Research

A qualitative exploration of acute mental health inpatient staff's experiences of working with high-risk behaviours, and the support they receive

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Abstract

Background/Aims Staff working in acute mental health inpatient environments are frequently exposed to high-risk behaviours. The aim of the study was to explore the experiences of staff working with patients with high-risk behaviours at acute mental health inpatient wards, and what support the staff receive following exposure to these incidents.

Methods A total of 10 participants were recruited from two acute mental health hospitals in England. Data were gathered using semi-structured interviews and analysed using inductive thematic analysis.

Results Three themes emerged: the direct impact of incidents, attempts to manage the impact of incidents, and current systems for managing incidents.

Conclusions Overall, staff felt that support was lacking, and there was a fear that seeking support was a sign of weakness. Clear differences in staff reactions and responses to varying high-risk behaviours were revealed. Staff person-centred reflective support spaces, debriefing support, and skills training, especially for self-harm and suicide, are required. Staff also require emotional support and emotion management skills.

Key words

Psychiatric inpatient care, Qualitative, Self-harm, Staff perspectives, Suicide

Introduction

Acute adult inpatient mental health services provide treatment and care for individuals who have complex mental health needs and may be at risk of harm to themselves or others (Department of Health, 2002). Approximately two-thirds of occupied inpatient beds were used for people with a diagnosis of psychosis, and the average length of stay was 31.6 days (NHS Benchmarking, 2020). There has been increased focus on providing mental health support to adults in the community, and the NHS Long Term Plan (NHS England, 2019) aims to provide primary care and community-based treatments to 370 000 adults with severe mental illnesses (psychosis, bipolar disorder, personality disorders, eating disorder and severe depression) by 2023/2024, reducing the need for admission to

hospital. However, this means that only those with the most complex needs and high levels of risk are now admitted.

Balancing the need for safety and security within a therapeutic environment can be a challenge for staff. Acute mental health inpatient staff are faced with the unique dilemma of helping to create a caring and therapeutic environment, while holding knowledge that they may be required to deploy physical or chemical restraint (through the use of medication and pharmacological treatment) to patients if they present with high-risk behaviours (Gelkopf et al, 2009). High risk behaviours can be defined as behaviours that threaten the life of the individual or others, for example, self-harm, suicide and physical violence (Wood et al, 2021). While restraint is designed to be a protective intervention, it appears that staff and patients alike consider this a stressful and coercive act that can negatively impact on staff, patients and the ward environment as a whole (Marangos-Frost and Wells, 2000). As such, there has been a move towards reducing the use of restrictive practice in acute mental health inpatient services (Royal College of Psychiatry, 2019).

Recent research has advocated for the use of multidisciplinary care plans, including behavioural support plans, to prevent the need for restraint, seclusion and rapid tranquilisation (Clark et al, 2017). These plans use a biopsychopharmacosocial approach exploring a patient's biological, psychological, social and pharmacological factors that may contribute to high-risk behaviours, and this information is used to form a management plan detailing least to most restrictive interventions (Clark et al, 2017). In addition, more system-wide interventions have been employed to reduce risk, increase safety and prevent high-risk behaviours, such as Safewards (Bowers, 2014) and relational security (Department of Health, 2010). These comprise psychosocially informed interventions to improve how inpatient care is delivered by impacting on wider cultural change (Department of Health, 2010; Bowers, 2014).

Despite such preventative interventions, managing high risk behaviours continues to be a key feature of acute mental health inpatient care (Slemon et al, 2017). As such, staff continue to be frequently exposed to high-risk incidents that require careful management and cohesive group working among colleagues (Sullivan, 1993; Royal College of Nursing, 2018). When the presence and management of these high-risk behaviours becomes overwhelming, staff may become emotionally detached from their work (Menzies, 1960; Morse et al, 2012). This can have negative consequences for staff on a personal level by feeling depleted and exhausted, and professionally, by feeling incompetent and lacking personal accomplishment (Maslach, 1998; Morse et al, 2012).

