

An investigation into staff burnout in forensic hospitals

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Abstract

This thesis provides a broad investigation into the issue of burnout in forensic hospital workers. The methods used include a critical review of a psychometric measure, a systematic review, a quantitative research study and a qualitative research study. To begin with, a critique of the Maslach Burnout Inventory (Maslach & Jackson, 1981; Maslach et al., 1996) assessed the psychometric properties of the tool, its applicability within occupational settings and its research use. The MBI is an assessment measure, used in many of the studies included in the systematic review and also in the quantitative research study. A number of limitations of the MBI were highlighted, including its self-report nature and the ongoing controversy regarding the number of dimensions that the MBI encompasses. However, the MBI has regularly demonstrated excellent levels of reliability and validity across a range of samples, cultures and professions. Therefore, it is concluded that the MBI is an effective tool for measuring burnout across a range of occupational settings. A systematic review of the existing literature identified a number of different risk factors for burnout in forensic hospital workers. Many variances were observed across studies, however, some commonalities were detected and the risk factors identified were grouped into four separate sub-categories: organisational/occupational factors, clinical factors, personal and individual factors and feeling detached from the outside world. The quantitative research study investigated the level of burnout experienced in a sample of 173 forensic hospital workers and the risk factors which may predict the development of burnout. When the results were compared to the normative data, it became apparent that participants were reporting higher than average levels of burnout. Moreover, quantitative outcome measures also yielded some statistically significant results regarding the associated risk factors for burnout, which included gender, age, length of time at the organisation, job role, children and level of education. Ward level of security and client group were also considered

in relation to staff burnout. The clinical implications and the research implications of the findings are both discussed, with the findings of the study providing ideas and directions for future research. The qualitative research study explored the experiences of 12 forensic hospital workers using thematic analysis. The data analysis yielded ten sub-themes, grouped under five superordinate themes, which were all perceived to contribute to feelings of stress and burnout at work. The themes identified through the data analysis included: inadequate resources (difficulty accessing support and training needs), the daily chaos (the nature of working with forensic patients and running the ward), no sense of community (problematic relationships with colleagues and a fractured team), consequences of the job (impact on my personal life and impact on my health) and rewarding our efforts (limited recognition and why I still do it). The findings are discussed in terms of practical implications for the organisation and a number of interventions to reduce burnout in forensic hospital staff are also suggested.

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Glossary of terms

3SQ	The staff support and satisfaction questionnaire
ANOVA	Analysis of variance
ATTQ	Attitudes to treatment questionnaire
BBC	British Broadcasting Company
BCI	Brief cope inventory
CCSS	Cooper coping skills scale
COR	Conservation of resources theory
CQC	Care Quality Commission
DP	Depersonalisation
DSM-5	Diagnostic and Statistical Manual of Mental Disorders - Version 5
EE	Emotional exhaustion
ERCBS	Emotional reactions to challenging behaviour scale
ERI	Effort-reward imbalance model
ERQ	Emotional response questionnaire
FMSS	Five minute speech sample
GHQ	General health questionnaire
GHQ-12	General health questionnaire - 12 item
GHQ-28	General health questionnaire - 28 item
HCR-20 V3	Historical, Clinical, Risk Management - Version 3
ICD-11	International Statistical Classification of Diseases and Related Health Problems - Version 11
JDR	Job-demands-resources model

JDC	Job-demands-control model
JDCS	Job-demands-control-support model
JSS	Job satisfaction scale
MBI	Maslach Burnout Inventory
MBI-ES	Maslach Burnout Inventory - Educators Survey
MBI-GS	Maslach Burnout Inventory - General Survey
MBI-HSS	Maslach Burnout Inventory - Human Services Survey
MDT	Multi-disciplinary team
MHPSS	Mental health professional stress scale
MJSS	Minnesota job satisfaction scale
NHS	National Health Service
OSI	Occupational stress indicator
PA	Personal accomplishment
PCL-C	Post-Traumatic Stress Disorder checklist - Civilian version
PEF	Person-environment fit model
PIE	Psychologically informed environment
PNOSS	Psychiatric nurse occupational stress scale
ProQOL	Professional quality of life scale
PTSD	Post-Traumatic Stress Disorder
SD	Standard deviation
SSQ	Staff stressor questionnaire
UK	United Kingdom
WAS	Ward atmosphere scale

Chapter 1 - General introduction

In the early 1970s, Herbert Freudenberger coined the term 'burnout' to describe the state of mental and physical exhaustion caused by one's professional life. He did this after analysing a mental condition that he observed in some of his colleagues and also experienced himself, whilst working at a clinic in New York City, with people who had substance abuse problems.

Since that time, a substantial amount of conceptual papers and empirical studies have focused on this complex phenomenon and the concept of burnout has subsequently been defined in various ways throughout the literature (Edelwich & Brodsky, 1980; Halbesleben & Demerouti, 2005; Kristensen et al., 2005; Pines & Aronson, 1981; Sarros & Densten, 1989; Shirom & Melamed, 2005). Freudenberger's initial work was followed by a considerable number of psychological and medical studies, beginning with research by Christina Maslach and her colleagues in the late 1970s and early 1980s (Maslach, 1976; Maslach & Jackson, 1981; Pines & Maslach, 1978). Maslach was one of the pioneers in burnout research and, to this day, she remains one of the most well-known and renowned scholars in this field.

Maslach and her colleagues initially encountered the term 'burnout' in California, when interviewing a variety of human services workers with the aim of establishing how they coped with their emotions. In analysing the interviews, Maslach observed a trend, noticing that workers often reported feelings of profound emotional exhaustion, negativity directed towards their clients and a crisis in feelings of professional competence (Maslach, 1976, 1993). She used these observations to develop a definition of burnout, which describes burnout as 'a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's capacity to perform'. In accordance with this definition, Maslach et al. (1996) further explain

that burnout can be characterised by symptoms across three distinct dimensions: emotional exhaustion (EE), depersonalisation (DP) and a decreased sense of personal accomplishment (PA). EE refers to feeling emotionally depleted, overextended and fatigued. DP is characterised by unsympathetic and impersonal responses towards clients, as well as negative and cynical attitudes toward clients or work in general. Finally, a decreased sense of PA is distinguished by negative self-evaluation of one's work with clients or overall job effectiveness.

