verstegen, N., Peters-Scheffer, N., Didden, R., & de Vogel, V. (2024). 'You Still Need to Care for the patient'. Experiences of Forensic Mental Health Professionals with Inpatient Aggression. *International Journal of Forensic Mental Health*, 1-12. https://doi.org/10.1080/14999013.2024.2354286

Ward, J., & Wood, C. (2000). Education and Training of Healthcare staff: the Barriers to Its Success. *European Journal of Cancer Care*, *9*(2), 80–85. https://doi.org/10.1046/j.1365-2354.2000.00205.x

Appendix 1: Staffordshire University Ethical Approval

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Esme Belcher
Title of Study	Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services: An IPA study
Status of approval:	**Approved**

Thank you for your submission to the Independent Peer Review (IPR) Panel. Your application is now approved

Action now required:
You must now apply to the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without Health Research Authority (HRA) approval, and relevant site-specific approvals. Please note that the University Sponsor contact to be named on the form is Prof Nachi Chockalingam.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received HRA approval, and participating Trusts/organisations have confirmed their capacity and capability to support your study, you can commence your research. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any divergence from this approved proposal.

When your study is complete, please send an end of study report to me: e.tolhurst@staffs.ac.uk. A template can be found on the ethics Blackboard site.

Comments for your consideration: None

g Tol

Signed: Dr Edward Tolhurst   Date: 16th January 2023
University IPR coordinator

Appendix 2: Health Research Authority Ethical Approval

Miss Esme Belcher
5 Hammond Close
Droitwich
WR9 7SZ

15 June 2023

Dear Miss Belcher

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services: An IPA study.**
IRAS project ID:	**326381**
Protocol number:	**N/A**
REC reference:	**23/HRA/1515**
Sponsor	**Staffordshire University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix 3: Recruitment flyer

Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services

STAFFORDSHIRE UNIVERSITY

Do you work in an administrative role in a Forensic Mental Health service?

Take part in a study exploring the emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services

Eligibility criteria:

· Have you worked in this administrative role for more than 6 months?

Participation involves:

· Completing an interview that will last up to 90 minutes, either online using Microsoft Teams or face to face at your place of work.

If interested please contact the lead researcher for more information:

Esme Belcher (Trainee Clinical Psychologist)
Contact number: 07713800487
Email: b026009l@student.staffs.ac.uk
This research is supervised by Dr Yvonne Melia (Principal Lecturer in Clinical Psychology at Staffordshire University)

This research is part of my Doctorate in Clinical Psychology at Staffordshire Univeristy and has gained ethical approval through the NHS Health Research Authority.

INFORMATION SHEET FOR PARTICIPANTS

Title of study

Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services: An IPA study.

Invitation Paragraph

I would like to invite you to participate in this research project which forms part of my Doctorate in Clinical Psychology. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This study is asking administrative staff members working in Forensic Mental Health Services about their emotional experiences and wellbeing when working in their role.

Why have I been invited to take part?

You have been invited to take part in this study because we are exploring the emotional experiences and wellbeing of administrative members of staff working in Forensic Mental Health Services. To be eligible to take part in this study you must meet the following criteria: currently work in an administrative role in a Forensic Mental Health Service for a minimum of six months.

What will happen if I take part?

If you choose to take part in this research then you will be asked to participate in an interview. This interview will ask you about your experiences of working in your role, for example *"please tell me about the responsibilities that make up your role"*.

This interview will take place either remotely using Microsoft Teams or face to face at your place of work, depending on your preference. The interview will last up to ninety minutes. The interview will provide important information on the emotional experiences of administrative members of staff who work in Forensic Mental Health Services, which is currently an under-researched area. The interview will be audio recorded using a Dictaphone if completed face to face and recorded audio/visually if over Microsoft Teams (you will have the choice whether to keep your camera on or off). This interview will only be recorded with your consent prior to recording, and the researcher will indicate the start of the recording. If you do not consent for the interview to be recorded it will not be possible to proceed with the interview.

When a recording of an interview is made on Microsoft Teams, it is saved to Microsoft Stream cloud storage. The recording will be immediately downloaded from Microsoft Stream and transferred to secure local storage on a Staffordshire University password protected computer using an anonymised file name. Any recordings made in person will also be anonymised and transferred from the Dictaphones memory card to the same secure local storage.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

We don't envisage any risks from taking part in this research. However, if you found discussing your experiences of working in your role distressing, we will provide you with signposting details to a number of services that can provide wellbeing support.

If you wish to make a disclosure about wrongdoing in your service, we suggest that you raise this with your manager/ HR. If you were to disclose something during your interview that may lead to yourself, members of the team or service-users being at risk of harm, we may have to take this outside of the research setting. Please take this into consideration whilst answering each question.

What are the possible benefits of taking part?

There are unlikely to be any direct benefits to you personally, however, sometimes participants can find benefit from discussing their experiences. Your information will help us to have a greater understanding of the emotional experiences of administrative staff working in Forensic Mental Health Services. In addition to recommendations that could support the wellbeing of administrative staff working in these roles.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your
- Name
- Contact details

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will be anonymised by using a pseudonym. Any information that could be identifiable will be removed or changed to ensure confidentiality. We will keep all information about you safe and secure on a password protected computer.

In line with University policy, your data will be retained for ten years before being destroyed. This will not include audio recordings, demographic information and contact details, which will be destroyed after the study has ended or when no longer required. Consent forms will be destroyed after 3 months of the study being completed.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data until up to two weeks after the interview has taken place, after which withdrawal of your data will no longer be possible due to the data already being committed to the final analysis

Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- Our leaflet available from http://www.hra.nhs.uk/patientdataandresearch
- by sending an email to dataprotection@staffs.ac.uk, or
- by ringing us on 07811 827763

Data Protection Statement

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are able to withdraw your data up until two weeks after the interview has taken place, after which withdrawal of your data will no longer be possible due to the data already being committed to the final analysis.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study. If you wish to withdraw please contact Esme Belcher on the contact details below.

What will happen to the results of the study?

The research will be written up as part of the researcher's doctoral thesis. The results of the study will be available after it finishes and will usually be published in a peer reviewed journal that will be publicly available. The research findings may also be presented in conferences/ seminars and may be used in teaching and training. The data, including quotations from your interview, will be anonymous and none of the participants involved in the study will be identifiable in any report or publication. An executive summary of the final research can be provided to you on request.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Principal Investigator

Name: Esme Belcher

Telephone: 07811 827763

Email: b026009l@student.staffs.ac.uk

Chief Investigator

Name: Dr Yvonne Melia

Telephone: 01782 294103

Email: Yvonne.melia@staffs.ac.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Director of Research

Name: Dr Nachiappan Chockalingam

Email: n.chockalingam@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research

RESEARCH PROJECT CONSENT FORM

Title of Project:

Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services: An IPA study.

Researcher: Esme Belcher

I have read and understood the information sheet.	Yes ☐	No ☐
I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.	Yes ☐	No ☐
I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation	Yes ☐	No ☐
I understand that the interview will be audio-recorded/video recorded. If the interview is taking place remotely, you are able to turn your camera off if preferred.	Yes ☐	No ☐
I consent that data (including direct quotes) collected could be used for publication in a scientific journal, could be presented in scientific forums (conferences, seminars, workshops), or can be used for teaching purposes. I understand that all data will be presented anonymously.	Yes ☐	No ☐
I agree that data will only be used for this project, although the data may also be audited for quality control purposes	Yes ☐	No ☐

All data will be stored safely on a password protected computer (electronic data), or locked away securely (hard copies of data) for 10 years before being destroyed   Yes ☐ No ☐

I understand that I can withdraw my data from the project up to two weeks post interview without having to give an explanation   Yes ☐ No ☐

I hereby give consent to take part in this study   Yes ☐ No ☐

_____   _____   _____

Name Participant (print)   Date   Signature

_____   _____   _____

Name Researcher (print)   Date   Signature

RESEARCH PROJECT DEBRIEF FORM

Title of Project:

Emotional experiences and wellbeing of administrative staff working in Forensic Mental Health Services: An IPA study.

Researcher:

Esme Belcher (Trainee Clinical Psychologist)

Aims of study:

The primary aim of this study is to explore the emotional experiences and wellbeing of administrative staff who work in Forensic Mental Health Services.

The secondary aim of this study is to make recommendations, based on the experiences of administrative staff working in Forensic Mental Health Services, on areas of support staff may need when working in administrative roles.

Why was this study developed?

The NHS Long Term Plan is working on improving the health and wellbeing of their workforce. Research has indicated that working in Forensic Mental Health Services can be especially challenging, due to the complex difficulties experienced by this client group. There is a large amount of published research on the experiences and wellbeing of mental health professionals who work in the NHS and Forensic Mental Health Services. However, there is very little research that explores the experiences of administrative members of staff who work in these services. Administrative members of staff are integral to services and your role is demanding and challenging. We therefore felt it was imperative to explore the experiences and wellbeing of administrative members of staff who work in Forensic Mental Health Services, and based on your experiences, make recommendations on areas of support that may be beneficial.

What if I change my mind about taking part?

You are able to withdraw your data up until two weeks after the interview has taken place, after which withdrawal of your data will no longer be possible due to the data already being committed to the final analysis. If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study. If

you wish to withdraw your data from this study please contact Esme Belcher on the details below.

Can I read the results of this study?

Yes, if you wish to read the results of this study then an executive summary can be sent to you once the research is complete and the study has been written up. Please contact Esme Belcher on the details below if you wish for this executive summary to be sent to you.

Whistleblowing:
If you wish to disclose information about wrongdoing in your workplace, please contact your line manager and/ or HR.

You can also contact Protect (https://protect-advice.org.uk/), which offers free confidential advice. Telephone number: 020 3117 2520.

Support services:
If you feel that you need support after participating in this interview or general wellbeing support, services that can offer this are listed below.

- If you have an issue at work please contact your manager, HR and/or Occupational Health to discuss this further.

  ➢ Citizens Advice Bureau provide free advice regarding dealing with a problem at work. You can find your nearest Citizens Advice Bureau by using this website: https://www.citizensadvice.org.uk/about-us/contact-us/contact-us/contact-us/ or contact 0800 144 8848 (9am-5pm Mon-Fri).

- You can self-refer to your local IAPT Service. This website helps you find your nearest IAPT service: https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

- You can contact the Samaritans on: www.samaritans.org or tel 116 123, who are open 24 hours a day.

- You can contact SANEline on: www.sane.org.uk or tel 0300 304 7000, who are open from 4.30pm-10.30pm.

- You can contact SHOUT on: www.giveusashout.org or text Shout to 85258, who are open 24 hours a day.

Who should I contact about this study?

If you have any further questions or wish to read the results of this study please contact:

Principle Investigator

Name: Esme Belcher

Telephone: 07811 827763

Email: b026009l@student.staffs.ac.uk

Chief Investigator

Name: Dr Yvonne Melia

Telephone: 01782 294103

Email: Yvonne.melia@staffs.ac.uk

I wish to thank you again for participating in this research. Your time given to this research and the experiences you discussed are highly valued and appreciated.

Interview Schedule

The aim of this interview is to gain an in-depth understanding of your experience of working in your role. I am interested in exploring your thoughts, feelings, perceptions and reflections. There are no right or wrong answers and I would like you to be as open and honest at possible. I may say very little because I am interested in listening to your views. Some questions may seem obvious but this is because I am interested in hearing your personal thoughts and feelings. Please take your time in thinking and talking.

If you wish to make a disclosure about wrongdoing in your service, we suggest that you raise this with your manager/ HR. If you were to disclose something during your interview that may lead to yourself, members of the team or service-users being at risk of harm, we may have to take this outside of the research setting. Please take this into consideration whilst answering each question.

Questions:

1. **Can you tell me about how you came to get your job?**
   - What drew you to working in FMHS?
   - What did you expect the role to be like?

2. **Tell me about the responsibilities that make up your role?**
   - What tasks make up your role? How do you feel when completing X task?
   - Describe to me what a day is like in your role?

3. **Can you tell me about your personal experiences of working in your role?**
   - Are there any experiences or significant days of work that stand out to you that you feel comfortable sharing today? How did you feel during that time/ on that day?

4. **What is the most satisfying/ rewarding aspect(s) of your role?**
   - What do you enjoy most about working in your role?
   - How do you feel when completing this part of your role?
   - What about this brings you satisfaction?
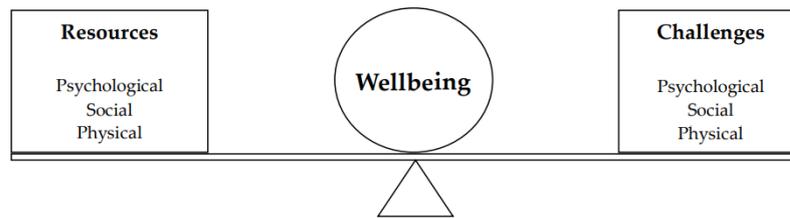   - Does this have an impact on your wellbeing?