A number of qualitative studies have been conducted to explore staff's experience of working in acute mental health inpatient settings including their experiences of working with patients that exhibit high-risk behaviours (Currid, 2009; Jussab and Murphy, 2015; Awenat et al, 2017; Hagen et al, 2017; Rouski et al, 2017). These studies have either focused on self-harm and suicidal behaviour or violence and aggression respectively. Collectively, these studies have identified that staff experience negative impacts on their health and wellbeing, negative emotional consequences and fears about their safety when working with patients with high-risk behaviours in inpatient settings, which demonstrates the detrimental psychological consequences from working in such environments. To date, there has not been any simultaneous qualitative exploration of staff's exposure to patients with high-risk behaviours more broadly and the support they would like to receive, which would be important in understanding their needs and being able to effectively respond to them. Therefore, the aim of this study is to examine inpatient staff experiences of managing patients with high-risk behaviours and the support the staff receive.

Methods

Design

Semi-structured interviews were undertaken with staff to examine their experiences of working with high-risk behaviours and the support they receive. The writing of this manuscript also followed guidance from the Consolidated Reporting for Qualitative Research (Tong et al, 2007) guidelines.

Setting

Two NHS adult acute mental health inpatient hospitals providing care for people detained under the Mental Health Act (1983; 2007), or who were informally admitted were chosen as one was in an urban area and one was in a rural area, allowing for coverage across different settings. Adults admitted to these units experience significant mental health difficulties and are deemed to pose a risk of harm to themselves or others, which cannot be adequately managed in the community.

Ethical approval

The study received NHS HRA approval (IRAS Project ID 249234). Approval was also received from the Essex Partnership University Trust and North East London Foundation Trust ethics committees. The study was sponsored by the University of Essex.

Participants

The study was promoted to staff at handover and at ward business meetings by the first author. Emails were also sent to the ward teams advertising the study. The importance of confidentiality was also emphasised, as some staff were worried that it would be possible to identify them if their quotes were used in the write up. Participants who expressed an interest in taking part in the study did so either by giving their name and email address directly to the researcher in meetings, or by emailing the lead author directly.

The authors aimed to recruit 8–12 participants, as recommended for a thematic analysis study (Creswell and Plano Clark, 2011).

Individuals were eligible to take part in the study if they:

- Were 18 years and over
- Were employed by the NHS and working at the units for a period of at least 6 months
- Subjectively felt that they could comment on exposure to high-risk behaviours that occurred while they were at work.

Staff who were not directly employed by the NHS, such as agency staff, were excluded from participating in the study. This is because support for agency staff may vary in comparison to those employed directly by the Trust.

Procedure

An interview schedule was developed for the purpose of this study and data was collected using semi-structured interviews. A scoping review of the existing literature examining current qualitative studies in the topic area was undertaken to inform the development of the interview schedule (Currid, 2009; Jussab and Murphy, 2015; Awenat et al, 2017; Hagen et al, 2017; Rouski et al, 2017). Consultation with members of staff currently working in acute mental health inpatient services (clinical psychologists and registered nurses) was also conducted to provide insight into

areas that might be worthy of exploration. Collectively, this information formed the first draft of the interview schedule. Further consultation with research supervisors and guidance for developing and conducting the interview (McNamara, 1999) led to the final schedule that was used in this study. Key topics for exploration within the interview included how incidents of high-risk behaviours are currently managed on the wards, the impact that exposure of high-risk behaviours has on staff, how staff personally manage their wellbeing following an incident, and what support staff receive following exposure to an incident. Participants were also given the opportunity to comment on any other aspect of exposure to high-risk behaviours and support at the end of the interview.

Data collection

Once screened for eligibility, staff were contacted to arrange suitable times to meet for the interview. Interviews were undertaken in a private room at the recruitment site and lasted between 22 and 46 minutes, with a mean length of 33 minutes.

Data analysis

Interviews were transcribed verbatim by the first author and analysed using thematic analysis (Braun and Clark, 2006). Thematic analysis requires the researcher to make several key decisions to inform how the approach is used. The researcher adopted a critical-realist position and an inductive approach was undertaken to analyse data at a semantic level. First, interviews were listened to, and transcripts read several times to ensure the researcher was fully immersed in the data. Line-by-line coding of individual interviews was then undertaken, followed by the synthesis of codes across interviews. Codes were then grouped together to form a final set of analytical themes and sub-themes.

Reflexivity

Both authors have experience of working in acute mental health inpatient settings. The first author had experience of working in a Child and Adolescent Mental Health Service inpatient mental health hospital as both as an assistant and trainee clinical psychologist. The second author had 7 years' experience of working as a clinical psychologist in in acute mental health inpatient hospital, which was also one of the recruiting sites. Both authors have an interest in reducing restrictive practices and improving staff wellbeing in the inpatient setting.