As outlined above, burnout was originally identified within the human services, as it was hypothesised that the emotional demands of working directly with people were highly associated with the development of burnout (Chemiss, 1980; Freudenberger, 1974; Maslach, 1982). Therefore, traditionally, the concept of burnout has been closely linked to the human services, where professionals work directly with people (Schaufeli et al., 1993). However, by the late 1980s, researchers and practitioners began to recognise that burnout occurred outside the human services, for instance, among managers, entrepreneurs, white collar workers and blue collar workers. Thus, the burnout metaphor was extended from the intense requirements of client service to other work requiring creativity, problem solving or mentoring (Schaufeli et al., 2008). Subsequently, there now appears to be little theoretical rationale for limiting burnout exclusively to human service professions (Maslach & Leiter, 1997; Schaufeli & Enzmann, 1998). In fact, sufficient empirical evidence now indicates that burnout transpires across numerous cultures, occupations and fields (Buunk et al., 1998; Kahn & Byosiere, 1992; Leiter & Schaufeli, 1996; Stalker & Harvey, 2002; Toppinen-Tanner et al., 2002).

At the present time, occupational stress and burnout experienced within the workplace are arguably one of the greatest occupational health problems in the United Kingdom (UK). Indeed, Hassard et al. (2017) completed a global systematic review into the cost of work-related

stress and found that, in the UK, the cost of work-related stress was estimated to range from \$13.13 to \$23.63 billion, which equates to approximately \$398.10 to \$716.58 per British worker. Moreover, a report by the Health and Safety Executive (2017) discovered that work-related stress, depression and anxiety represent a significant ill health condition in the workforce of the UK. The report highlights that, in the year 2016/17, work-related stress, depression and anxiety accounted for 40% of work-related ill health and 49% of working days lost (which totalled 12.5 million). The same report also outlines that occupations and industries reporting the highest rates of work-related stress, depression or anxiety remain consistently in the human health and social work sectors of the economy. Overall, the evidence reviewed here suggests a sizeable financial burden imposed by work-related stress on society.

Eurofund (2018) provides a review of data and policy responses in the European Union. The report cites the primary determinants of burnout as: a lack of social support, value conflicts, the physical aspects of the working environment, conflicts in the work place, a heavy workload, working long hours, less autonomy, poor teamwork, a lack of opportunities for development and a lack of rewards. The same report also cites the consequences of burnout as declining job satisfaction, poor performance and motivation, increased sick leave, increased turnover and eventual work disengagement. The review concludes that burnout research is growing, particularly when it comes to small-scale occupational studies. However, those studies tended to be patchy, with a range of different instruments to measure burnout and were not always carried out by the most authoritative organisations, such as governmental institutions and health institutes. Therefore, further research is necessary to assess whether the data that has so far been collected and the subsequent policy responses are successfully addressing the topic.

It has now become clear that burnout transpires cross culturally and is predominant across a variety of occupations and fields (Leiter & Schaufeli, 1996; Stalker & Harvey, 2002). However, the prevalence of burnout has consistently been found to be higher among professionals who work in certain settings, particularly healthcare settings (Kilfedder et al., 2001; Severinsson & Kamaker, 1999; Tillet, 2003). This is likely due to the therapeutic relationships that healthcare workers develop with their recipients, which require an ongoing and intense level of personal and emotional contact (Maslach & Leiter, 2016). Within healthcare occupations, it is typically customary to behave selflessly and empathically towards recipients, putting their needs first. With this in mind, while such professions can be rewarding, they can also be stressful (Maslach & Leiter, 2016). Indeed, studies have shown how, despite being a key component of effective care, empathy also creates vulnerability for stress-related conditions (Figley, 2002; Rothschild, 2006). In the UK, it has been estimated that sick leave costs the National Health Service (NHS) £1.7 billion a year, with more than a quarter of this sick leave being taken due to stress, depression and anxiety (Boorman, 2009). High levels of burnout and poor well-being in healthcare staff are also present outside the UK too. Indeed, an international study of 61,168 nurses across 12 countries found that in nine countries, a quarter or more of the nursing workforce was burnt-out, with rates as high as 78% in Greek nurses (Aiken et al., 2012).

Burnout in the mental health field:

Historically, research into burnout in mental healthcare staff has lagged behind other areas of health care. However, the research which does exist suggests that burnout may be a particular problem among individuals who work in the mental health field, with prevalence rates ranging from 21% to 67% (Morse et al., 2012). More recently, a growing body of literature has begun to provide more emphasis on the link between the mental health field and burnout (Awa et al., 2010; Dickinson & Wright, 2008; Edwards & Burnard, 2003; Morse et al., 2012; Paris & Hoge,

2010). Currently, work-related stress and burnout in mental health employees is considered to be a significant problem. Indeed, figures suggest mental health staff take more sick days than those in both acute trusts and primary care (NHS Digital, 2016). Work-related stress is also higher in mental health staff, with 41% reporting feeling unwell due to stress in the last year, compared with 35% in acute trusts (NHS Digital, 2017). Additionally, recent statistics gathered by the British Broadcasting Corporation (BBC) in 2017, through freedom of information requests, outline that the number of NHS mental health staff who have had to take sick leave due to their own mental health issues has risen by 22% in the past five years. Moreover, those taking long-term leave of a month or more rose from 7,580 in 2012-13 to 9,285 in 2016-17.

From reviewing the research, it is apparent that the causes of burnout in mental healthcare staff overlap with those of healthcare staff in other areas, with these causes including: inadequate staffing, excessive workload, poor leadership, lack of support and lack of opportunity for skills development (Bressi et al., 2009; Graber et al., 2008; Pinikahana & Happell, 2004; Willard-Grace et al., 2014). However, there are a number of differences between mental health services and other healthcare services, with one of these differences being the emotional demands of caring for mentally unwell patients (Edwards & Burnard, 2003; Mann & Cowburn, 2005).

Indeed, being a mental health worker can be a demanding profession, as it involves putting the needs of others before yourself and caring for an array of challenging individuals, whose needs are often complex (Adshead, 2011; Mann et al., 2014; Neil, 2012). Contact with the patients over prolonged periods of time can be intense and working with people who have extreme emotional needs can be particularly demanding (Maslach & Leiter, 2016). With this in mind, mental health professionals can be particularly vulnerable to stress and burnout.