5. **What do you find most difficult/ challenging about working in your role?**
   - What makes this part of your role feel challenging?
   - How do you feel when completing this part of your role?

- Does this have an impact on your wellbeing?

6. **As part of this research we are trying to understand your wellbeing and experiences of working in your role. For the purpose of this project we are defining wellbeing as:**

Wellbeing is "the balance point between an individual's resources and the challenges faced" (Dodge et al. 2012)

Figure 4. Definition of Wellbeing

Resources	Wellbeing	Challenges
Psychological Social Physical		Psychological Social Physical

If you were to reflect on your general sense of wellbeing, how would you sum this up?

- How do you cope with or manage these feelings/ experiences?
- Is there anything you do more of, less of or avoid to help with this?
- Does this have any impact on other areas of your life e.g. home, relationships with others?
- How easy do you find it to switch off from work?

7. **You may work with a variety of different healthcare professionals and workers within your role, can you please tell me about your experiences of this?**
- For example, psychologists, psychiatrists, OT's, nurses, HCA's
- What do you think about that? How does it make you feel?

8. **Can you tell me about the support you receive to perform your role?**
- What support is of most benefit, why?
- Tell me about how you cope.
- Would any additional support be beneficial?

9. **From your experience, do any factors help you to meet your responsibilities? Can you tell me about these please.**
- What about this helps you meet your responsibilities?
- Does this have an impact on how you feel?
- Does this have an impact on your wellbeing?

10. **From your experience, do any factors hinder your ability to meet your responsibilities? Can you tell me about these please.**
- What about this does not help you meet your responsibilities?
- Does this have an impact on how you feel?
- Does this have an impact on your wellbeing?

11. **Is there anything that we haven't talked about that you think is an important part of your experiences of working in your role?**

General probes:

Why? How? Can you tell me more about that? Tell me what you were thinking? How did you feel? What do you mean by...? Can you give me an example of...?

<u>Appendix 8: Demographic form</u>

<u>Demographic Questionnaire</u>

What age range group do you fit into from the following?

Below 18	☐
18-24	☐
25-34	☐
35-44	☐
45-54	☐
55-64	☐
65 and above	☐

What is your ethnic group?

White	☐
Asian/ Asian British	☐
Black/ African/ Caribbean/ Black British	☐
Mixed/ Multiple Ethnic Groups	☐
Other Ethnic group (please describe)	

What gender do you identify as?

Male	☐
Female	☐
Transgender	☐
Non-binary	☐
Prefer not to say	☐
Other (please describe)	

How long have you worked in an administrative role in a Forensic Mental Health Service?

Less than a year	☐

If more than a year, please state how long

Appendix 9: Example analysis showing exploratory noting and experiential statements (example from Louise and Molly)

Experiential statements		Exploratory notes
	Louise 6:15	
Experience of the Service users and possible assumptions about them has been challenged. Relationships with service users have been positive. Dissonance between assumptions and reality of what service users are like	Yeah, yeah, yeah. Not really so much in negative. More in a positive way. I think like if you spoke to anyone that doesn't work here and told them kind of what kind of service users are here you know, sometimes you are in a room with them and you do activities and stuff with them, like when sometimes in the hospital or you know you pass them like all the time. People wouldn't believe like they'd probably think like we don't believe you. But I think the positive thing that I got out of it is actually what you think and expect is actually nothing like what it is in real life because they (service users) are pleasant and you sometimes forget actually what they're here for what they've done. And that's I think it was so hard	Expectations became positive Other people may not understand the role, may be shocked if they knew that admin staff was in contact with service users – may think it should not be part of role? Service users are pleasant and I can forget what they are in there for.
You can't decompartmentalise. You start to see them more holistically not just by their crime	to decompartmentalise like that. This person actually did such a horrible thing, but they are really pleasant and actually funny and have a good personality and sense of humour. So it's quite difficult to split the two, but I think you do learn to do that though when you work in a setting like this, yeah.	Hard when you remember what crime service users did, but do learn to decompartmentalise Learn over time – comes with experience?

Despite the lack of support being demoralising for staff, there is a reflection of feeling worried that patients safety is at risk and the significant consequences that could happen if a resolution is not found.	**Molly** 1:10. :38 And you know, something could seriously go wrong. You know if we've got a patient, I mean, thankfully they have the office number and they also have other numbers like mobile numbers that they use to call members of the team. However, that sometimes they can't get hold of the members of the team if they are driving or whatever.	Something may go seriously wrong – sense of feeling scared and worried
	If they're in crisis they need to talk to somebody and they need to talk to somebody that will positively react and when you're not there at the office to be able to do that.	Feeling concerned and exasperated over what happens if whilst the phones are down a patient is in crisis and cannot get the help they need?
It is a war against teams, and it is infuriating and exasperating that they are forgetting that the purpose of the service is to help improve people's mental health. A sense that they are purposefully hindering my teams role and sadness over this	Now I know that the one particular patient didn't do anything. It's luckily it wasn't anything bad, but it could have been, you know, and that somebody could be in crisis, that they take their own life. This is what mental health is all about, which is what the NHS trust stands for, but it's like knocking your head up a brick wall with this service.	It feels like you're knocking your head on a brick wall – you cant do anything but its having such a big impact on us and patients

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witnessing traumatic incident indirectly through working online	Witness a service user being restrained when working virtually	**Witnessing incident was quite traumatic. It has had an impact on how I saw other service users**
More hyper vigilant to other service users since incident, read into body language more.	Able to move on from this concern regarding safety	**By witnessing one service user become violent, had more awareness of others that could also become violent**
Worried about safety to self when around service users after witnessing the incident	Hypervigilance around feeling threatened when around service users that reminded me of the incident	Lack of control of situation when witnessing incident online
Incident possibly more frightening due to being in the role for a year and not witnessing a similar incident	Two members of the team checked on wellbeing after witnessing the incident.	Surprised that clinical staff were concerned about wellbeing
Validation of experiences by clinical staff	Shock and amazement that clinical staff took time out to talk to me	**I cant believe they called me just to make sure I was OK**
Spoke to ward manager about feeling threatened by other service users	**When saw service user heart raced and was experiencing dreams about him becoming violent**	Ward manager offered advice on how to cope with feeling unsafe
Feel very supported by team to manage challenges with service users. Now able to talk to service user without feeling threatened	Hypervigilance and threat due to being body language of service user triggering previous memories of incident.	Appreciated the debrief
Practical solution focused advice was most helpful. Stating that it is normal for incidents to happen, but it will be dealt with in a calm manner	I was coached on how to deal with incidents with service users	I get on really well with all the different professional teams
Was apprehensive to be on wards when first started role, but now able to go onto wards and communicate with service users	Now confident enough to talk to service users how I would wish to be spoken to.	The ward manager coached me on how to effectively communicate with service users
Nice to have a normal conversation with service users too.	**Being coached by ward manager gave me confidence to communicate with service users**	Saw service users as separate and different, but since coaching this is no longer the case
I didn't know I was allowed to speak with service users when I first started because im not	**Did not receive any training on communication or de-escalation with service users**	Surprised to not have training.

Surprised to not have training on how to manage these situations	I would run for safety but it would be nice to know if I need to do anything	What would I do, who would I tell? I've never asked these questions but ive also never been told
It would be helpful for a new started to have training on de-escalation	We all know what to do if there is a fire, but what do we do if a service user becomes violent?	Have lots of questions about situations where service users can become violent, such as what happens to the other service users
Confidence and ease in role would increase if had more information regarding tours of the ward and training on communication and de-escalation	Emotional story on what is the most satisfying part of role	Feel emotional thinking about most satisfying part of role, where get to see the journey of service users reaching recovery and going back into the community and have learned from mistakes
Hope service users do not come back into services and stay in recovery	Comparison of feelings of reward when a service users leaves services to a child leaving home	Satisfying to see rehabilitation process and wish service users best for their future
Do sometimes get to hear about how service users are doing, which is very satisfying	Satisfying to see that service users make mistakes but learn from their mistakes	**Seeing rehabilitation first hand makes me see people in a different light**
Link between seeing service users who have committed a crime and rehabilitated and crime seen in personal life	If I was to see a service user in the street I would think how well they are doing	Can now show more hope towards others who have committed crimes
Everyone deserves to be treated equally	World view has changed, people should be treated equally no matter what their mental health difficulty	It is frightening that people who have committed crimes is in the community, but trust in treatment and that they wont reoffend
Second chances and having a fresh start	Most challenging part of the role is knowing what crimes service users have committed, especially if they are crimes against children.	My manager will always pre-brief on any reports that are especially challenging to write and ask if I am ok to write the report
Impact of reading about crimes against children, as a mother feel protective of children and it is hard and distressing	Since working in this role able to look at crimes from a different perspective. Can understand that people were often abused themselves as children.	Find it helpful for wellbeing to read clinical notes for new service users, so that it does not come as a shock when information is shared in meetings
Even though it is distressing to read clinical notes, its good to learn it in own time then be caught off guard	The psychiatrist offers to debrief and checks on wellbeing after reading or writing about distressing information	Due to confidentiality limits, you need to be able to speak to the team as cant talk to family

Key:

Hypervigilance and fear

Learning to not feel threatened: surprise and amazement, coaching alleviated fear and feeling untrained
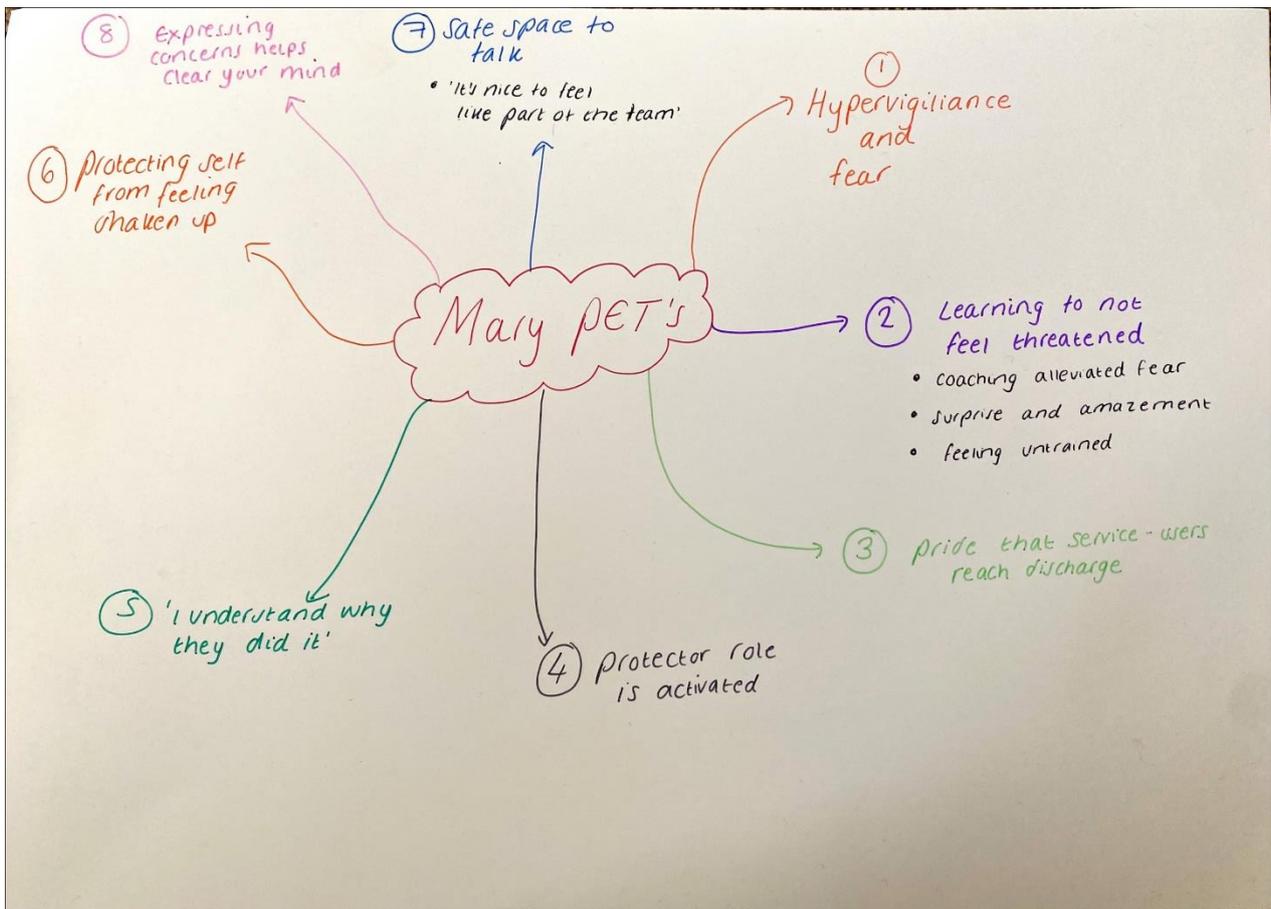
I understand why they did it