Results

A total of 10 participants took part in the study. Participant characteristics for the ten participants are outlined in Table 1. Seven identified as female, and three identified as male. Participants described themselves as Black African, Black British Caribbean, Indian, Northern European, White British, British Pakistani, Asian, Mixed British Asian and Pakistani. Ages ranged from 24–56 years. The mean length of experience of working on acute inpatient wards was 4.6 years.

Table 1. Participant characteristics

Participant	**Sex**	**Job role**	**Ward Type**
1	Female	Nursing associate	Male only
2	Female	Occupational therapist	Acute
3	Female	Ward manager	Male only
4	Female	Nursing associate	Older adult
5	Male	Occupational therapist	Acute

6	Male	Psychiatrist	Male only
7	Female	Assistant psychologist	Female only
8	Male	Staff nurse	Psychiatric Intensive Care Unit
9	Female	Psychiatrist	Psychiatric Intensive Care Unit
10	Female	Assistant psychologist	Acute

Themes

Three main themes were identified from the analysis: direct impact of incidents, attempts to manage impact and current systems for managing. All themes are outlined in Table 2.

Table 2. Themes and sub-themes

Themes	**Sub-themes**
Direct impact of incidents	Heightened threat system
	Feeling emotionally overwhelmed
	What do I do to help you? The struggle with self-harm
	The worst-case scenario
	Fighting an uphill battle
Attempts to manage impact	Defending against the impact of incidents
	Just get on with it
Current systems for managing	Practical incident management
	Support systems: good, bad and absent

Direct impact of the incidents

Exposure to incidents of high-risk behaviours had both short- and long-term consequences for staff, including feeling emotionally vulnerable and on high alert. In addition, exposure to these incidents left staff feeling demotivated and deskilled in their work.

Heightened threat system

Staff described feeling on edge and wary around patients following incidents of violence and aggression, suggesting that their biological threat system may be overactive while on shift. This feeling would be long-lasting and endure long after the high-risk event:

> ‘I was put on the floor by a female patient, who the week before had tore a muscle in my arm … so I became slightly wary of her on the ward … and I’m still wary of this woman. Every time I see this woman … I can feel myself going slightly to one side of her.’ (P5)

Exposure to these incidents had an impact on the physical and psychological wellbeing of staff. This culminated in a feeling of dread for the staff, something which later impacted on their physical and psychological wellbeing and on their therapeutic relationships with patients. Some were unable to sleep following incidents of violence and aggression:

> ‘It was [a physical violence] incident which I was very stressed about and … it affected me quite a lot. For a few days I couldn’t even sleep properly.’ (P4)

Furthermore, gender bias towards threat was also apparent in interviews with female staff who described interactions with male patients who were, or had a history of, displaying violent or aggressive behaviour. One participant directly named gender as being a threat issue and another identified feeling more intimidated around male patients. The issue of gender was not mentioned by male members of staff.

> '… for males I always find it quite intimidating if they're very near me, or they're standing about [near to] me or if I'm sitting and they're standing. It does make you feel quite intimidated.'(P3)

Feeling emotionally overwhelmed

Staff were left feeling emotionally overwhelmed following incidents of self-harm and suicidal ideation. Staff described feelings of being under considerable pressure and strain, and that there had been times (both at work and at home) where these feelings could no longer be contained and were outwardly expressed in the form of crying:

> 'I'm actually embarrassed about it, I started to cry in front of her [patient] **…** I didn't cry, I just had tears in my eyes, and I couldn't control them coming down … I had to go in the toilet and have a complete and absolute breakdown.' (P10)

Despite staff beginning to talk about the emotional impact of exposure to incidents of self-harm and suicide ideation in their interviews, it seemed that there was little room for reflection on this, and the topic would quickly move on despite researcher attempts to explore this further. This directly reflected a conflict staff were facing in addressing their emotions on the wards.

> 'And we went to this debrief and two of the nurses were sobbing. The new nurses. And I said, … "You know what, it's good that you're crying. This is the first time – I've been here in almost 10 years. We have these debriefs, and these debriefs are for people crying. That's why we have them. And yet I've never seen anyone cry. Ever".' (P5)

The overwhelming impact of working with incidents of high-risk behaviours had a negative impact on staff morale, increased sickness levels, and a need for constant risk assessment, painting a picture of what it might be like for staff who work in these settings.