It is also important to note that violence against staff is higher in mental healthcare services than other sectors. In the UK, there were 46,107 reported assaults on mental health staff in 2015-2016 and, overall, assaults in mental health settings account for nearly 70% of all NHS reports of assaults on staff (NHS Business Services Authority, 2016; Renwick et al., 2016). Moreover, research by Shiao et al. (2010) found that 19.3% of psychiatric nurses experienced physical violence annually, compared with just 5.9% of general nurses. Unfortunately, far too often, physical violence and aggression is simply seen as 'part of the job' of mental health staff, by their employers and the authorities. However, the impact of these assaults is costly both in terms of sickness and litigation, as well as the physical and psychological impact on the staff.

Theoretical framework and conceptual models:

Initial explorations of burnout began through bottom-up approaches, investigating personal experiences of the workplace through qualitative research designs (Freudenberger, 1974; Maslach, 1976). Indeed, after interviewing a variety of human service workers, Maslach et al. (1986) developed a psychometric tool to measure the level of burnout among such workers, named the Maslach Burnout Inventory (MBI). This tool is now widely used within both clinical and research settings and has demonstrated effective psychometric properties (which are explored at length in Chapter 2). While the MBI has been widely implemented and recognised for its use across a range of settings, its development and the definition of burnout have been criticised for their atheoretical nature. Both Freudenberger (1974) and Maslach (1976) began developing the construct of burnout based on clinical experience, rather than on theoretical understandings of the construct. The definition of burnout is based on three core components (EE, DP and PA), however, these core components are not embedded within a theoretical understanding of the construct, which can make the relationship between the definition and the measure somewhat tautological in nature. Since these initial explorations, various conceptual

models of burnout have been developed, along with an increasing number of empirical studies that have been conducted (Maslach et al., 2001).

Much of the early burnout research focused on the relationship between the three dimensions of burnout and depicted burnout as a process, which involved a number of sequential stages (Burke, 1987; Greenglass & Burke, 1990; Burke et al., 1984; Leiter & Maslach, 1988; Maslach, 1982; Pines et al., 1981). Exhaustion was hypothesised to develop first, in response to high demands and work overload. Subsequent to this, detachment, cynicism and negative feelings towards clients would develop. If this continued, then the next stage would be feelings of reduced personal accomplishment and professional inefficacy. However, while burnout has typically been conceptualised as a process, the appropriate sequencing among the components of burnout has been extensively debated. Three specific models have emerged at the forefront of this debate: Cherniss' process model of burnout (1980), Golembiewski and Munzenrider's (1988) phase model of burnout and Leiter and Maslach's (1988) process model of burnout.

The first model of burnout was Cherniss's (1980) process model, also referred to as the transaction model, hypothesised that burnout developed when work setting characteristics interacted with an individual's response to their working environment. Cherniss (1980) proposed that burnout occurred in a sequence: a first stage of an imbalance between work demands and individual resources (job stressors), a second stage of an emotional response of exhaustion and anxiety (individual strain), and a third stage of changes in attitudes and behaviour, such as greater cynicism (defensive coping). Alternatively, Golembiewski and Munzenrider's (1988) phase model of burnout proposed that each of the three dimensions be split into high and low scores, so that all possible combinations of the three dimensions resulted in eight patterns, or phases, of burnout. In terms of development, it was proposed that

depersonalisation is the first phase of burnout, followed by inefficacy, and finally exhaustion. Finally, Leiter and Maslach's (1988) process model of burnout hypothesised a different sequential progression over time, in which the occurrence of one dimension of burnout precipitates the development of another. According to this model, exhaustion occurs first, leading to the development of cynicism, which subsequently leads to inefficacy.

More recently, emerging burnout models have been based on theories about job stress, and the notion of imbalances leading to strain. Indeed, there are now many different psychological models of occupational stress and burnout, which are important in guiding research and practice. The job-demands-resources (JDR) model (Demerouti et al., 2001) suggests that burnout is a response to imbalance between demands on the individual and the resources that he or she has to deal with those demands. The demands of a situation are the aspects of the job that require sustained physical or mental effort, while the resources of a situation help with the achievement of work goals, reduce job demands, or stimulate growth and development. Demanding and resource-providing job conditions influence the key processes of health impairment and motivation. In the current research, participants typically expressed that the demands of the job (such as workload, time pressures and patient contact) considerably outweighed the resources provided (such as support, feedback, rewards and recognition).

The job-demands-control (JDC) model (Karasek, 1979) is established on the balance of job requirements and autonomy. Karasek's (1979) research showed that those exposed to high levels of demand, as well as having low levels of job control, were disproportionately more likely to show increased levels of depression, fatigue, cardiovascular disease and mortality. However, the lowest levels of illness were found in individuals with moderate or even high demands, if they also had high levels of job control. Therefore, the JDC model suggests that

those who experience high job demands, with little control over their working environment, are more likely to feel stressed. Moreover, control buffers the impact of job demands and can enhance job satisfaction. The model has since been expanded (Johnson & Hall, 1988) to also include social support (JDACS), as evidence has suggested that support may act as a buffer in high demand situations (Cooper et al., 2001; Karasek & Theorell, 1990; Lim, 1996).

The effort-reward imbalance (ERI) model (Siegrist, 1996) is based on reciprocity, where effort at work should be compensated by suitable rewards, and a mismatch between these will lead to stressful experiences (Peter & Siegrist, 1999). Rewards can include money, esteem, career opportunities, job security and positive job feedback. The ERI model places emphasis on subjective perceptions of the environment and, therefore, it is not the actual level of mismatch between efforts and rewards that is important, but rather the mismatch that the individual perceives. The ERI model subsequently implies that those exposed to high-effort and low-reward conditions are more likely to suffer from stress and burnout at work.

The person-environment fit (PEF) model (French, 1973) suggests that the match between a person and their work environment is key in influencing their health. For good well-being, it is necessary that employees' attitudes, skills, abilities and resources match the demands of their job, and that work environments should meet workers' needs, knowledge, and skills potential. Lack of fit in either of these domains can cause problems, and the greater the gap or misfit (either subjective or objective) between the person and their environment, the greater the strain.

A range of important psychological models have been considered in the development of the theoretical framework of this thesis, which have been influential in the field of occupational stress and burnout. However, the number of models discussed shows just how many different

viewpoints there are of occupational stress and burnout and how complex these processes may be to understand. Some models place emphasis on job characteristics (e.g. the JDCS); some models include a role for subjective perceptions of stressors (e.g. the PEF) while other models combine aspects of both (e.g. the ERI). Additionally, some models focus on the psychological processes that may occur in stressful situations, such as Cherniss' process model (1980), whereas others encompass aspects of all of the above models, such as the JDR. While these features are all useful for understanding the development of stress models, there is another feature that remains crucial. This feature is whether or not the model includes a role for individual difference variables. While the possible influence of individual differences is implicit in some models (such as the ERI), few models actually have an explicit role for individual difference factors. However, research has shown that a large range of individual difference factors may be involved in the stress process such as personality type, self-esteem, locus of control, coping style, hardiness, attributional style, demographics, expectations, preferences, health-related factors, abilities and skills (Payne, 1988; Parkes, 1994).