Pride that service users reach discharge
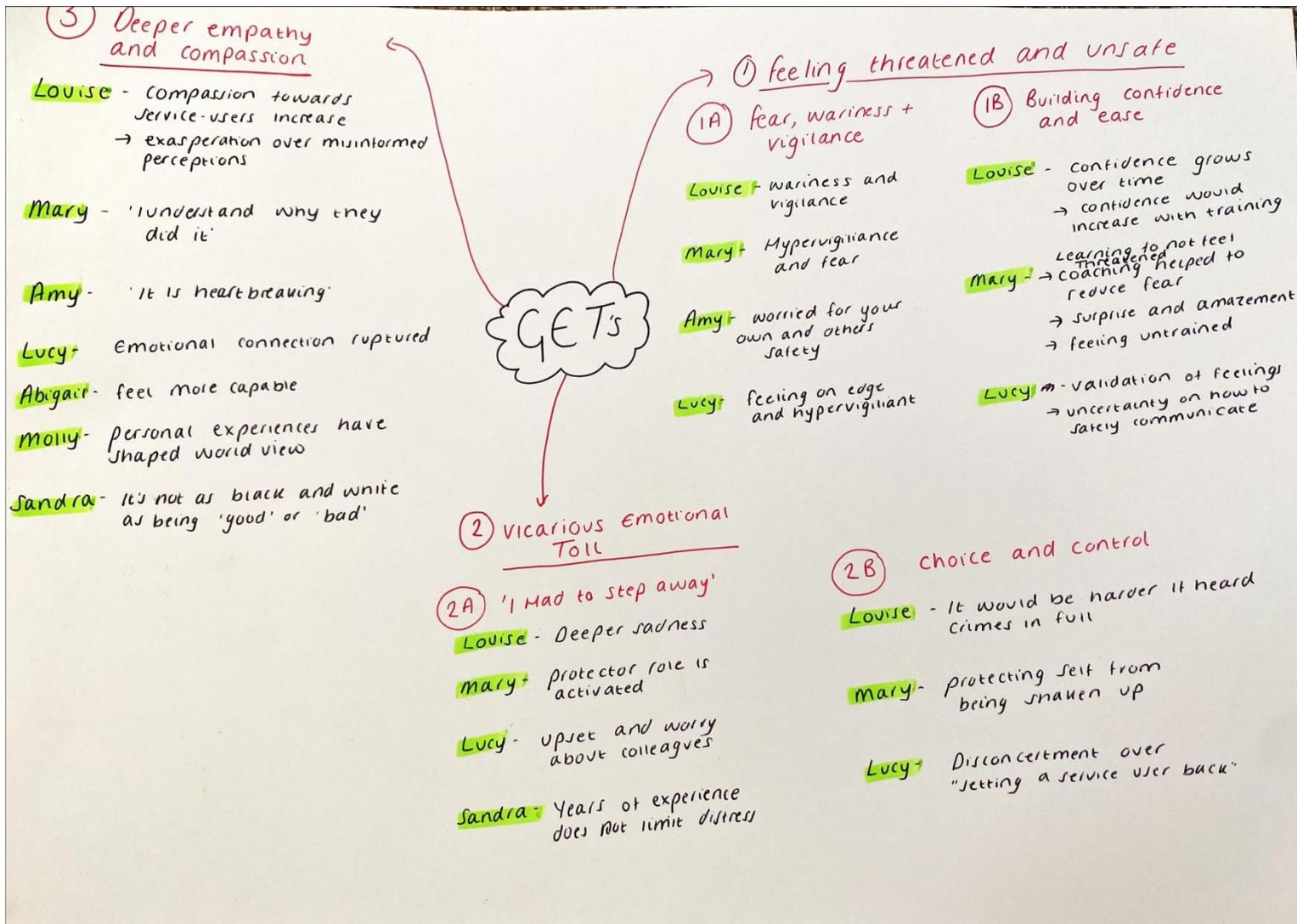
Protector role is activated

Safe space to talk

Protecting self from feeling shaken up

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③ Deeper empathy and compassion

Louise - Compassion towards service-users increase
→ exasperation over misinformed perceptions

Mary - 'I understand why they did it'

Amy - 'It is heartbreaking'

Lucy - Emotional connection ruptured

Abigail - feel more capable

Molly - personal experiences have shaped world view

Sandra - It's not as black and white as being 'good' or 'bad'

GETs

① feeling threatened and unsafe

1A fear, wariness + vigilance

Louise - wariness and vigilance

Mary - Hypervigilance and fear

Amy - worried for your own and others safety

Lucy - feeling on edge and hypervigilant

1B Building confidence and ease

Louise - confidence grows over time
→ confidence would increase with training
Learning to not feel threatened

Mary - coaching helped to reduce fear
→ surprise and amazement
→ feeling untrained

Lucy - validation of feelings
→ uncertainty on how to safely communicate

② Vicarious emotional toll

2A 'I had to step away'

Louise - Deeper sadness

Mary - protector role is activated

Lucy - upset and worry about colleagues

Sandra - Years of experience does not limit distress

2B choice and control

Louise - It would be harder if heard crimes in full

Mary - protecting self from being shaken up

Lucy - Disconcertment over "letting a service user back"

(6) 'Not bottom of the pile'

Louise - Appreciated and valued

Mary - 'Nice to feel part of a team'

Amy - Feel independent and trusted
Being appreciated gives you a boost to carry on

Lucy - Happiness that voice is valued

Abigail - Do not feel taken for granted

GET'S
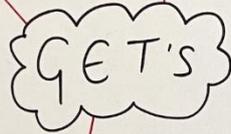
(4) 'Bask in their glory'

Mary - Pride that service-users reach discharge

Abigail - Satisfying to see service-users go onto better things

Sandra - 'sharing a tear'

Lucy - Pride and purpose

Molly - See a service-user as a human being

(5) Safe and supported

(5A) 'You do not feel on your own'

Louise - Appreciation of being part of a community comradeship
- The support is the biggest thing

Mary - Safe space to talk
It's nice to feel like part of a team

Amy - Safe and supportive team culture
feel cared for

Lucy - Emotionally aware and supportive
Abigail - 'It's ok to not be ok'
Molly - Responsibility sits on my shoulders
- psychological safety has been breached
- extreme variations in support

(5B) 'Talking to someone helps clear your mind'

Mary - expressing concerns helps clear your mind

Lucy - opportunities to let go of frustration is vital

Abigail - conceal feelings
- comradery between admin colleagues

Sandra - feeling isolated

GET 1: Feeling threatened and unsafe

1a. Fear, wariness and vigilance

Louise

No matter what you look like service users will make you feel uncomfortable. Recognition that this can be frightening as not exposed to this in real life. Feeling scared over possible escalations.

"And I think as well like it doesn't so much matter like what you look like cause you will always have like little comments or like you'll just feel like eyes like staring at you all like coming towards you like whilst you walking and I think sometimes that can be quite scary." Page 40

Male service-users make inappropriate comments in community, but comparison of knowing offences that have been committed in the service makes this feel more threatening

"Like I said, you're not exposed to that in real life because you just you just know and I think I guess obviously you do, you will go certain places and men will sometimes make comments or like look for maybe a bit longer than they should. And you do feel a bit like "ohh, I feel a bit uncomfortable". Page 40

Male service users making inappropriate comments can make you feel uncomfortable. This can happen in meetings and when walking around communal areas. A sense that male service users make you feel uncomfortable on purpose in disguise of being polite.

"and you do feel a bit like "ohh, I feel a bit uncomfortable". And so that I think it does happen here like in meetings and just like I just in general like as you walking around and sometimes they just kind of obviously they just think they're being polite. But you kind of know that this is overly polite." Page 40

Mary

Witnessed traumatic incident indirectly through working online. Sense of surprise that the incident happened and feeling like the situation was out of my control due to being online and the incident happening in person

"I suppose it was one day when I was covering an MDT and one of the lads kicked off. Obviously in the MDT room, but I was virtual, but that was quite that was quite traumatic for me because at the time I wasn't going in, I was only going into the office once a week and I wasn't joining the MDT though. It was all virtual, so I mean this lad just completely kicked off and was hitting out and obviously everyone was like jumping on him and I was kind of just there watching it and it was quite frightening actually. It was quite frightening." Page 28

More hypervigilant to other service users since incident, read into body language more.

"But yeah, that was quite traumatic. And then there is another one. Actually, I was in the office and one of our chaps is a bit scary, let's just say that without being disrespectful to him. But every time I kind of saw him, I felt quite nervous. And it wasn't because of what he did and why he's here. It is just the way he looked. I actually said to the ward manager, he terrifies me and that was quite frightening." Page 30

By witnessing one service user become violent, had more awareness of others that could also become violent. Had a sense of unease and being more alert around service users. Guard was up more.

"But actually seeing it was was quite frightening. And then seeing my patient just the way he was quite sort of arrogant and I don't wanna say like aggressive. The way he spoke, it was quite aggressive sort of thing and I used to feel for my team when he was in the room. I used to think God hope it doesn't kick off. Sort of thing like that other lad." Page 31

Experienced post traumatic stress symptoms after incident

"And I said I just get real bad heart palpitations and I'd had a dream about him. About like kicking off and stuff."

Amy

Hypervigilance to ensure each staff member was safe. Staff felt unsafe to leave work on their own, awareness of potential violence was greater after this incident.

"There was a violent man where you know people got hurt outside the office and police were called. So it was it was, you know, that was hard…that's the one time I think that really that I'll never forget that people were scared to just even go to the car to go home. We weren't leaving the office on our own, you know, we if one person was going to be left on their own, they just had to go at the same time as everybody else." Page 25

Worrying about the safety of colleagues when not in work. Feeling uncertain about safety and alertness and vigilance over what could happen next

"And over that time I was an annual leave for some of it. So I did worry while I was off work about people at work. UM, but yeah, it was coming to work the next day because you didn't know what you were driving into, but we've got like a WhatsApp group, so people would say on there, you know, it's safe to come we have looked outside, it's safe to come in." page 58

Walking on egg shells whilst at work as you're worried about individual and collective safety

"And yeah, so definitely the most challenging and difficult thing is is gonna be times like that spoke about earlier where, you know, somebody's mental health has gone quite downhill. And then you are walking on egg shells and worried for your own safety and your colleagues really." Page 42

Lucy

Saw the patient at a local shopping centre, felt shock and concern around mine and my families' safety

"But then when she was discharged and I was out in the community, I was at home at a shopping centre, local shopping centre and I suddenly heard somebody called my name and I looked over and it was the patient. Now I was really, really shocked because I didn't know she lived anywhere or she'd moved anywhere by me." Page 23

Was thankful was on my own, rather than the patient being aware of who my family or friends are and possibly put them at risk of harm. Wary of what could happen now patient has seen me

"I was thankful that I was on my own and because I would have, wouldn't have wanted to explain to the person I was with. But also I wouldn't want the patient to have known to have seen anybody a member of my family or a friend or one of the children or anything like that. So I was a bit more wary there and and I think I was very shocked because it's something that I just wasn't expecting." page 24

The situation was unnerving and I felt unsafe due to how close to home it was. Work and home life boundaries were crossed during this incident

"It was not because of what she had done, but because it was just so close to home." Page 25

Because the incident happened so close to home it unsettled me

"I really didn't like it because it was so close to home and it unsettled me" page 28

Hyper vigilant when going to shopping centre after seeing patient due to worrying about seeing them again

"I'll admit a few weeks because it's my local shopping centre and when I used to go down there that like regularly, I would be looking around to make sure all sorts of looking out for her but not really wanting to see her." Page 28

Felt confusion over why I had these feelings if the person had rehabilitated and been discharged

"I'll admit that and you know, I came into work and I I explained what happened to people and I said I can't understand why I'm feeling on edge because of the crime that that person had committed." Page 29

1b. Building confidence and ease

Louise

Asking service users to stop making inappropriate comments is uncomfortable. It is not something you would anticipate in an administrative role. Reflection that this contact is minimal and would likely have greater impact if it was more frequent.