> 'I think you definitely get higher sickness levels. You definitely get the morale just go a little bit when you've got a couple of people – one or two people that are showing that kind of aggression. So that's a bit difficult … and it's hard to manage a team where you're constantly trying to beg someone to go [into work].' (P3)

What do I do to help you? The struggle with self-harm

Incidents of self-harm and suicide ideation had a profound effect on staff sense of competence in incident management. Staff appeared to lack confidence in knowing how to practically and emotionally support a patient who was self-harming.

> '… he was just trying to harm himself. Was just really fixed on harming himself … that was quite hard. I find that quite difficult. I'm not very good at that. De-escalation, violence and aggression, I got that. But with that, I'm just wondering "what do I do to help you?".' (P3)

P9 was able to summarise the difference between nursing a patient who was expressing violent and aggressive behaviour, compared with someone expressing self-harm and suicide ideation.

Again, this further supported the idea that there might be a deficit in the training provided to staff working in NHS inpatient mental health services, and may highlight a need for ongoing or more thorough and in-depth education in this area, both for the benefit of the staff and the patients they work with.

> 'I think you have to be so much more psychologically minded … constantly providing hope, you know? Encouraging – even though they're probably thinking "oh my god, this is never go[ing to] change", they probably feel quite desperate at that time. But … when the patients are aggressive, some of it is actually about basic nursing needs isn't it? Feeding the patient, helping them, you know? Nursing them in a kind of more direct, general nursing kind of way. And that might feel a bit more comfortable to them.' (P9)

The worst-case scenario

The lack of confidence expressed by staff also led to worrying about the worst-case scenario for patients who self-harm, and the impact this would have on both staff and patients.

> 'I think of the worst-case scenario. If he had died. If he had cut himself in his room and then … bled to death rather than come to us for help. Even among staff we talk about it, we said it could have gone much, much worse.'(P8)

Similarly, staff reflected that incidents of aggression can escalate very quickly, highlighting the importance of not underestimating the impact of any incident on the wards.

> '…it was the fact that I wasn't expecting it [hot drink thrown in face by patient] and I said, 'oh my god. If it was very hot this might have scarred my face or something,' you know? That was frightening.' (P1)

Fighting an uphill battle

Daily work in a high-stress environment led to staff feeling demotivated, withdrawing from their work, and feeling like they had failed the patients when incidents involving high-risk behaviours continued to occur.

> '…you're just fighting an uphill battle and it can completely just tire you out and exhaust you, and you just lose that drive … which is a shame for them then, because I don't try as much because … it's kind of demotivating actually.' (P10)

P10's demotivation also highlighted an important consequence for the patients they work with, and their colleagues, a feeling of pulling back from their work and not trying as much as they used to. While this helps to protect P10 against further burnout and exhaustion, it increases the potential risk that patients do not have their needs met, and may further increase the workload of the rest of their colleagues.

> '… they might not react but their attitude to work might be different. So .. for example, if they were doing ten tasks … they might decide to do six or seven… I'm not saying that's what I'm doing, but that might happen.' (P1)

Attempts to manage impact

Staff attempted to manage the impact of exposure to high-risk behaviours through focusing on their own wellbeing, cutting off from the incident and trying to find ways to explain away the behaviour of the patient.

Defending against the impact of incidents

Staff found it difficult to identify positive coping strategies, and recognised that not taking care of themselves could have further consequences for their wellbeing.

> '…these things that I teach them to do, I wasn't even doing myself.' (P10)

Often staff found it difficult to identify what they did to manage their own wellbeing following exposure to an incident at work. There was a need for staff to shut off or distract themselves from the incident, and some members of staff attempted to draw a clear line between work and home life.

> '… I go straight to the pub … to get drunk.' (P5)

> 'Usually when I'm at work I don't think about home. When I'm at home I don't think about work. Once I've left that place **[work]** it's over.' (P8)

Just get on with it

Cutting off and shutting down from incidents was also seen on the ward, with staff needing to desensitise from incidents in order to carry on doing their jobs.

> '… I deal with it, I'm used to it, tomorrow's another day. If it happens, I'll deal with it again… If I see an incident happen on the ward, it's just part of the job. It's happened too many times and now [I] look at it as if it's just anything – another day.' (P8)

> '… we were talking and someone said "oh I would just deal with it".' (P7)

The idea that exposure to incidents of violence, aggression, self-harm and suicide ideation is 'just part of the job' is one that is ingrained among the staff team, and contributes to the culture of being desensitised and immune to the effects across the different wards that participants worked on. Worryingly perhaps, cutting off and becoming desensitised was often framed as an example of resilience, a more positive and valued quality of staff working in mental health settings, and cause a split in the staff team.