When taking the above models of burnout into consideration, it becomes clear that certain factors (both situational and individual) cause people to experience burnout, and once burnout occurs, it causes certain outcomes (both situational and individual). A different variation of an imbalance model of burnout is the Areas of Worklife (AW) model (Leiter & Maslach, 1999, 2003). The AW model collates a wide range of research on workplace factors contributing to burnout into six general areas of work-life: workload, control, reward, community, fairness and values. The model proposes a general principle that mismatches in these areas impacts upon an individual's level of experienced burnout, which subsequently determines various outcomes, such as job performance, social behaviours and personal well-being. Employees need not be mismatched on every area of work-life for the situation to aggravate the process of burnout,

rather, mismatches in a few key areas may be enough to generate distress. However, the greater the mismatch between the person and the job, the greater the likelihood of burnout. Conversely, the greater the match, the greater the likelihood of work engagement.

Heavy workload diminishes the capacity of employees to effectively meet their job demands. When this kind of overload is a chronic job condition, there is little opportunity to rest and recuperate. A lack of control can cause employees to feel that they are unable to influence decisions or exercise their professional autonomy. On the contrary, when employees have the capacity to influence decisions that affect their work and to exercise professional autonomy, they are more likely to experience job engagement. A lack of rewards and recognition makes employees feel under-valued, ineffective and fails to reinforce positive behaviour at work. When relationships with work colleagues are characterised by conflict and a lack of support and trust, there is a greater risk of burnout. Burnout is also more likely to arise when employees perceive they are not being treated fairly or with respect. Finally, values are the ideals and motivations that originally attracted employees to their job. However, a conflict of values at work can lead to a greater degree of burnout.

The theoretical framework of this thesis is grounded in the foundations of equity theory, whilst also considering a number of the conceptual models discussed above, including the JDR, JDC and ERI models. Equity theory (Adams, 1963) asserts that subtle and variable factors can affect an employee's assessment and perception of their relationship with their job. Equity theory is built on the belief that employees become de-motivated, both in relation to their job and their employer, if they feel as though their inputs are greater than the outputs. In return for their investments at work, an employee may expect certain things, such as a reasonable workload, financial rewards, appreciation, career progression and sufficient support (Smets et al., 2004).

However, the experience of persistent inequity at work may eventually lead to an employee experiencing emotional discomfort, a negative attitude towards the organisation and, ultimately, burnout (Adams, 1963, 1965; Smets et al., 2004; Walster et al., 1978).

Equity theory also claims that people pursue reciprocity in their relationships and that what they invest and gain from a relationship should be balanced (Adams, 1963; Walster et al., 1978). With this in mind, forensic hospital staff may perceive intrapersonal inequity in their relationships with patients, as the relationship between staff and patients is inequitable by its very nature. Indeed, staff provide the care and patients receive it. Seeing a patient's health improve may lead to staff feeling that they are owed respect and gratitude (Van Dierendonck et al., 1996). These gains, however, are not always forthcoming in a forensic setting, where strict boundaries must be adhered to, given the security of the setting and the nature of the client group. Moreover, forensic hospital staff may encounter patients who are challenging, requiring considerable emotional support from the staff member. As a result, staff may feel that they invest more in their relationships with patients than they gain in return. Therefore, guided by the principles of equity theory, whilst also considering a number of occupational stress models, this thesis aims to build on the current body of literature regarding staff burnout in forensic hospitals and provide results which can supplement the already existing findings.

The theoretical framework of this thesis will also consider the Conservation of Resources (COR) theory (Hobfoll, 1988, 1989, 1998), which has become one of the most widely cited theories in organisational psychology and organisational behaviour (Hobfoll et al., 2018). The COR theory theory begins with the principle that individuals strive to obtain, retain, foster and protect the things which they value the most. Following this principle, the COR theory outlines that stress occurs (a) when central or key resources are threatened with loss, (b) when central

or key resources are lost, or (c) when there is a failure to gain central or key resources following significant effort. Essentially, the COR theory is a motivational theory that explains much of human behaviour, based on the evolutionary need to acquire/conserves resources for survival.

The first principle of the COR theory is that resource loss is more important than resource gain. Resources include object resources (e.g. tools for work), condition resources (e.g. employment, tenure and seniority), personal resources (e.g. skills, experience and personal traits) and energy resources (e.g. credit, knowledge and money). The disproportionate impact of resource loss compared to resource gain is expressed in the much greater effect of resources loss, the speed of that impact and the length of time the impact remains salient. The COR theory also suggests that resource loss is not only more powerful than resource gain in magnitude, but can also affect people more rapidly. This may be because loss is primary in human systems, as people are products of evolution. In evolutionary terms, even small losses are linked to failure to survive. The second principle of the COR theory is that people must invest resources in order to protect against resource loss, recover from losses and gain resources. This includes direct replacement of resources, such as using savings to pay for lost income and indirect investment of resources, such as increasing employees' skills to prepare for a difficult working environment. In the latter case, skills and confidence resources are increased to offset the loss of potential income if gains are not made. The third principle of the COR theory is paradoxical, as it states that resource gains become more important in the context of resource loss. That is, when resource loss circumstances are high, resource gains become more important. The fourth principle of the COR theory is that when resources are overstretched or exhausted, individuals enter a defensive mode to preserve the self, that can become aggressive or irrational. Like other aspects of the COR theory, this is likely to be a built-in evolutionary strategy that may be defensive (i.e. to conserve resources) or exploratory (i.e. to search for alternative strategies for survival).

To summarise, taking the above information into consideration, the conceptual framework of this thesis has been based on theories about job stress and the notion of imbalances leading to strain. Particular focus has been given to equity theory in this thesis, which assumes that people pursue a balance between what they invest in a particular relationship and the benefits they gain from it. The conceptual framework of this thesis also incorporates elements from the AW model, which collates a wide range of research on workplace factors contributing to burnout into six general areas of work-life: workload, control, reward, community, fairness and values. The AW model proposes a general principle that mismatches in these areas impacts upon an individual's level of experienced burnout. Additionally, recent work on burnout has begun to develop theoretical frameworks that more explicitly integrate both individual and situational factors, rather than considering them in separate either-or terms. This approach is evident in the PEF model and is particularly useful when considering how the results of Chapter 4 and Chapter 5 can be integrated, to provide a clearer overall picture of the problem. This distinct conceptual framework was decided upon due to the uniqueness of the forensic hospital environment and the type of challenges that working in such an environment entails.