"They need to learn like those boundaries and know what to say at those points where actually I don't feel comfortable that you're doing that. So please can you stop? And so I think stuff like that sometimes can be a little uncomfortable. And again, I don't think it's something that you anticipate would happen working in a role like this. And again I think because that contact is minimal and don't feel like It's too bad with myself because I know it can be worse with others. It's important to say "no, that that this is not okay you need to stop doing that. I don't feel comfortable". They will like stop straight away." Page 41

Seeking advice from member of staff after boundaries were crossed the first time. Felt uncertain in how to appropriately respond to service user. Had a lack of confidence in communicating with service users due to no specific training on this

"Not really, no, I think. Um, I think after it happened the first time, like I did speak to a member of the team that I felt comfortable speaking to when I did say that like this happened, and I'm not sure like if this is normal because it was the first time I said. I did tell them like what I said and that it is OK to say because I think as well when you join a service like this as admin, there is certain training that you don't undergo" page 42

Assumption that a lot of clinical training is not needed for admin staff as the situation is not likely to occur. Recognition that if admin staff were appropriately trained to communicate with service users they would feel safer being on the wards. There would be reduced concern about causing a service user to become agitated or aggressive.

"I think a lot of things actually that admin are not trained on because you never gonna be in that situation where you need to like, get a service user in holds or something like that. They don't teach you any of that. And I would never want to be anywhere like that, I've never had to pull my alarm or anything like that. But equally, I think they should teach us about, like, what we should say in situations like that because you don't want to escalate a situation because what if you say something and it makes them actually feel embarrassed or actually just really angry." Page 43

Gain experience in how to appropriately communicate with service users and this allows you to feel more confident in how to respond if boundaries are crossed or situations are escalated. This happens with time.

"But since then, it's kind of just it decreases because you just implement those boundaries and then they don't start again. And it's really funny because after me,

I have had new members of staff in the team that have started and they've had the same things I've had to say. Like are you OK? And like, yeah, this does happen and they tend to do it to people that are new, but once you like, tell them they'll they'll, like, slowly. Just stop. See here. It's really rubbish actually. But yeah, it's something again that you just can't be prepared for" page 44

Training on how to safely communicate with service users would be beneficial to help feel safe when in contact with service users.

"I'm actually not 100% sure if if clinical staff are trained on that and I assume they are. I'm assuming it's probably like one part of a training that they do and but in terms of admin stuff, we're not trained on that. But I feel like it would be beneficial to be trained on that and just because It does happen as you do come face to face with them" page 47

Mary

Ward manager and team offered advice on how to cope with feeling unsafe around service users. Advice around directly speaking to service users rather than avoiding them to help alleviate fear. Reflection that this advice has been very helpful in managing fear of service users

"And then she said OK, So what you need to do is when you see him is instead of like freezing like you do, you just walk past him and just say hello to him. So that's how I started and that's what I like about the team is that they're all really knowledgeable and they'll give you advice as to how to deal with it. So yeah, I've I've learned. I'm like now I can have a full blown conversation with him and I don't feel threatened in any way" page 35

"She said you know, when we come into work, we don't know what's gonna happen during the day, she said. You know, we've got 20 lads on there and they could just, they could all you know, five of them could get in a massive fight and you know, kick off and hit staff and all that, she said." Page 36

Being coached by ward manager gave me confidence to communicate with service users

"So from that point where I spoke to my manager, the ward manager that gave me the confidence and now they're just like anybody else, I don't."

Was apprehensive to be on wards when first started role, but now able to go onto wards and communicate with service users

"And you know that my deputy ward manager said to me once, why don't you just pop through there and just say hello? And I was like, oh, God, I can't do that. You know, they're patients. I can't do that, but I do. I do do that and I'll just pop and just say hi, guys." Page 38

Did not receive a tour of wards when started role, which has made role more challenging. Would feel more confident to know where to go on wards in order to have a sense of belonging

"No, no, nothing at all (when asked if received any training). It does surprise me. It did. I mean obviously I joined in lockdown, so all my learning was at home, so it was all of that, all of that. But three years down, I've I've still never had a tour of where the service users live." Page 43

Lucy

It was helpful to gain advice from manager who had many years of clinical experience and was able to use these experiences to validate and normalise feelings

"Well, it was helpful for me for one thing, because she had years and years of experience. I mean, she was a nurse to start off with. Not that obviously moved up the ranks and and it helped because she could give me her advice and tell me about her experiences over the years." page 32

Validated feelings by explaining that they were normal and there is no right or wrong way to feel after an incident

And obviously a lot of the other nurses and a lot of the other colleagues that over the years that had spoken to her and I think it's because she was saying it was all perfectly natural. There wasn't anything wrong with me for feeling like that, and there's no right or wrong way feeling about things, if that's how you feel, that's how you feel. Page 33

It helped wellbeing by just sharing thoughts and feelings and someone listening and saying its ok

"And it just it just helped just talking and for somebody with all that experience being able to say to me, no, that's fine. You know you're not a bad person because you're thinking this and you know, do you feel that you don't want to be involved in that side, finding out about patients?" Page 33

Manager was understanding of the impact of knowing patients forensic history, and offered to ensure that it does not happen again. Sense of relief over this

"If that's the case, you know, we'll make sure that you don't have anything to do with that. If anything comes up, we'll get somebody else to do. You know, there was ways around this and I said no, it's just that because it was, it was the first time and it did just make me feel bad." Page 33

Wellbeing improved after sharing feelings and worries with management and them offering clinical advice

"You won't be doing anything that you shouldn't be doing, so once it was all explained to me, it it just helped knowing and talking to somebody about it and sharing it with somebody." Page 33

Understood role and working in forensic mental health by constantly asking questions. Uncertainty about how to communicate with patients

"You know, is it OK for them to know my name. You know my full name because we wear staff name badges or do I have to take it off? So it was more I was constantly asking because I was completely new to the environment." Page 38

Was able to clarify with manager how to appropriately and safely communicate with patients

"But after that I did sort of say how do I handle it when I'm talking to somebody? How do I do this? How do I do that? What can I say? What can't I say? Is it OK for them to for patient to touch me on my shoulder or touch my hair?" Page 34

Manager suggested stating 'boundaries' to patients should be sufficient and will not upset them. Reassuring to know what you can and cannot say

"And if that's how your hair looks really nice and touchy, and she'd say no, you know, all you have to do is all you have to say is boundaries. They know because they have to, therapy sessions and so by you saying ohh mention the name, is that. Ohh, you know, don't forget boundaries. They know then to back off. You won't be setting them off". Page 35

GET 2: Vicarious emotional toll

2a. 'It really brings you down'

Louise

Difference in hypervigilance and worrying regarding crimes before and after having a child, and impact this has at work

"Like I said I went on maternity leave, so I had a daughter and she is 2 years old now and I will say that prior to having a child nothing really fazed me. But I guess I'm human, I do have those feelings, but It didn't faze me too much, but I think like since having a child, I do feel things a little bit more deeper now because I kind of always think 'like ohh God, I've got a child now'. It's almost like when you see a crime against a child and you think how anyone could do that to a child or anything like that." Page 31

Personally struggle with reading about crimes against children more since having a child. Sadness over crimes against children and sense of wanting to protect child.

"And I think you do feel that more when you've had your own. So I think that that's something I guess personally that I struggle with maybe a little bit more now because although nothing like nothing's happened to my child at all, but I can't help but think like that was someone's child and that something horrible happened too."

Mary

It Is distressing to read about crimes against children. Feel as a mother it is my duty to protect children.

"But then, like, you're typing and sometimes I have to stop and think 'ohh my goodness', that's just you know that that side of it really gets me. And when it comes to crimes against children, I've got four children when it comes to children, you know and I mean with my neighbour. She was, you know, I was like say what you like to me. And when she threatened my daughter, that was it. That I flipped,

you know, don't threaten my daughter so that that side of it I find really hard and and distressing.

Lucy

Deep concern if colleagues have had a bad day, spend time worrying about how they are feeling when at home

"But when it when it's something bad that's happened and because if it's a colleague that you know really well as well, it makes you, you take it home with you and you think, oh God, you know, just can't imagine that that happened with all the staff on the wards and how they must be feeling." Page 76

Sharing the office with clinical staff means that if they have had a bad day, it can have a negative knock on effect on mood. Being an empath to colleagues, feel how they are feeling when they come into the office, whether good or bad. If we lose a patient it is very upsetting, as all the hard work you put in hasn't been enough to save someone

"The patient has said there's been an incident or, you know, when we've had something really bad. We have had deaths. It can, it obviously impacts because I I share a room with my team. So if if a member of staff has had a bad day on on the ward or had a bad therapy session, an incident happened, they come in. It affects you because you're upset for them and what's happened and and obviously when we lose patients, we're all upset them because you think all that treatment that you've done, all the hard work that everybody's putting in and we still couldn't help that person when you think you are and it's just like a normal life, it just really brings you down." page 65

Sandra

Majority of time when typing reports I am able to ignore the distressing history and see it as words on a page. Exception to this is if the report involves crimes against children, it is hard to not become emotionally involved and this can cause distress.

"And I think 9 times out of 10, it's just words. When I'm typing it, but if children have been involved, I I do find that hard and there's just one occasion really that comes to mind." Page 28

Sometimes need to step away from the dictation to emotionally disconnect. It is helpful to lean on other colleagues during these times for emotional support

"When I had to step away from the dictation for an hour just to gather my thoughts, have a little think I even had a little cry. And but it's it's sad. The whole story. Sad. And when you're typing it but the the team, and again I was based in the office with four other ladies who were all in the same role. And we. Yeah, you just give each other support.And yeah, my manager was brilliant, she asked me if I wanted to speak to somebody or, you know" page 29

Reflection that we are not robots, we will be emotionally impacted by what we read and hear and its important to reach out for support during these times

"But on the other hand, you are human, and it just seeped through your little Shields and barriers Sometimes, but yeah, the teams are very supportive, yeah."page 29

2b. Choice and control affects wellbeing

Louise

Always have the choice to read as much or as little as I want to help ensure my wellbeing is managed

"Yeah, I mean with the psychologist, they're quite open. So they will say like, "if you are interested in like like reading more like by all means, you can go on and read about it if you'd like" page 35

Reflection of not having to debrief with team after reading something difficult as it is infrequent, do not know the full forensic history

"Yeah, like I said, I've never. I've never really felt like I'm not OK, but I think it is because it's so minimal." Page 36

Being in contact with service users on an ad-hoc basis helps being able to switch off from work. If had more consistent contact it would be more challenging to switch off due to hearing service users stories from the start to the end. I am only hearing a small infrequent part of their history and this is helpful.

"Yeah. I think like in my role it's not too intense if that makes sense. So I think like if I was doing these kind of one to ones with service users and like a psychologist

for example, like on a long term basis and it like if I heard this service user story from the beginning till the end because I attended every single appointment. I think that that would be a lot harder for me because it's kind of you learn everything, whereas like I kind of do it really ad hoc cause it's sometimes not needed. Some psychologists do it all themselves, some do so I think like with that as well."

Mary

Find it helpful for wellbeing to read clinical notes for new service users, so that it does not come as a shock when information is shared in meetings. By reading clinical notes in advance it protects wellbeing.

"And so yeah, that that can be quite distressing as me when I'm typing reports or or I know because when we have a new chap, we've got a new chap coming next week, I'll spend a couple of hours a day just reading up on what he's done, what he's been charged with. It's not because I'm I wanna know so that I can look at him any differently or anything like that. It's so that I know that when they're talking about him, it won't come as such a shock to me because I I'll already know what he's done." Page 57

Even though it is distressing to read clinical notes, its good to learn it in own time than be caught off guard

"But even though it's distressing, I think it's good to know it's good to know."

Learned that not knowing service user background impacted on wellbeing in role. Mind was not prepared for what was spoken about and became very overwhelming.

"And I was like, oh, OK, because when the scary man came, I obviously didn't know what he'd done, And when I found out what he'd done, I think that was when I started to get really nervous. And obviously he's done this and this and this And I was like ohh and that it really kind of freaked me out because I wasn't prepared. Whereas if you read up, you're prepared And I think that that just helps me in my little brain, yeah."

Lucy

Do not wish to know crimes patients had committed in order to not change perceptions of patients and to maintain enjoyment at work

"And I always said to everybody, I don't want to know unless I really have to, because to me, they are not just patients, They're people and I know that there are

boundaries, that certain things I can't talk about and they can't talk about with me, but I don't want to know what they're in here for because I was worried that that would change my perception and maybe I wouldn't enjoy my work as much And I would be treating the patients differently." Page 15

Over the 10 years worked in service have only had to read 4 crimes that had been committed

"And and I've been here 10 years and I can honestly say it's probably only been, I mean we have when we maximum we have 30 patients and the women's obviously we have a COM service as well. And I'll probably only ever known about four out of all those. There's only ever been four people that I've known what they're actually in here for, so I think I've done quite well and that's only because I've had to type up reports on them in this role that I'm doing now. But yeah, I'd rather not know." Page 17

It is easy to forget that you are working in Forensic Mental Health and patients' mental health can become unstable. Sense of being alert and vigilant when around patients.