> 'That's a massive thing … being weak. That's not allowed … you have to be strong and tough. Like a prison guard. Like "oh if these things affect you, they shouldn't" … even though they're quite horrible things.'(P10)

As well as desensitising to the incidents that they are required to manage on a daily basis, staff further attempt to explain away these incidents by highlighting that the patients are unwell, something that appeared to help them cope with being exposed to high-risk behaviours.

> '… he's just having a bad day, he's just not well on that particular day … later on, he will remember this and will probably apologise for it.' (P6)

Current systems for managing

Staff described times where attempts to manage incidents of high-risk behaviour had been successful, as well as times where these attempts had failed. They spoke of the impact of support from their colleagues, as well as the detrimental impact of a lack of support following exposure to an incident.

Practical incident management

Staff described a clear understanding of how incidents should be managed according to their ward guidelines, and generally felt that this was an area that was followed well by themselves and their colleagues. They described a number of interventions, ranging from verbal de-escalation, through to restraint and seclusion.

> 'Very often you have patients being aggressive and violent towards other patients and staff, and obviously we have seclusion, where we have to seclude that person to manage the risk to themselves or others.' (P8)

Staff who reported using the Safewards (Bowers, 2014) intervention felt that they could effectively communicate with the patients and achieve de-escalation, reducing the levels of restraint and seclusion on the wards.

> 'Overall I think the team in general have used a lot of Safewards and things like that to reduce violence and aggression. Which is really good.' (P3)

Despite having clear guidelines to follow to manage high-risk behaviours, staff felt that there were times where any intervention would be unsuccessful and result in failure.

> '… there [are] some incidents where … that person is just a very angry person at the time, and there's very little you can do to try and minimise that.' (P3)

Support systems: good, bad and absent

Support varied greatly among the staff teams. Those who spoke of positive experiences of support referred to their colleagues who had been on shift with them at the time, checking in on them and their wellbeing.

> '… throughout the whole day, staff w[ere] very … helpful. Always asking "Do you need a break?" "Do you wan[t to] go on your break?" "Have you had your lunch yet?".' (P2)

Overall, staff felt that there was a lack of support on the wards and felt that mandatory reporting of incidents was more of a tick-box exercise with little obvious outcome, making them less likely to seek support in the future.

> '… [I submitted an incident on] Datix [NHS risk reporting system]. Nothing came out of it. Nothing was done. Nobody approached me. I just had to deal with it myself. So that was it.' (P1)

Staff felt that more should be done to provide them with a person-centred space to explore their wellbeing. Support also felt difficult to access because of ward limitations.

> '… they definitely need more support and space to reflect and think … their demands are just too high … even in team meetings … the attendance is low because the staff are needed on the floor.' (P10)

> 'The way I handle the situation is different to how somebody else might handle the situation … I think there should be more support … for them to express themselves and make sure that they're mentally healthy and ready to work.' (P8)

Discussion

Participants were able to describe the immediate and longer-term consequences of exposure to patients' high-risk behaviours in an adult inpatient setting, and how these impact on them individually and the staff team as a whole. Findings demonstrated that staff working in acute mental health inpatient wards are faced with unique challenges in their attempts to manage and respond to incidents of high-risk behaviours.

The results highlighted that exposure to violence and aggression caused staff to experience a heightened sense of threat and vigilance while on shift. They described having to resist their innate threat responses in favour of carrying out their professional duties, which supports previous qualitative literature (Jussab & Murphy, 2015). As a result, staff appeared to establish safety by turning to structures and procedures on the wards, which incidents of violence and aggression have the potential to displace (Weisman et al, 2011). The management of the ward requires staff members to maintain a constant level of vigilance, which can lead to increased stress levels and burnout (Maslach, 1982), and poorer physical and mental health for inpatient staff, which is well-established in existing literature (Whittington and Wykes, 1992; Reininghaus et al, 2007; Currid, 2009). Staff described a need to shut themselves off from the incidents, contributing to and maintaining a ward culture where the impact of incidents was not discussed. Staff experiences of support varied, and a narrative unfolded that suggested asking for support demonstrated weakness. This led to staff expressing a desire for more person-centred support, which is currently a NHS priority (Alderwick & Dixon, 2019).