Critiques of burnout research:

The experience of occupational burnout has been the focus of much research during the past few decades. Psychometric measures have been developed, theoretical models have been conceptualised and research studies have been conducted in many different countries around the world. Subsequently, this has contributed to a better understanding of the causes and consequences of this complex phenomenon. Unfortunately, over the years, the mental health field has given little consideration to the health and well-being of its own workers, as relatively few well-designed, empirical studies have investigated burnout in mental health settings. Moreover, many of the existing studies are awash with significant methodological weaknesses,

including a lack of experimental designs, samples of convenience, small sample sizes, limited demographic data, high attrition rates, cross-sectional designs, limited follow-up periods, the use of single assessment measures only and the use of bivariate rather than multivariate models. Furthermore, the conclusions of many of the existing studies are limited in their scope for generalisation, as they involve the analysis of a small area of practice only. Despite these frequent methodological limitations, it is clear that burnout is a significant problem in the mental health field, both in its prevalence and its association with a wide range of other problems for the individual staff, the organisations that employ them and the patients who are entrusted into their care. Therefore, it is evident that further research in this area is necessary.

Thesis structure:

This research thesis aims to provide a broad investigation into the issue of staff burnout in forensic hospitals, including the prevalence of burnout, the risk factors for burnout and the experiences of individuals who are employed in such settings. The thesis aims to address issues and gaps within the field of burnout literature, probing deeper into current understanding of the area from a forensic psychological perspective. The thesis will focus exclusively on a forensic population for two main reasons, as it aims to address an under-researched area where further investigation is evidently needed, whilst simultaneously fulfilling the requirements for an accredited professional doctorate. The overarching theme of the thesis is to examine the variables that may contribute to the development of staff burnout in forensic hospital settings. The thesis comprises four main chapters, including a critical review of a psychometric measure, a systematic review, a quantitative research study and a qualitative research study. Each chapter examines a different focus of burnout and the chapters follow in sequence. However, the chapters are sufficiently varied in focus and method to stand alone as independent studies.

Chapter 2 evaluates the psychometric properties of the Maslach Burnout Inventory - Human Services Survey (MBI-HSS, Maslach et al., 1996), which is used in many of the studies included in the systematic review in Chapter 3 and also in the quantitative research study in Chapter 4. The MBI is founded on a three-dimensional conceptualisation of burnout and it incorporates 22 items into three separate subscales (EE, DP and PA). The authors of the MBI do not recommend generating an overall burnout score, rather, from each subscale should be analysed separately. Scores from each subscale can subsequently be categorised as low, moderate or high. The MBI is a well-established, valid and reliable measure of burnout (Maslach et al., 1996) and there is now a considerable amount of research exploring the use of the MBI in a range of samples, cross-culturally and across different professions. However, limitations of the MBI do exist and are highlighted in this chapter. These limitations should be reflected on when considering the results of the quantitative study in Chapter 4.

Chapter 3 systematically reviews the existing literature regarding burnout in forensic hospital workers, in order to determine which risk factors can be linked to the development of burnout in such individuals. The review supplements a small body of review literature dedicated to exploring burnout in health care professionals. The review also provides a unique perspective, given that it is the first systematic review to exclusively focus on staff burnout in a forensic hospital setting. As such, this review is unique in its aims, and its findings can potentially have considerable impact on the development of future research studies. All studies were selected based on the inclusion/exclusion criteria and were subsequently assessed for their relevance to the review question. The methodological quality of each included study was assessed and the findings of the review were considered in relation to study quality and methodological limitations. The review found that although some of the risk factors identified were consistent across studies, each study included appeared to pinpoint some unique risk factors for the

development of burnout. The possibility that this was attributable to individual differences was discussed. Overall, based on this systematic review alone, it was not possible to provide a comprehensive conclusion regarding the specific risk factors for the development of burnout in forensic hospital staff. As a result of this, future research recommendations were made, which included the use of comparison studies and longitudinal research.

As outlined in Chapter 3, burnout in forensic hospital workers remains an under-researched area, with limited concepts generated and many contrasting findings. Therefore, it is evident that further research in this area is necessary, in order to identify the unique stressors related to caring for this complex population, which can lead to the development of burnout. The current dearth of research in this particular area provides the rationale for the quantitative research study, outlined in Chapter 4. The quantitative research study aimed to identify the level of burnout experienced in a sample of forensic hospital workers and the risk factors which may have led to this burnout developing. A cross-sectional design was adopted to explore the relationship between a number of individual demographic factors and overall EE, DP and PA scores, as determined by the MBI. The rationale for the research study was that, while a number of previous studies have considered the possible risk factors for burnout in mental health workers, the literature base that has focused specifically on the risk factors for burnout in forensic hospital staff is much smaller. However, as forensic hospital staff typically work with a very unique client base, it is possible that there is a unique set of risk factors associated with caring for this complex population.

The quantitative study in Chapter 4 determined the overall prevalence rates of EE, DP and PA in the sample and compared these levels of burnout to the normative data. Results of statistical analyses also indicated that a number of risk factors may be related to the level of burnout in

the sample. The uses and limitations of this research are discussed, alongside the clinical implications, research implications and recommendations for future research. In particular, it is suggested that the use of more qualitative methods to study burnout in forensic hospitals would be advantageous, in order to provide a deeper insight into the daily experiences of forensic hospital workers. With this in mind, the following chapter utilises a qualitative methodology to explore the experiences of stress and burnout in forensic hospital workers.

Chapter 5 outlines an exploratory qualitative research study which aims to examine the lived experiences of forensic hospital workers. More specifically, the study aims to explore how forensic hospital workers may come to develop feelings of burnout and which occupational stressors influence how they feel about their jobs. The study aims to build on the existing body of literature regarding staff burnout in forensic hospitals, by supplementing the quantitative findings outlined in Chapter 4. Qualitative methods were considered to be most helpful in aiding the collection of in-depth information from interviews and ensuring a thorough and detailed explanation of participants' views. Qualitative methods also aimed to bridge the gap between the existing literature, which consists of a small amount of quantitative results, and the real life experiences of forensic hospital staff. The interview data was analysed through the process of thematic analysis, which aims to identify patterns within the data that are important or interesting, and use these themes to make a statement about an issue. In order to do this, the researcher followed Braun and Clarke's (2006) six-step framework. The study reports data from twelve participants who were employed in a private forensic hospital in the North West of England. The results have clinical implications for organisations and recommendations are made on the basis of these results. Directions for future research are also considered.