"So it's that I try not to let it cloud my judgment, but it does make you a little bit if you have to see that person, you just make sure that you know that that you, you know that that person can anything can trigger them and you have to remember where you actually are because it is quite easy for me again to forget where I'm working." Page 19

Do not read patients notes to protect patients, rather than own wellbeing. Any judgement would show on my face and this could upset patients. Would feel awful if I unconsciously hindered a patients progress

"And I think if I knew what they did and because obviously its something really, really bad. And if I knew what they did, I think it would show on my face whilst talking to them. And they'd you'd be able to see it. I'd feel I'd feel awful if something I said or something I did would would set back a patient. It's so it's not so much for me because I I don't deal with them day day in, day out." Page 20

<u>**GET 3: Deeper empathy and compassion**</u>

<u>Louise</u>

You can't decompartmentalise. You start to see them more holistically not just by their crime

"And that's I think it was so hard to decompartmentalise like that. This person actually did such a horrible thing, but they are really pleasant and actually funny and have a good personality and sense of humour. So it's quite difficult to split the two, but I think you do learn to do that though when you work in a setting like this, yeah." Page 9

Need to manage discomfort about past crime and responses to this whilst recognising their potential to change

"Yeah, for sure. I think like at the start it was quite difficult. Like I'd be writing like notes from a psychology had a one to one with this service user and then they give me the notes to type up and then I'd be typing them up and then some of the things that at type up I'd think I was just sat in a room with him and I had no clue about this, and then it's really hard cause you don't want to feel or act a certain way towards that person because of what they doing because they are on the road to recovery now. But yeah, at the start it was really like "Oh my God like but he's so nice and like yeah". "He smiled but he did this", how like it just didn't make sense I guess like it didn't add up but I think now like especially I think after a couple of years I've like learned more about like mental health itself," page 10

Hard to reconcile the person with their crime at first. Over time, develop of an appreciation of the potential for rehabilitation. Professionals help me through understanding service users experiences

"Working with psychology and OT. They're so different, but I guess like the way they help service users like rehabilitate in their own different ways, that like helps me a lot more. Like to understand actually like where there were to where they are and that helps a lot as well, I think and I guess the teams that are working as well are quite open about like sharing the therapy that they do with the service users." Page 11

Mary

Able to understand that early adverse experiences can be a predisposing factor of why crimes are committed. Perspective has changed as able to see that they were mentally ill when they committed the crime

"But at the same time, I understand I look at it from a different perspective because I understand that they're mentally ill, so they've committed whatever they've done and what really gets me is that majority of these people were abused as well,

which that really gets me because I think that they've grown up thinking that that's the right way to be." Page 57

Show compassion to service users' early experiences and use this knowledge to help deal with reading distressing information

"I think I deal with it in in the respect again that I think well, they've committed this, they've done this, but they were mentally unwell when they did it, so it's not, it's not a case of, oh, well, I forgive them It's a case of, well, I understand why they did it. It's the people that are imprisoned that I have no sympathy for because they've done it like, right?" page 62

Comparing own childhood to service users in order to show empathy to the crimes they have committed

"I kind of think, oh, that must be really awful because especially when you come from such a loving family background, it's it's hard to imagine that a father or brother can do something like that to their daughter and sister." Page 63

Amy

Comparing patients early experiences with children's childhood

"Yeah, it makes me think about it. I just think about my children. I've got 27 year old and a 19 year old. It makes me think about, you know, how their life has been and how upsetting it is to know somebody could be treated in that way or brought up that way. And it makes you think about your own life. But it does get quite upsetting." Page 44

Challenging to read notes and understand the early experiences of individual's who have committed a crime

"It was hard and and sometimes when you, when you have to go through notes and and say sometimes you know how bad people have been brought up and sometimes it's quite it it can hit you sometimes."

Despite patients' crimes, it is heart-breaking to read what they have been through in their early years

"But you know, sometimes it is quite heartbreaking to see what some of these have been through in the past you know, it's it's quite difficult." Page 33

Reading clinical notes about service users' early experiences can be challenging, but the majority of tasks do not feel like a challenge and are enjoyed.

"I mean, maybe, yeah. When I'm when I'm having to read into upsetting past details that can be quite hard, but there's nothing I wouldn't say about the actual work that I do apart from that that I'd class as a challenge. I love everything that I do, really." Page 43

Lucy

When I found out what she had done my view of her changed as I couldn't put the patient and the crime together

"There was only one patient who used to talk to quite a lot. She's no longer here and we used to talk quite often. She was always like hi, how are you? You know she always wanted to hug me. And you know, I did like her as a person. And if I'm honest when I found out what she's actually done my view of her did change because I couldn't put the two together, couldn't put the patient and the crime together and I was very, very surprised."

The forensic history I knew did not impact me due to not having a relationship with the service-user's prior to reading their notes

"I've not had an experience since, so I don't know how I would react now and as for the other three patients who I knew why they were here for, I didn't have that kind of relationship with them. And so I didn't see them as often. So it didn't really on the odd occasion when I saw them, I just tried not to think about what they had done." Page 27

Felt concerned around the first patient due to the relationship that was built prior to reading notes

"So but as I say, it was only this one patient. It was more because we used to talk an awful lot together and that I had that experience, but with the other three it it was the same. I just thought I thought, oh, I wouldn't have thought that. But then that would be it" Page 27

Abigail

Support of team made me go from feeling out of my depth to capable of doing role

"I've seen I've said over the three years because when I first started the job, I was like my God, what the hell am I doing? And I'm so out of my depth here." Page 45

Sense that administrative staff do not work with patients when first started role and surprise over this

"And but because what, like I said, when I first took the role and I actually I because I didn't, I don't think I realized I would actually be working with patients that have done what some of them have done. And you know, their index offenses. Some of them are quite frightening and scary, but then when you look at the patients and you see them, it's like how can you look so normal? But you know it and, but yeah, it's it's It's satisfying to know that they're going on to better things, really, I suppose so" page 48

Sense of complete shock and disbelief of working in close proximity to patients who have committed crimes when first started role which made me question sustainability of the job

"So I did find it more difficult in the beginning. UM, but because it was like, Oh my God, you know what? What on Earth am I doing? He's done this and this is his index offence and he's in in, in now and I'm sat right next to him in a a ward round. But now it's I I I try not to let it affect me, I'd say 90% of the time I I succeed in that." Page 82

Molly

Personal view of patients helps with coping in the role. View that patients are mentally ill and that's why they commit crimes and need our help to get better

" And and obviously to see you know. Some of the index offences can be quite horrifying, you know. And but I think I get my head around it by thinking that they are mentally ill" page 13

Recognition that this view was built from own personal experiences of family members own mental health experiences. It was not her fault she became ill, it can happen to anybody. This non-judgemental view helps with working in FMH environment

"you know that that I had a family member that had paranoid schizophrenia. She didn't hurt anyone. She harmed herself. And you know, so you know you you've

got people that have got paranoid schizophrenia here that you know were very, very unwell, you know. And some people will go well, that's no excuse. Well, if it was, yeah, as a person that you know, anybody can develop paranoid schizophrenia, you know, and especially with the amount of drugs that are being used, it's well known that cannabis, you know, can affect somebody. You know, it could happen to anybody." Page 13

Dissonance between the patients you see in services and how they are talked about in society. Who are we to judge when we do not know the circumstances.

"You know you'd like to think that it wouldn't go to that extent and they'd murder somebody, rapes somebody or or whatever. And but also I wouldn't want it to be like my family member, trying to commit suicide. I don't know how many times people out there judge that don't know the indepth reasons behind why the crime was done. I know some people were like ohh it's still not an excuse and you hear it on the television for crimes that you know or will they had a bad upbringing and this that and the other but who are we to judge? You know, I have faith in what the doctors are doing and I did." Page 13

People deserve a second chance. There is no such thing as an easy way out.

"I believe that people deserve a second chance And you know, it's just I think people feel that when this sort of happens, there horrific crimes and the hospital order is given that they think they've got the easy way and out of it that rather than going to prison. But I don't think it is an easy way out for them. You know that quite often they end up in hospital a lot longer than what they would have done if they've gone to prison." Page 13

Sandra

Feeling of apprehension of working on the wards when first started role. felt frightened by their index offences and forensic history

"When she was explaining about the patients and about the ward being a secure unit I was really apprehensive about going on the wards and I felt really new, did feel very nervous. When you think of the types of history and and sections and the crimes, the index offence, that's the phrase I'm searching for" page 26

Discord from how first viewed patients, to how I view them now. You forget about their index offences and see them as a human being that needs some help

"Their index offenses and when you're sitting next to or across from a young lad who you know is just speaking to the team and you, you forget all of that. And it's just that person sitting there." Page 27

Confidence grew in being on the wards through shadowing opportunities when first started role. It allowed me to be present in patients company, rather than worry about their forensic history.

"So I was saying that I was given a lot of support when I first started and I shadowed my manager for a couple of weeks on the wards, just and then once you're in the role doing it, you could be sitting anywhere, really. You're just in the bubble. It's it's fine." Page 27

Change in view of patients grew with experience of being in the role. It is no longer black and white, do not judge patients solely on the crime they have committed

"It's probably just experience over time because obviously when I started a baddy is a baddy and a goody was a goody and the fact that I'd be sitting there in this lad would be so excited that he's bought his first bike he's bought himself for mountain bike and he was being learned to ride a bike in his early 20s and but then on the other hand he has killed somebody. But you know the fact how poorly he was and having seen the the treatments and the medication and the support he's he's had has turned him into or he's developed into this lovely young man" page 35

Through experience of seeing patients journey first hand you develop trust in the system that they will help people recover, which allows you to not see a patient as only a criminal but someone who has needed help.

"so I think the experience of trust in the teams, trust in the system just helps you not be judgmental she just think it's the poorly you know you've got to take that into account" page 35

GET 4: 'Bask in their glory'

Mary

Comparison of feelings of reward when a service users leaves services to a child leaving home

"We, you know, we live and hope that they don't (come back in). But that is so rewarding as me to just see them go. And it and it's it's I suppose for me it's like a child, like my child leaving home. It's like, Oh my God, you know, you you've learned, and now you're going back out into the community. Please don't make that mistake again and it's it's it's really satisfying." Page 50

Satisfying to see that service users make mistakes during their rehabilitation process but learn from their mistakes.

"Yeah, I mean, I remember this particular chap he was on unescorted leave and and he went to the pub and had a pint. And of course, you're not allowed to do that. So he came back and he obviously had his leave revoked and everything. And I remember I saw I was on reception and he came through and I just looked him and I went, "what am I going to do with you?" and he said "I know I didn't realize I wasn't allowed to do it," and I said "you're not gonna do it again, Are you?" And he didn't. And and it wasn't because I said anything. It's because he realized that he shouldn't have done it, and he didn't do it again. And then, like I say, he's like in the community and that's that's really satisfying. Yeah." Page 51

Abigail

Helping patients on their journey to recovery is the most satisfying part of the job

"I suppose knowing that we're helping, you know, in a way the patients, it's nice to see them." Page 45

Recognition that although it is difficult seeing patients' be admitted, it is rewarding to see their journey of recovery through to discharge

"I mean, it's not nice to see them come in or be admitted, but then once they are admitted, it's nice to see them progress through to discharge." Page 45

Time passes in the role, but it is satisfying when you get to see how much a patient has improved from when they were first admitted

"Like I said, a covered for and colleague on Wednesday afternoon and one of the patients we saw was admitted to to my ward, a few like about a year ago, I think and but it's so nice to see the difference. It was nice to see a difference in him with me when I saw him on Wednesday to how I saw him when he was on our ward." Page 46

It is satisfying to know that I am helping people to better their life and make progress

"And so yeah, it's it's nice to know that we are helping people and and I mean doctor always says, you know, when people are discharged in the nicest possible way. I don't wanna see you again." Page 47

Sandra

Getting to see patients journey to being discharged and have faith in how the intervention has allowed them to have a new opportunity in life. Genuine happiness over this

"He's developed into this lovely young man who is like I said you shared a tear but they were happy tears because you can see you know he's only been in for perhaps three years but that he could turn his life around". Page 36

It is so rewarding seeing a patient be discharged, you get to really celebrate their successes as you've been able to witness the hardships to get to this point.

"But it's it is lovely to say it's so rewarding and that's just me sitting typing for them I kind of bask in their glory" page 36

Lucy

I am getting to help patients journey of recovery in my own way. Sense of reward of being part of the team and seeing the process of rehabilitation from start to end.

"I would say being part of the team and feeling as though in my own way, I am helping patients, people on there I'm gonna use the J word. Their journey. And yeah, I think that's what it is. And I work with people. So it's it's, uh, it's being part of the team and feeling like I say and feeling there's something at the end of it that I've helped."