Consistent with the literature on burnout (Menzies, 1960; Maslach, 1998), staff felt demotivated and deskilled in their abilities to effectively manage incidents, which further impacted on their wellbeing. These feelings were further exacerbated in response to incidents of self-harm and suicide ideation. This is consistent with previous research that demonstrated staff felt powerless to prevent incidents of self-harm, resulting in feelings of failure and responsibility when incidents occurred (Rouski et al., 2017; Beryl et al., 2018). Staff felt able to manage incidents of violence and aggression more effectively, stating that they were less likely to be emotionally impacted by these experiences. However, incidents of self-harm and suicide ideation left staff feeling deskilled and defeated and had a tangible emotional impact.

Staff described a ward culture that was intolerant of emotional expression, and encouraged professional detachment (Menzies, 1960) through the rhetoric that staff should 'just get on with it.' Detachment is a common strategy that staff use to manage high threat levels in the inpatient settings and has been identified in the previous literature (Tane, Fletcher & Bensa, 2022). This rhetoric prevents the opportunity to explore the impact of incidents, thereby reinforcing the ward culture and preventing opportunity for change (Jacques, 1953). Because there is no space to explore these incidents, staff increasingly feel hopeless and deskilled, which caused staff to become fearful for the safety of the patients in their care. This study contributes to the existing literature, which found that staff struggle to make sense of incidents of self-harm and suicide ideation, and can feel responsible for the incidents because they do not know how best to manage the situation (Rouski et al, 2017; Beryl et al, 2018).

Recommendations for practice

Staff require more specialist high-risk training, independent reflective spaces, post-vention (i.e. organizational support for staff post-suicide), and supervision to specifically have support tailored support for managing self-harm and suicide. A reflective debriefing space should be provided for staff individually and as a group to discuss incidents of self-harm and suicide, rather than a procedural driven space.

Individualised and timely support should be given to give staff the opportunity to address the practical and emotional components of working with patients with high-risk behaviours, particularly self-harm and suicide. Recommendations have been made for organisations on how to do this in the self-harm and suicide framework (National Collaborating Centre for Mental Health, 2018), outlining organisational competences for post-vention, supervision, and reflective practice, which can be applied to the inpatient context. Safewards (Bowers, 2014) was cited by participants as important in minimising risk behaviours; therefore, inpatient managers should ensure existing initiatives are consistently and well-implemented.

To mitigate against the view that asking for support is a sign of weakness, and that incident reporting is not followed-up, higher management should have more presence on the wards. The aims of this should be to promote a reflective and open culture to discuss some of the challenges of working in this environment.

To address the negative culture around asking for support, management need to develop an open and collaborative support system that can offer relief from these experiences, which additionally is shown to mitigate against the risk of burnout (Sullivan, 1993; Fenlason and Beehr, 1994).

Strengths and limitations

This study is novel in the fact that it combines staff experiences of harm to self and other in one project, allowing for direct comparisons to be drawn between the different types of incidents. One of the limitations of this study was the small sample size. Although in line with recommendations for thematic analysis, a larger sample size may have brought further valuable insight into the topic area (Creswell and Piano Clark, 2011). This, along with the qualitative nature of the study may mean the results are not generalisable across other acute services in the UK. In addition, experiences of staff on acute wards may be different to those working in other services, such as forensic services or patients with learning disabilities. Furthermore, there was a lack of staff nurses in this study, which may reflect the high stress this group of professionals are under when it comes to the day-to-day running of the ward, and therefore important insight from their perspective may be missing from this study. Moreover, the interviews were relatively short in length. It is recommended that qualitative interviews should last about 45–60 minutes (Braun & Clarke, 2013) ;however, the average length in this study was 33 minutes. This may reflect the busy nature of the ward environment and that staff completed the interviews during their shifts. Future research should try and ensure protected time for inpatient staff to undertake interviews.

Conclusions

This study has highlighted the challenges that staff face in managing high-risk behaviours. Staff reported feeling less skilled and not emotionally supported with incidents of self-harm and suicide, demonstrating the importance of further support and training in this area. Inpatient work can be a highly challenging and emotional experience and appropriate support structures need to be in place to ensure that staff feel safe and valued.

Conflict of interest

LW worked clinically in the hospital where this research was conducted. To manage this, LW was not involved in the recruitment or conduct of interviews.

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