Finally, Chapter 6 presents an overall discussion of the research findings, alongside potential implications for research, clinical practice and policy, as well as directions for future research.

To summarise, the aims of this thesis were as follows:

- To critically evaluate the psychometric properties of the MBI-HSS as a measure of burnout and compare its standing with alternative measures in the field.
- To explore, review and assess the quality of all the available research into the risk factors for stress and burnout in forensic hospital workers.
- To use the MBI-HSS to investigate the prevalence of burnout in a sample of forensic hospital workers and determine the risk factors related to the development of burnout.
- To explore the lived experiences of individuals who work in a secure forensic hospital, in order to develop a greater insight into what it is like to work in such an environment and how such individuals may come to develop feelings of stress and burnout.

Chapter 2

A critique of the Maslach Burnout Inventory - Human Services Survey

Abstract

The MBI, in its various forms, is the most widely used measure in burnout research and is typically regarded as the measure of choice for any self-report assessment of this syndrome. Despite being the mainstream measure for burnout for decades, its psychometric properties have often been questioned and alternative measures of burnout have been proposed by a number of different researchers. Therefore, the aim of this critique was to assess the psychometric properties of the MBI, its applicability within occupational settings and its research use. To assess these factors, the validity and reliability of the measure, as well as normative samples, were explored. This chapter initially begins with an overview of the psychometric properties of the tool. The MBI is then compared with the other available measures of burnout and the three-factor structure of the MBI is discussed and critiqued in relation to the other available burnout measures. Limitations of the MBI are also discussed, including the self-report nature of the MBI and the use of a Likert scale of measurement. Despite the limitations discussed, there also appears to be significant research exploring the use of the MBI in a range of samples, cross-culturally and across different professions, which has regularly demonstrated excellent levels of reliability and validity. Therefore, it is concluded that the MBI is an effective tool for measuring burnout in a range of occupational settings. Furthermore, the use of the MBI-HSS within forensic mental health populations is discussed.

Introduction

Burnout was first described in the 1970s (Freudenberger, 1974). Since then, the concept of burnout has been defined in various different ways. However, many researchers prefer Maslach et al.'s (1996) definition, which describes burnout as 'a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment, which can occur among individuals who work with people in some capacity'. A generally consistent pattern of findings that emerged from a growing body of empirical research led Maslach et al. (1981, 1986, 1996) to hypothesise about a specific syndrome of burnout and to devise a psychometric measure to assess it. Subsequently, the original version of the MBI was developed in 1981, in an attempt to reliably measure burnout within organisations in a standardised manner.

The MBI is now widely used within both clinical and research settings and has demonstrated effective psychometric properties. The MBI incorporates an extensive body of research that has been conducted in the past 35 years since its initial publication and addresses three general scales: emotional exhaustion (EE), de-personalisation (DP) and personal accomplishment (PA). The element of EE refers to feelings of being emotionally depleted, overextended and fatigued. The element of DP is characterised by negative and cynical attitudes about one's clients. The element of reduced PA refers to the tendency to negatively evaluate oneself and feel dissatisfied with one's accomplishments on the job.

The MBI is the most widely used measure in research on burnout and is generally regarded as the measure of choice for any self-report assessment of this syndrome. More psychometric research has been completed on the MBI than any other measure of burnout. Indeed, research demonstrates that the MBI is considerably the most popular instrument to assess burnout and

that over 90% of journal articles and dissertations use the MBI as their chosen measure of burnout (Schaufeli & Enzmann, 1998; Schaufeli et al., 2008). Extensive literature documents the psychometric quality of the MBI, particularly in human services professions. Various versions of the MBI now exist and the MBI has been translated into 36 different languages. It should be noted, though, that many such translations are made by individuals who are not necessarily familiar with the particular language or dialect used in the MBI. Furthermore, it is stated that some of the translations of the MBI are only partial and do not have validation data.

Alternative versions of the MBI:

Traditionally, the concept of burnout has been closely linked to the human services, where professionals work directly with people (Maslach & Schaufeli, 1993). The original edition of the MBI was, therefore, designed to assess burnout in a variety of human service occupations. However, since that time, alternative versions of the MBI have been developed. The MBI has been adapted over time, in line with our changing attitudes and society and in order to keep abreast of current research. Indeed, it had begun to become apparent that there was little theoretical rationale for limiting burnout exclusively to the human service professions and sufficient empirical evidence was developing to demonstrate that burnout occurred in a variety of other work settings too (Maslach & Leiter, 1997; Schaufeli & Enzmann, 1998). Therefore, the original version of the MBI is now referred to as the MBI-HSS (Human Services Study).

The two alternative versions of the MBI are distinguished by their subtitles. The MBI-ES (Educators Survey) was developed in 1986 and first published in the second edition of the MBI manual (Maslach & Jackson, 1986). It was developed due to the high level of interest in teacher burnout and the need for more research in this area. The apparent need for a scale that measures burnout in other occupational groups prompted the development of the MBI-GS (General

Survey), which was first published in the third edition of the MBI manual in 1996 (Maslach et al., 1996). The goal was to adapt the MBI to occupations in which employees do not have personal contact with service recipients. Therefore, the MBI-GS defines burnout as a crisis in one's relationship with work, not necessarily a crisis in one's relationships with people at work.

An overview of the MBI:

The MBI, in its various forms, is considered to be the current leading measure of burnout. The present review aims to examine the psychometric properties of the MBI-HSS in particular, as it is the measure used in the primary research study. Its applicability within organisational settings and its use in research will also be explored.

The MBI is founded on a three-dimensional conceptualisation of burnout and it incorporates 22 items into three separate subscales (EE, DP and PA). While the three-factor structure of the MBI remains debated, it has been shown to be consistent across occupations and national contexts (Belcastro et al., 1983; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998). Several studies using confirmatory factor analyses have substantiated the validity of the hypothesised three-factor structure of the MBI (Lee & Ashforth, 1993; Li & Shi, 2003; Shirom & Melamed, 2006). The three-factor structure of the MBI has also been replicated in various samples, including teachers (Byrne, 1993; Gold, 1984; Iwanicki & Schwab, 1981), psychologists (Aronin & Kubelun, 1981), therapists (King & Beehr, 1983) medical/nursing staff (Poghosyan et al., 2009; Ramirez et al., 1996) and legal aid employees (Jackson, 1985).