I am not just doing a job, I am helping to better people's lives. Sense of reward and making a difference in role.

"It just makes me happy. I suppose because I do like helping helping people and. I don't feel as though I'm just doing a job" page 64

I am not directly helping people, but I am indirectly helping people everyday

"Like say, because you can see everything, everything that you doing, even though it may not be direct with the patient's, it's indirectly everything that you're doing is affecting the patient." Page 64

Feel proud getting to see someone's journey and move into the community and knowing I've helped in some little way. It is more than a 9-5 job, there is a sense of purpose as to why you come to work each day.

"So when you hear good things about ohh so soon. Now some move from acute to rehab and then when it's from rehab to going out into the community, you know when they've got leave and things and you can see the change in them. It just makes me happy when we have helped some little way. I've helped to change that." Page 64

Molly

Emphasis on having the opportunity to really be present with each patient, they are more than numbers on a screen

"I think that that's it really is, is is seeing the end is taking them through that process and seeing the end journey because even though they're they're discharged to our team and it's a community team, I still take part in what are called their CPA's. And so, because I minute it, so they see me on teams. So I I do follow through" page 6

Working in FMHS feels more than a job, you are present with patients and get to know them. They are not fictious like in other roles

"Yeah, that's what that's right, definitely, you know and didn't realize how much Mental health would be. It would have that impact on me as well, so much more than the other roles. Like I've said that it's because I've seen somebody as a person, not as a number on the computer. You know, you you actually get to know these patients. See what they physically look like. Whereas in the any other role you don't. No, it does make a big difference." Page 9

The satisfaction of getting to be part of the patients journey to recovery outweigh the challenges, and makes the role worthwhile and rewarding.

"I'd still say it's one of the best jobs even with because I've worked in a lot of situations, so that no honestly, it still come from the job satisfaction and it is the job satisfaction and the fact that, you know I the patients are patients, they have names you know…But that's still comes down to the satisfaction that I get out of seeing the pathway. That the patients go down, you know, It's not because my job is easier or anything like that. It it's the job satisfaction. I've seen the patients and the the journey that they go on, yeah" page 48

GET 5: Safe and supported

You do not feel on your own

Louise

Appreciation of being part of a community at work. Joy around bringing together everyone's cultures and individuality and celebrating this collectively as a service. This helps to bring strong relationships outside of a usual work context

"So we had like a music festival that went on here and it was for World Music Day. So one of the consultants, he actually organised it, so it was kind of celebrating music from different backgrounds and we had like performances done by staff, but also service users. So like the service users rapped and things like that. So they'll make their own like beats and their own like lyrics and things and I feel like that day it was actually just so fun. I feel like people let their hair down, but kind of just relaxed a little bit and just enjoy the event. And I think it was really nice as well because we saw like different sides to people, not only service users but also like staff." page 25

Do not have to wait until supervision to speak about problems – can receive support whenever it is needed

"So generally supervision is face to face and it's like a form that we fill in and it's more just to check in. If anything comes up that needs to be recorded, but it's generally just a check in and we don't have to wait until WBT to speak about our problems or issues." page 66

Opportunities to start additional training with the role, this is supported by manager

"If I if I felt like I was lacking on like, I don't know leadership skills, for example, I could kind of take up a course and do that. And I did a business administration levels three. So that was like something that was open to me. A Level 4 is open to me as well if I wanted." Page 67

"So it's like it's really nice to know that those things are there for us to to do if we want to. And I think again like because I'm not at this current moment in time, I'm not looking for a leadership role or a management role like that. but it's nice to know that it's there and my manager always will make sure that I'm aware of what's open to me and what I can kind of have and do to get under my belt as well. So that's really cool to know. Page 67

Manager will check in every couple of days, which helps in feeling supported. Encouraged to speak about issues as they come rather than bottling them up.

She'll (my manager) will always check in with us anyway, like every week or like every other day. Like to see how we are. "Is everything OK?" So, yeah, I feel I definitely feel supported.

Most beneficial support is knowing I can contact my manager whenever I need to. Knowing she is always there is a huge support.

"But yeah, I think like kind of knowing just that that supports there whenever you need it is probably the biggest thing" page 70

Mary

Opened up about struggling with mental health and manager made referral for support without any judgement

"I mean, I mean when I was saying to my manager, I was quite down… So like I said at the start I had CBT, manager said to me. What about CBT? And I was like, oh, I don't need that. You know I'm not lunatic. and she was like "It's not about that. It's about them helping you" and I thought, OK, I'll give it a go. That was the first time I'd been offered it. The first time that I had accepted it, so I said OK, I'll give it a go and actually I am bloody glad that I did it because it has helped me so much being more assertive and looking after myself and looking at bad situations or you know distress and situation and thinking right." Page 97

Reassured that can ask for more mental health support if it was needed

"And to know that I can just say to my manager I need, I need to do CBT again. Can I, you know, do a referral or whatever and she would refer to occupational health" page 98

Manager actively asks about wellbeing

"Yeah, I mean, I mean, my manager is really helpful as a manager and she's really supportive and I know I mean I suffer with SAD, but I I deal with it and she's really supportive. So we had supervision a couple of weeks ago and she said and you know, "I'm very aware that SAD may kick in So let me know" and she is really supportive and I know I can message her and just say I need to talk to you for five minutes and she will, you know, come back to me and say I've got a meeting, Can we make it like this afternoon? Are you OK to wait till then?" page 92

Amy

Team is a family unit and this is above and beyond other teams worked in

"they are like family, they they really do support each other and I've seen it in other jobs where people have, you know, kinda got on, but nothing to this extent." Page 30

A key resource Is how effective team is in noticing if anyone is struggling and offering support

"So like I said, the team are really good at seeing if you've got any issues." Page 54

You're asked if you're OK everyday

"People are very openly spoken, checking if you're OK every day, how have you been?" page 54

Inclusive environment of all feelings, nobody has to hide how they are feeling and pretend that they are OK when they are not.

"Yeah, they they just seem to know when you're feeling like crying, but the the the good thing is everybody talks. Nobody hides away or so yeah." Page 55

Even during difficult experiences at work, the team still prioritised staff wellbeing and safety

" So even then, the team were making sure that everyone was OK, just to get into work, to make sure that no one was hanging about so" page 59

How personal challenges are managed at work. Team come together to offer assistance

"And the social workers. I've had a lot going on. I've lost my father-in-law, you know in August and my mother-in-law's ill. So I have a lot of the social workers telling me how they could help and you know, and I just do different bits for each of the different teams. So I just generally get on with all of them so."page 61

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147

Lucy

The team are very open about their feelings, if one person comes into the office upset we are all there to offer support. Feel very lucky to be in a team that cares so greatly for each other

"So we're we're very open about our feelings and we will all you know, even if one person out of the there's or was in there, one person comes in really down. We're all there. Are you OK? You know you're feeling alright. Do you want some water, or a biscuit or cake. You got this. You know do you want to talk to me about it? Just sit there and talk about it. So yeah, you have your options and so it you and and, but we're all very supportive of each other and I think that's what makes me feel Very lucky." page 65

Abigail

You're made to feel that it's ok to not be OK, you will be supported through it

"And and yeah, it's just, it just makes you feel better about yourself knowing that it's OK not to be. Does that make sense?" page 31

Every colleague, no matter what their role or band is happy to help. There is no judgement or impatience

"Yeah, I've got that while I'm now. I've got the support of the team. Like I said, you know, cause I I'll quite often go to message my social worker and say, and I've had this email from such and such. I'm not sure who to what to do and how to do it. And yeah, that's fine. It's for me to do I'll sort that out and also the the the ward staff as well are very supportive and in in anything like I said to you before you know if I if I get something through and I'm not sure who to send it to, I'll just send it to the whole team and somebody will say yeah that's fine. That's for me to sort out." Page 108

A supportive work culture exists where there is no such thing as a stupid question

"You know the the everybody down, you know, the psychologists, the social work of the ward staff and even the psychiatrist, you know, I'll, I'll think I'm asking him a stupid question and but he's like, no, it's absolutely fine." Page 108

There is no such thing as an individual problem, the team come together to help each other

"But yeah, I just feel like I've got the support of my team as a whole as well. My MDT team and I feel that they're very approachable. I feel like an I can go to any of them and say, you know, I don't know what to do with this. I've been asked to do this. I don't know how to do it. Can you advise me on what to do and they'll tell me? I just feel supported by all of them." Page 109

Molly

A challenge in the role is feeling demoralised by a high staff turnover. Sense of wrongness that staff leave so quickly.

"From the admin side, yeah, You find that a lot of us can feel a bit demoralised in the fact that the staff turnover is so great, I've never seen this before." Page 18

Burning myself out and used me as a scapegoat to avoid taking on extra tasks themselves

"It's not in my job description or anything and and it was because with such a small team, it was felt that that was my way of supporting the team, but it was not In my particular role. It was not in my job description and I tried to keep as much as I could last year and eventually something had to give. And and I had to turn around. I went through my manager first of all and said to her I've gotta stop doing the CPA's for the time being. I can't do everything and it was good that I recognized that and I recognized something that wasn't part of my job that I could say, hey guys, you're gonna have to have it back for a bit. And my manager supported me and she said yes do an email to them explaining the situation, which I did. And members of my team went above it. Even my managers had and reported me to higher up." Page 23

Unfairness that I was covering for a colleague and being asked to do something that wasn't part of my JD. Something had to give?

"And I was absolutely devastated, you know, because this was never a role of mine and it was never part of my, my job, my job description or anything. And I'm I've I found that really difficult last year." Page 24

Kept spinning all of the plates despite voicing burnout, pushing myself above what I was capable of in order to not let the team or patients down. Colleagues watched me go downhill but did nothing to support me.

"They they watched the they watched me then go downhill, you know. And but I still supported it until admin colleague came back to work and I took a month off because psychologically I couldn't cope with the fact that I felt that my team that I've worked for couldn't come back and say what's the problem? That, you know, we're sorry that we you know that that you're struggling but they would have rather have stabbed me in the back and taken it further." Page 25

Speaking up and being ostrecised consequently led to not feeling safe to speak up. This has impacted me both physically and psychologically

"The situation over my back. You know this could be wow, that they didn't put the tumour there, but because of the excessive sitting because of the issue that there was too much work ultimately its had an impact on my physical health. So I've had two significant issues, one with my mental health and one with my physical health and you know, but on the whole they have been possibly related to, one definitely related to work. The other one I can't say for certain and any of the issues that I've had that have been Personal that affected me mentally." Page 30

5b. Talking to someone helps clear your mind

Mary

Team are always happy to talk if I need to get something off my chest, which is important for maintaining wellbeing

"Really good. I can just pop them a message. Say if you got chance for a chat I just need to get something off my chest and they are really good, the teams really good and that's that's what's important." Page 60

I have less experience so why should I keep it all on my shoulders

"Actually, I think to me, Why keep it all on my shoulders? That they're more used to it than me. So that's, that's what I think." Page 60

Able to switch off from work as talk to team if have any concerns. Recognition that if feeling impacted by something at work will always prioritise speaking to someone to let that concern go

"It doesn't happen now and I I am able to switch off. I think I I can I can switch off. Sometimes it's hard, but if if I'm feeling if I'm feeling like, "oh God, that's a really difficult one" I will always talk to somebody." Page 63

Lucy

Ways to manage frustration and overwhelm when demands get too much. Walk away and take 5 minutes away from computer. Supervision also helps with when situations feel frustrating and overwhelming

"It can get frustrating, but on the whole it is manageable if it just gets too much, I just get off, walk away for 5 minutes, come back again and obviously we all have regular supervisions every 6 to 8 weeks.So you've got your manager that you can sit there and talk to. If there's anything major, obviously just like little niggling things, I'm I'm lucky. I've got a really good manager." Page 56

Manager is always available to contact if feeling exasperated or overwhelmed, which helps to cope with these feelings. Talking to my manager quickly improves how I am feeling, as provides safe space to vent

"I can just phone her up and so kind of a quick five minute chat or whatever or phone on teams and have a little winge or just say this has happened and this is how it's making me feel and I'm just at the end of my tether or whatever. I have a little chat and before I know it I'm fine" page 57

Abigail

Determination to switch off from work, but sometimes I can take work home with me and cannot discuss worries with husband due to confidentiality

"Yeah, I don't think that I try not to let it affect me when I'm at home.
And I mean, sometimes it does. You know my husband will say have you had a bad day today? Yes. And but obviously I know there's the confidentiality issue there as well. So you know, we're working within the NHS and and I cant say what's happened, I'm like ohh I'll be fine."

Cannot talk to husband about details so need space on my own when its been a difficult day to decompartmentalise

"I'll be fine. Just leave me to it. You know, just just give me half an hour and I'll be fine" page 79

Sense of covering up negative feelings to husband as the situation cannot be shared, so what is the point in telling him how I feel?

"It's not daily daily occurrence at all and you know and then if something funny happened during the day, you know, I'll, I'll tell him about that. So on the flip side of that, then you know and that makes me feel better as well." Page 80

Acknowledgement that it is important to be able to vent feelings to someone, cannot vent to husband but can do admin colleague friend

"And but I also do meet up with another secretarial colleague and we we do meet up every now and again and kind of that things off one another as well, you know, because she has a Friday afternoon off as well. So we tend to meet up on a Friday afternoon and go for a coffee and have a moan about things. You know what I mean? And get things off your chest." Page 83

Sense of helpfulness of shared understanding and empathy within admin colleagues that is different to talking to loved ones

"Because she's within this the same role as me, I know she works for a different ward, but because she's within the same role as me, she understands a little bit better, I think than like husband, obviously, but but now? So it it's nice just to to have a rant to to her as well. And and she knows I'm here for her in the same capacity as well. If she needs it" page 84

Sandra

Never had any problems switching off from work. A busy family life means that there was no choice but to switch off from work as energy had to be given to children and not to work.

"To be honest, I don't have any problems switching off and never have had and and I think it's with having quite the busy family life that helped me so that as soon as I walked away, I was taking my children to gymnastics and you know, and that enabled me to to switch off." Page 30

Colleagues have had trouble switching off from work and find it helpful to share their concern. Sense of being in the role for several years and colleagues coming to me for advice

"But I know colleagues have had that trouble. Where they've messaged because we have like a group and WhatsApp group and they'll say, oh, this has been really worrying me and you, you can just sometimes it's just having somebody to listen to you" page 31

Contrast between being embedded into a med-sec team, to now being only secretary in current role and feelings of isolation this leads to.

" And and initially when I was a med sec I was very much part of the medsec team. I think there's seven or eight med secs full and part time. they are a team, they are an absolute team of lovely bunch of ladies. Whereas now I feel quite on my own, I've still got the same line manager." Page 5

Feel like an outsider. Still have the opportunity to see med-sec colleagues but the whole support network is not available in this current role

"I'm still lucky that I've got my line manager who's really supportive, And I still see the other girls in admin meetings and whatever, but I don't feel like I've got the support network as a whole. I've I've still obviously got people who aren't particularly close with for support, but I do feel a bit more isolated." Page 5

Despite colleagues trying to actively make me feel part of the team, it is difficult to not feel intimidated by them due to them being in senior positions

" And I know they would be upset if I if I said that because they just include me as the team it was being in the team, whereas I included myself as being their admin and they are this bigger, better being" page 47

6. Not bottom of the pile

Louise

There is not a hierarchy in the team, admin are treated as an equal member of the team.

"Yeah. I don't feel like there's a hierarchy here. Like, I don't feel a hierarchy at all. And I think as well, like I'm admin and I don't feel like I'm treated like admin. I'm

just treated as part of the team. So it's just, it's just really nice, basically, I guess I consider myself lucky for sure" page 65

Never thought of self as "only admin"

"And honestly, like I've never had that mindset anywhere I go like whether it's any role I do like I've never just thought of myself like "ohh, I'm only admin and I'm bottom of the barrel" like no like I'm a human and I work really hard and I'm sorry, but without me, none of that would be done. So actually, if you're not appreciating me, I'll appreciate myself. So it's a bit of sass, I guess. But yeah." Page 84

The importance of feeling valued and appreciated

"I think one thing that I'm sure admin lack a lot is like feeling appreciated for the role that they do" page 20

Normal for administrative staff to feel underappreciated and not valued at all

"I think you might find that that's kind of a common thing that we all have in common and that we do feel really underappreciated and not valued at all. And I think that that's why I'm so happy in this role, because I really am valued and as much as I guess I'm not somebody that looks for that, but it is really nice to have it because I've been in jobs where I haven't had it and I know how that feels" page 21

Mary

The team being approachable supports feeling like an equal team member

" (the team being approachable) makes me feel like part of the team. Whereas before I used to just feel like a secretary and you know, sit there quietly and type the minutes. Sort of thing. Whereas now I feel like the team and I'm involved in everything." Page 83

Feel equal and valued due to being included in all communications

"Every time someone sends an email about one of the lads, I get copied into it. So it's the, you know, I'm on the the team distribution list and and it's really weird because you you don't really need to know but it's nice to be kept in the loop. So it's it's really nice because I I just feel like I'm part of the team and I know I'm not clinical, but I'm still part of the team and it makes you feel really nice." page 84

Amy

More autonomy over workload and tasks in this role

"I get to choose more of what I'm adding to my workload, you know?" page 64

Have choice over what tasks are completed when and if more are added to workload

"Yeah, I'll check on all the tasks that was expected of me as my role, but then might throw some other ones in." page 64

Had autonomy to adapt job to meet own needs. Have been able to do role in own way without any questions. This is in contrast to other services who would not let you change things.

"I've I've kind of tweaked a lot of how I do things myself to my own job. Easier recreating things that they already got in place, but doing it my own way and I've been allowed to. And I know that some places wouldn't let you change things, you know?" page 88

Being appreciated by colleagues is rewarding

"Uhm, appreciation is definitely one reward aspect of my role" page 37

Creative ways to share appreciation of each other in the team

"We started something called the positivity box and in our main group room we've got like a a post box and anonymous little slips and the team putting positivity about each other." Page 37

Feel very appreciated when you see that someone has commented on how well you've done something

"And you know, when you get a positivity to to see how well you've done something."

Lucy

Participation is welcome and valued in meetings, my views are heard and listened to

"So I do all of that and I help with as I said anything that's administrative, obviously a minute meetings and go to meetings and minute then I also with our psychology meetings I participate and have my views are heard as well." Page 42

Feel valued by my team, they rely on me and provide good feedback

" It's not just a case of I'm very lucky in the team that I work in because they they do rely on me a lot and they do always give me really good feedback, which is really nice and they say, you know what, I'm on holiday, can't cope with that." Page 43

Sense that previous background in law supported ability to share views in meetings

"I mean, I suppose I've been quite lucky because even when I worked for the clinical Nurse manager and I used to go to all the the corporate meetings that we had and I always used to get involved and I didn't just sit there minuting and obviously the business support manager used to say to me you're really good with with the clinical Nurse manager because we always see you prompting them and saying, oh, don't forget this. And don't forget you've gotta do that." Page 43

Abigail

There is a give and take. If you work overtime you can accrue toil. This flexibility makes you want to go the extra mile knowing you're not taken for granted

"I do try and stick to my working hours if I can, but obviously there's some sort of, there is give and take you know if if you do work early, start early or work late one one night there is give and take and you can then. Perhaps finish early another day when you you have caught up and you haven't got it as much to do." Page 62

It is swings and roundabouts, you work overtime but then can finish work earlier the next day

"So yeah, it's kind of swings around abouts, isn't it? All the time but but yeah, if you've got, you know, my manager is always supportive of us. If we've got toil accrued or whatever, you know she encourages not not to have it, not to let it build up above 7 hours or 8 hours, I think." page 65

During interviews:

31/08/23

I just completed my first interview. One thing I am reflecting on afterwards is how much this participant enjoyed their role. This has surprised me a little, as I came into the interview possibly thinking that more negative experiences may be shared. I need to ensure I go into each interview with a very open mind. There was a sense of this participant developing over many years working in an administrative role and knowing their worth and being able to advocate for what they deserve. It will be interesting to interview a participant with less administrative experience.

13/10/23

I really felt for this participant and their experiences at work. There was a sense of injustice and being treated unfairly. What surprised me was that despite this they still reflected that it is their favourite job and can see themselves being in their role until retirement. It was like working with and helping service-users outweighed the challenges they were experiencing with the other team. I could really feel a pull to want to help this participant during the interview, and I got a sense that it was helpful for them to share their experiences with an objective person.

During analysis:

15/10/23

I'm surprised by how many participants had experienced a challenging and distressing situation that was linked to service user's at work. Although there were general patterns of feeling fearful and wary, each participant's experiences of the events were different. I was really pleased that each participant received support from their team, but also surprised at the lack of training administrative staff have about managing conflict with service-users when they start their role. I wonder if this is the case with all administrative staff?

20/10/23

My reason for being interested in this research topic was seeing administrative staff being treated unequally in some services I have worked in, and I feel a sense of warmth and happiness that for a lot of participants this is not the case. Although each person is different, there is a sense of basic gratitude and appreciation going a long way for participants in terms of their wellbeing, and this seems to have contrasted with negative experiences that some participants have had in previous roles.

<u>Appendix 14</u>

Author guidelines for the Journal of Occupational Health Science can be accessed here: https://link.springer.com/journal/41542/submission-guidelines

Paper 3: Executive Summary

"Why keep it all on my shoulders?": Emotional Experiences and Wellbeing of Administrative Staff Working in Forensic Mental Health Services; an Interpretative Phenomenological Analysis

Target Audience:

This research summary will be informative for administrative staff who work in Forensic Mental Health Services (FMHS's), in addition to senior leadership teams, management and clinicians who work alongside administrative staff. It is hopeful that this research could help FMHS management better understand the experiences and wellbeing of administrative staff and identify any areas that could further support them. Four participants provided feedback on the content and design of this executive summary to ensure it is accessible and understandable.

Background:

Staff that work in Forensic Mental Health Services (FMHS's) are especially vulnerable to job related stress, due to the enduring and complex difficulties experienced by this client group (Ewers et al., 2002). This includes non-clinical staff, such as administrators. Administrative staff may be exposed to distressing incidents and material within their role. Despite this, there is currently limited research exploring the wellbeing of administrative staff in the NHS and no existing research on the well-being of administrative staff who work in FMHS's.

Non-clinical staff, including administration, make up 47% of NHS roles and are integral to the effective running of NHS services (NHS England, 2023). The 2023 NHS staff survey indicated that 70% of administrative staff reported frequently having contact with service-users. The NHS is working on improving the health and wellbeing of their workforce as part of their Long-Term Plan (NHS, 2019) and the People Plan (NHS England, 2020). Staff wellbeing is imperative, with good wellbeing being linked to increased job satisfaction, morale, performance and retention (Malik, Blake & Batt, 2011; Quirk et al., 2018).

Administrative staff working in FMHS's may experience verbal abuse or intimidation from service-users (Chambers & Kelly, 2006) and experience incidents where service-users or colleagues may have been harmed (O'Beirne et al., 2012). It is likely that administrative staff would be routinely exposed to distressing material, such as when typing dictated tribunal reports (Twigg et al., 2020). This exposure can have a detrimental impact on psychological and physical wellbeing (Ireland et al., 2021; Newman et al., 2021).

There is a growing number of published studies exploring the impact of working in FMHS's on mental health professionals (Cramer et al., 2020; Mullholland, 2015; Taylor & Trout, 2013; Rodrigues et al., 2021). Verstegen et al. (2024) explored the experiences of FMHS professionals who were exposed to service-user aggression. In response to service-user aggression, professionals experienced feelings of anger and fear that affected them both personally and professionally. Despite this, there is very limited research that explores the wellbeing of administrative staff working in healthcare settings or FMHS's specifically, even though they routinely face challenges in their role.

AIM: *what were the aims of this research?*
To understand the emotional experiences and wellbeing of administrative staff who work in Forensic Mental Health services, in order to better understand the demands of their role and whether there are any unmet support needs.

Method:

Step 1: A proposal for this research was reviewed by the Staffordshire University Ethics Committee and NHS Ethics Committee (called the Health Research Authority), who confirmed the study was safe and ethical.

Step 2: A research flyer was shared with FMH administrative managers and team leaders from two NHS Trusts, who passed this onto administrative members of staff. The researcher also joined a team meeting with one team to share the aims and purpose of the research.

Step 3: Administrative staff who were eligible to participate in the study read an information sheet about what would be involved and completed a consent form.

Step 4: Interviews took place over Microsoft teams. These were recorded and transcribed by the researcher.

Step 5: Transcripts were analysed using 'Interpretative Phenomenological Analysis' (IPA). The researcher familiarised themselves with each interview transcript by re-watching the recordings and reading the transcripts several times. Detailed notes were then made on what was said, how participants were feeling and possible

meanings. The researcher interpreted meaning from each participant's interview and then created a number of themes for each interview. The final step was then to look across all interviews to create group themes.

What is IPA?
IPA is a research method used to analyse what people say. It involves an in-depth exploration of people's experiences, in order to make sense of their experiences and develop meaning. It is especially useful when the research topic has not been explored widely and is potentially emotive (Smith, Flowers & Larkin, 2021).