The MBI is self-administered by participants and it takes approximately 10-15 minutes to complete. The MBI presents participants with various statements about their feelings towards their job. There are nine statements relating to the EE subscale, five statements relating to the

DP subscale and eight statements relating to the PA subscale. The items are answered in terms of the frequency with which the respondent experiences these feelings. A seven-point Likert scale is used, which ranges from zero (never) to six (every day). Each respondent's test form is scored by using a scoring key, which contains directions for scoring each subscale. The scores for each subscale are considered separately and are not combined into a single total score. Therefore, three total scores are computed for each respondent. Each total score is assessed along a continuum and can be categorised as ranging from low, to moderate, to high.

Although the MBI is self-administered, the MBI manual (Maslach & Jackson, 1996) gives optimal testing conditions in order to ensure that response bias is minimised. Respondents should complete the MBI privately, without knowing how other respondents are answering. If respondents take the MBI home, the problems with this must be acknowledged, in that their answers may be influenced if they talk to other people. Additionally, because of the sensitive nature of some of the items, respondents must feel comfortable about expressing their true feelings. Ideally, they should be able to complete the MBI anonymously. If identification is required (for example, in a longitudinal study), then efforts should be made to use a form of identification that is not personally revealing, such as a code number.

Respondents must be unaware that the MBI is a burnout measure and must not be sensitised to the general issue of burnout. Instead, the scale should be presented as a survey of job-related attitudes. Once the measure has been administered to all respondents, then a discussion of burnout and the MBI's assessment of it is appropriate. A major responsibility of the examiner is to minimise response bias. No special qualification is required of the person who is administering the MBI. However, the examiner should not be a person who has direct authority over the respondents, because this approach could cause the respondents to be less honest in

their answers. Ideally, the examiner should be seen as a neutral person. However, if the examiner is well known to the respondents, he or she should be someone they trust.

Other measures to assess burnout:

The Burnout Measure (BM, Pines et al., 1981): The BM is reportedly the second most widely used measure of burnout (Schaufeli & Enzmann, 1998). The BM is an internally consistent questionnaire (Cronbach's α is usually above .90), which represents a different philosophy on burnout, when compared to the MBI. The BM assumes that burnout is a one-dimensional construct, exclusively reflecting exhaustion (mental, emotional and physical). A total score is used to assess burnout, as it is easier to interpret and to communicate than a test profile (Pines, 1993). Initial studies on the factorial validity failed to distinguish more than one burnout dimension in the BM (Corcoran, 1986; Justice et al., 1981). However, more recent studies revealed a three-dimensional structure (Schaufeli & Van Dierendonck, 1993; Enzmann et al., 1998), these include: exhaustion, demoralisation and loss of motive. Schaufeli and Van Dierendonck (1993) found that over 50 per cent of the variance of the BM total score is shared with the EE aspect of the MBI ($r = .73, p < .001$). Therefore, the BM appears to reduce burnout to different kinds of exhaustion. Additionally, the BM is founded on the principle that burnout does not only occur at work, but also in non-occupational contexts, such as marriage, because it is caused by long-term involvement in any emotionally demanding situation.

The Copenhagen Burnout Inventory (CBI, Kristensen et al., 2005): The CBI consists of three scales measuring personal burnout, work-related burnout and client-related burnout. The authors of the CBI state that all three scales have very high internal reliability. They state that the scales differentiate between human service occupational groups and that correlations with other measures of fatigue and psychological well-being were found. Moreover, the scales

predicted future sickness absence, sleep problems, use of pain-killers and intention to quit. They authors concluded that the analyses indicate very satisfactory reliability and validity. However, a paper by Schaufeli and Tari (2005), published after the publication of the CBI comments that, while the authors of the CBI make a number of valid points, the distinction between the MBI and CBI is a matter of specificity, and does not involve a major change in orientation towards the basic conceptualisation of burnout.

The Oldenburg Burnout Inventory (OLBI, Demerouti & Nachreiner, 1996; Demerouti et al, 2003): The OLBI was initially developed to overcome most of the limitations of the MBI-GS. The OLBI consists of 16 positively and negatively formulated items that are used to evaluate the two dimensions of burnout (exhaustion and disengagement). These positive and negatively framed items reflect the theoretical assumption that the two main dimensions of burnout can be interpreted in terms of a continuum that ranges from disengagement to dedication and a continuum that ranges from exhaustion to vigour. The OLBI items assess cognitive and physical components of exhaustion, in addition to the affective component included in the MBI. Finally, the OLBI is not restricted to human services and can be used to measure burnout in all occupations. When assessing the convergent validity of the OLBI, the correlations between the MBI and the OLBI exceeded .70 ($p < .001$), indicating that the two burnout measures share a high level of similarity (Demerouti et al., 2003; Halbesleben & Demerouti, 2005).

Psychometric properties:

Psychometric measures are regarded as well-equipped to measure social constructs when they include an appropriate scale with adequate levels of reliability and validity, and appropriately normed data comparisons (Kline, 1998). Therefore, the following sections will critically analyse the MBI with reference to these psychometric properties.

Measurement:

Various kinds of rating scales have been developed to measure attitudes, with the most widely used being the Likert scale. Likert (1932) developed the principle of measuring attitudes by asking people to respond to a series of statements about a topic, in terms of the extent to which they agree with them. A Likert scale assumes that the strength/intensity of an experience is linear and makes the assumption that attitudes can be measured. In the case of the MBI, respondents are offered a choice of seven pre-coded responses to assess the frequency that they experience certain attitudes or feelings, these responses range from 'never' to 'every day'.

The advantages of the Likert scale is that they are the most universal method for survey collection, therefore, they are easily understood. The responses are easily quantifiable and can be analysed with relative ease. Since it does not require the participant to provide a concrete yes or no answer, it does not force the participant to take a stance on a particular topic, but allows them to consider their own opinion and respond in a degree of agreement. Therefore, this makes it easier for the respondent to answer the question. Also, the responses typically accommodate neutral or undecided feelings of participants. These responses are easy to code when accumulating data, since a single number represents the participant's response.