Key Findings:

Six main themes were identified, alongside six sub-themes. Key quotes are shared to highlight what was described within each theme.

Feeling threatened and unsafe	Vicarious emotional toll	Deeper empathy and compassion
'Bask in their glory'	Safe and supported	'Not bottom of the pile'

1. *Feeling threatened and unsafe*

Four participants described a time where they felt fearful, wary and vigilant whilst at work. This led to feelings of pre-occupation and anticipation that other service-users could act violently, a sense of walking on eggshells, feeling concerned for colleague's safety, and feelings of confusion over feeling fearful.

> *I used to think God I hope he doesn't kick off like that other lad"* (Mary, p. 31)

> *You'll just feel like eyes like staring at you and I think sometimes that can be quite scary (Louise, p. 40)*

The four participants shared ways that they had built confidence and ease around participants. There were some reflections on the helpfulness of colleagues, with some participants sharing that their clinical team provided practical advice on how to communicate with service-users, in addition to validating their feelings.

> *My ward manager said, 'so what you need to do is when you see him is instead of freezing, you walk past him and say hello to him'. I've learned, now I can have a full-blown conversation with him and I do not feel threatened (Mary, p. 34)*

> *"And it helped just talking and for somebody with all that experience being able to say to me, 'no, that's fine, you're not a bad person because you're thinking this'." (Lucy, p. 33)*

Some participants reflected that it would have been beneficial to have training on conflict management and communicating with service-users when they were new in their role, to help support them to feel confident and safe around service-users.

2. *Vicarious emotional toll*

Four participants spoke about the impact reading and hearing distressing information about service-users had on them. Some participants shared how reading about service-users index offences was sometimes distressing, and there were some reflections that reading about crimes against children was especially challenging for

participants who were mothers. A participant shared having to step away from their screen and take a moment to themselves. Another shared feeling worried about their colleagues when they had a difficult day.

> *I had to step away from the dictation for an hour just to gather my thoughts, I think I even had a little cry (Sandra, p. 29)*

> *When it's something bad that's happened and if it's a colleague that you know really well, you take it home with you (Lucy, p. 76)*

There were individual differences across three participants in their preference in knowing about service-user index offences, which seemed to help them to manage the emotional demands of the role. One participant preferred to know service-user forensic history on an ad-hoc basis, another preferred to read service-user clinical notes in advance to limit any surprises in MDT meetings, and one preferred to not know service-user index offences at all. All three participants reflected that their manager/ team respected their wishes and that they had a sense of autonomy and choice in this.

> *(The nurse manager said) do you feel that you don't want to be involved in that side, finding out about patients? If that's the case, you know we'll make sure that you don't have anything to do with that" (Lucy, p. 12)*

3. *Deeper empathy and compassion*

This theme is based on participant's perceptions of service-users. Some participants shared that they developed a more holistic and compassionate view of service-users since working in a FMHS.

There were some reflections that this holistic view developed through having a greater awareness of how adverse early experiences can be linked to mental health difficulties. One participant shared how building a relationship with service-users made it harder to separate the person from the crime.

> *Sometimes it is quite heart-breaking to see what some of these have been through in the past you know, it's quite difficult. (Amy, p. 33)*

> *When I found out what she'd actually done my view of her did change because I couldn't put the patient and the crime together and I was very, very surprised. (Lucy, p.22)*

Some participants shared that their clinical team have helped them to develop a more holistic view of service-users through sharing the work they do with service-users

> *Working with psychology and OT helps me to understand where they (service-users) were to where they are now (Louise, p. 11)*

4. 'Bask in their glory'

Participants shared experiences of feeling pride, reward and satisfaction in getting to witness service-users progress first hand. There were also reflections on how participants have made a positive difference to a service-user's journey through their administrative role. Many participants shared that this was the most satisfying part of their role.

> *So it's like a journey that you take with them, you know I get to go with them and the rest of my team on their journey (Molly, p.4)*

> *I suppose knowing that we're helping in a way the patients…it's nice to see them progress through to discharge (Abigail, p.45)*

5. Safe and supported

All participants reflected on the importance of a safe and supportive environment and team culture as a way to protect their wellbeing when working in a FMHS. Five participants spoke about how safety is created through not feeling alone, with their team and manager being approachable and non-judgemental to any questions or concerns.

> *You just know that you can come in with any issue that can be helped or spoke about it (Amy, p. 72)*

One participant's experiences amplified the importance of this. They were in a unique and different work context and described how their work environment was unpredictable and had a sense of feeling unwelcome by some colleagues. They shared that consequently they had to take some time off work due to being physically and psychologically unwell.

> *They watched me then go downhill…I've had two significant issues, one with my mental health and one with my physical health (Molly p. 25)*

Participants also reflected on the importance of sharing their feelings with colleagues to help clear their mind and switch off from work. One participant shared feeling more isolated and missed the support network of other administrative colleagues.

> *"Being able to talk to someone helps clears your mind" (Mary, p.65)*

> *I don't feel like I've got the support network as a whole… I do feel a bit more isolated (Sandra, p.5)*

6. *'Not bottom of the pile'*

This theme is related to participants' experiences of being treated equally and their hard work being recognised and appreciated. Happiness in the role of all participants seemed to be directly linked to feeling respected, appreciated and valued. Acts of respect included being included in team communications, kind gestures, and having flexibility and autonomy at work.

> *"I feel like I'm on the same level with the psychiatrist and the team. I don't feel like I'm down the bottom of the pile, which is what I felt in other roles" (Abigail, p. 27)*

> *"I think if you feel supported, cared for and appreciated by your manager it really comes out in the quality of your work and how you feel" (Louise, p. 72)*

Summary of findings

This study was the first to explore the emotional experiences and wellbeing of administrative staff who work in FMHS's. The findings indicated that administrative staff can be at risk of direct exposure to traumatic incidents and subsequent fear,

wariness, vigilance both at and outside of work. Support from management and their clinical teams seemed to be beneficial in supporting participants, with some reflections being offered on the helpfulness of debriefing, having a safe space to talk and being offered practical solution focused advice on how to manage conflict. Administrative staff are also at risk of indirect exposure to traumatic information through their role requiring reading and hearing about service-users index offences and forensic history. There was individual differences in how much information participants preferred to know about service-user index offences, and these individual differences were respected by management.

A holistic view of service-users developed through working in a FMHS for many participants. Developing this view can support administrative staff to feel safer at work (Simjouw, Vogel & de Ruiter, 2024), and there were some reflections from participants that their clinical team helped shape this view through sharing their understanding of participants early experiences and the clinical work they do. Job satisfaction for all participants seemed to be directly linked to making a difference to service-users lives and witnessing their progression. Lastly, being part of a safe and supportive environment and being treated as an equal were key in protecting participant's wellbeing. Recommendations for practice and future research are set out in the tables below.

Recommendations for practice:
• Administrative staff may benefit from post-incident debriefing and allocated reflective spaces facilitated by clinical staff; where they have the opportunity to explore their feelings, receive validation and learn new skills. This may be especially helpful for newly appointed administrators.
• Training on conflict management and de-escalation should be offered to administrative staff during their induction period.
• Managers should offer a person-centred and flexible approach to administrative staff's duties, where choice is offered based on individual needs and feelings.
• Administrative staff could be offered allocated time to understand service-user's crimes in the context of their early experiences and mental health difficulties.

- Managers should prioritise creating a psychologically safe work environment, where all staff feel able to ask questions and voice concerns without fear of judgement.

- Managers should ensure that administrative staff are not working in isolation and have opportunities to connect with their colleagues and other administrators.

- Administrative staff may thrive best under leadership that appreciates and values their work, in addition to promoting autonomy, choice and flexibility in the workplace.

Future research:

- Further research is needed to understand the experiences and wellbeing of FMH administrators. Recruiting from NHS Trusts in a larger geographical area than the Midlands may assist with capturing a variety of experiences.

- Research should also explore the experiences and wellbeing of administrators working in other NHS services, such as primary and secondary care mental health services.

Limitations of this research:

- This study only captured the voices of administrative staff who on the whole were satisfied in their role. Administrative staff who had less job satisfaction may not have felt comfortable or safe to share their experiences.

- This study did not include the voices of FMH administrators who had left their role, meaning their experiences and reason for leaving was not captured.

References

Chambers, F., & Kelly, M. (2006). Violence at work: the experience of general practice receptionists. *Irish medical journal*, *99*(6), 169-171

Cramer, R. J., Ireland, J. L., Hartley, V., Long, M. M., Ireland, C. A., & Wilkins, T. (2020). Coping, mental health, and subjective well-being among mental health staff working in secure forensic psychiatric settings: Results from a workplace health assessment. *Psychological Services, 17*(2), 160–169. https://doi.org/10.1037/ser0000354

Ewers, P., Bradshaw, T., McGovern, J., & Ewers, B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of advanced nursing*, *37*(5), 470-476. https://doi.org/10.1046/j.1365-2648.2002.02115.x

Ireland, C. A., Chu, S., Ireland, J. L., Hartley, V., Ozanne, R., & Lewis, M. (2021). Extreme stress events in a forensic hospital setting: Prevalence, impact, and protective factors in staff. *Issues in Mental Health Nursing*, *43*(5), 418–433. https://doi.org/10.1080/01612840.2021.2003492

Malik, S., Blake, H., & Batt, M. (2011). How healthy are our nurses? New and registered nurses compared. *British Journal of Nursing*, *20*(8), 489–496. https://doi.org/10.12968/bjon.2011.20.8.489

Mullholland, R. (2015). Resilience, burnout and psychological well-being in forensic health care professionals working in a secure setting. In *20th NAPICU Annual Conference. University of Warwick*.

Newman, C., Roche, M., & Elliott, D. (2021). Exposure to workplace trauma for forensic mental health nurses: A scoping review. *International journal of nursing studies*, *117*, 103897. https://doi.org/10.1016/j.ijnurstu.2021.103897

NHS England. (2020). *NHS People Plan for 2020/2021 – action for us all.* NHS England. https://www.england.nhs.uk/ournhspeople/

NHS England. (2023). *Consolidated NHS Provider Accounts 2021/22.* NHS England. consolidated-provider-accounts-21-22-final.pdf (england.nhs.uk)

NHS Staff Survey Results. (2023). *2023 National NHS Staff Survey.* NHS Staff Survey. https://www.nhsstaffsurveys.com/results/national-results/

NHS. (2019). *NHS Long Term Plan*. NHS. https://www.longtermplan.nhs.uk/

O'Beirne, M., Sterling, P., Palacios-Derflingher, L., Hohman, S., & Zwicker, K. (2012). Emotional impact of patient safety incidents on family physicians and their office staff. *The Journal of the American Board of Family Medicine*, *25*(2), 177-183. DOI: https://doi.org/10.3122/jabfm.2012.02.110166

Quirk, H., Crank, H., Carter, A., Leahy, H., & Copeland, R. J. (2018). Barriers and facilitators to implementing workplace health and wellbeing services in the NHS from the perspective of senior leaders and wellbeing practitioners: a qualitative study. *BMC Public Health*, *18*(1), 1-14. https://doi.org/10.1186/s12889-018-6283-y

Rodrigues, N. C., Ham, E., Kirsh, B., Seto, M. C., & Hilton, N. Z. (2021). Mental health workers' experiences of support and help-seeking following workplace violence: A qualitative study. *Nursing & Health Sciences*, *23*(2), 381-388. https://doi.org/10.1111/nhs.12816

Simjouw, A., de Vogel, V., & de Ruiter, C. (2024). Trauma-Informed Care Training in Forensic Mental Health Services: A Scoping Review. *International Journal of Forensic Mental Health*, 1-15. https://doi.org/10.1080/14999013.2024.2323934

Smith, J. A., Flowers, P., Larkin, M. (2021). *Interpretative Phenomenological Analysis: Theory, Method and Research* (2nd ed.). Sage Publications.

Taylor, J., & Trout, S. (2013). Lessons from the front line: working with offenders with learning disability and personality disorder in a high secure therapeutic community. *Mental Health Review Journal*, *18*(1), 44-52. https://doi.org/10.1108/13619321311306974

Twigg, J., Methley, A., Leighton, Z., Meehan, R., & Kirkby, A. (2020). Using supervision to improve the wellbeing of administrative staff in a busy Neuropsychology department: A pilot service initiative. *Clinical Psychology Forum*, *1*(334), 39–44. https://doi.org/10.53841/bpscpf.2020.1.334.39

Verstegen, N., Peters-Scheffer, N., Didden, R., & de Vogel, V. (2024). 'You Still Need to Care for the patient'. Experiences of Forensic Mental Health Professionals with Inpatient Aggression. *International Journal of Forensic Mental Health*, 1-12. https://doi.org/10.1080/14999013.2024.2354286