However, the validity of Likert scale attitude measurement can be compromised due social desirability, meaning that individuals may lie to present themselves in a positive light. For example, one of the statements on the MBI reads: 'I don't really care what happens to some of my recipients' and this may not be something that an employee is willing to openly admit. Offering anonymity on self-administered questionnaires should reduce social desirability bias.

Moreover, attitudes of the population for one particular item, in reality, exist on a vast, multi-dimensional continuum. However, the Likert scale that the MBI uses is one-dimensional. It only gives seven options of choice and the space between each choice cannot possibly be equidistant. Therefore, it may fail to measure the true attitudes of respondents. Also, it is possible that respondents' answers may be influenced by previous questions, or will heavily concentrate on one response side. It is also possible that respondents will avoid choosing the extreme options on either side of the scale, even if an extreme choice would be the most accurate representation of their attitudes.

The MBI generates ordinal data and the presence of burnout is conceptualised on a continuum, rather than dichotomously. It has been suggested that interval data is the optimal level of measurement (Furr, 2011). However, when assessing social and psychological constructs, trying to achieve this optimum level of measurement is often problematic. Indeed, with regards to the MBI, it is not possible to establish the exact distances between two units, due to the constructs that the MBI is measuring. Therefore, while it is possible to state that one individual may exhibit a higher level of burnout when compared with another, the relative distance between the two individual cases cannot be measured.

Self-report:

The self-report nature of the MBI can be favourable, as it means that the measure is easy to administer. It is a cost-effective method of collecting data and it can be implemented to large samples (Westen & Rosenthal, 2005). However, many researchers are sceptical and cautious about results that have come from self-report questionnaires that ask people to report about themselves. Indeed, limitations of self-reporting can include introspective ability, socially desirable responding and response bias. Introspective ability represents the respondents' ability

to think about their own attitudes and beliefs. Deficits in introspective ability can occur because respondents' evaluations may not accurately represent their internal states, thus negatively impacting upon the outcome. With regards to the MBI, problems with introspective ability may overestimate or underestimate true levels of burnout. Socially desirable responding refers to a respondent's inclination to alter his or her responses in order to present themselves in a more desirable way. The effects of social desirability and response biases can be detrimental to the outcome of a test and can affect the validity of the findings. Threats to the validity can have subsequently have implications with regards to the generalisability of the findings. To minimise the impact of response bias and socially desirable responding, Maslach et al. (1986) indicate optimal testing conditions, as discussed previously.

However, it is also important to consider the strengths of the self-report nature of the MBI. Due to the self-report nature of the MBI, the tool is able to provide a measure of the internal state of respondents, which is not something that could otherwise be objectively observed. In fact, responses given on the MBI have been shown to accurately predict a range of objectively measured health outcomes across a number of studies. One such study is Marchand et al. (2014), who found that self-reported burnout, as assessed by the MBI, was associated with objectively assessed diurnal cortisol profiles. Moreover, distinct time points of diurnal cortisol variation were consistently associated with increased psychological distress and depressive and burnout symptoms. Therefore, the findings of this study link subjective psychometrics with objective biometrics, which demonstrates the strength of the self-report nature. Overall, while self-report measures do have their weaknesses, they can still be useful in providing a picture of how people feel and what their views are on a certain subject. In turn, this can provide important insights and can be useful for deriving hypotheses. Additional methodologies may be needed to fully test hypotheses, but self-report measures can provide a relatively easy first

step in studying phenomena of interest. Unfortunately, self-report measures have often been considered unfavourably by researchers, as highlighted by Spector (1994). However, it seems appropriate to conclude that self-report studies should not be automatically dismissed as being an inferior method to others and their use should be encouraged where suitable.

Reliability:

Internal reliability: Internal reliability refers to consistency of results delivered by a measure. Findings published within the original MBI manual (Maslach et al., 1986) were based on a large sample (n = 1,316) with Cronbach's (1951) alpha coefficients of 0.90 for EE, 0.79 for DP and 0.71 for PA. Reliability coefficients for DP and PA indicate acceptable internal reliability, with EE reaching excellent internal reliability, according to Nunnally's (1978) thresholds. Therefore, it appears that participants are responding consistently to each item. Supporting these findings are alpha coefficients derived from further research, across a variety of samples and occupational settings. Several studies have found alpha coefficients in the region of 0.81 to 0.92 for EE, 0.57 to 0.82 for DP and 0.50 to 0.86 for PA (Aluja et al., 2005; Kantas & Vassilaki, 1997; Kim & Ji, 2009; Richardsen & Martinussen, 2005).

However, it has been argued that the majority of research relies on the alpha coefficients provided in the MBI manual, rather than exploring the alpha coefficients within their specific sample. To overcome this issue, Aguayo et al. (2011) undertook a meta-analysis to explore the reliability estimates of the MBI across a range of studies. A total of 45 studies were synthesised and the average alpha coefficient was 0.87 for EE, 0.70 for DP and 0.76 for PA. These findings support the original values provided by Maslach et al. (1986) and suggest acceptable to excellent levels of reliability, according to Nunnally's thresholds (1978).

Test-retest reliability: Test-retest reliability refers to the stability of test results over repeated administrations. Assessing the test-retest reliability of the MBI can be challenging, as the MBI measures social and psychological constructs and it is possible that an individual's experience of burnout may change over time. Nonetheless, research has indicated that the MBI has good levels of test-retest reliability. Corrigan et al. (1994) investigated burnout within a psychiatric hospital and found high levels of test-retest reliability at eight-month intervals, with p levels of < 0.001 for each subscale of the MBI. Other studies have also found the MBI subscales to be stable over time, with test-retest correlations of 0.75, 0.64 and 0.62 after a three month interval (Leiter & Durup, 1996), 0.74, 0.72 and 0.65 after an eight month interval (Lee & Ashforth, 1993) and 0.59, 0.50 and 0.63 after a six month interval (Leiter, 1990).

Validity:

Face validity: Face validity refers to the transparency of a test and the extent to which a test measures what it claims to measure. As reported by Maslach and Jackson (1981), the original version of the MBI consisted of 47 items, but was reduced to 22 items after a series of testing and factor analyses. The original MBI also required respondents to report both the frequency and intensity of their feelings towards each statement. However, the current version of the MBI requires respondents to rate the frequency only. This change was the result of a factor analysis, which provided evidence of moderate to strong correlations between the two domains, indicating that the use of both measures was unnecessary. These adaptations have resulted in greater clarity of the MBI, which has subsequently increased the face validity of the measure.

Concurrent validity: Concurrent validity refers to the extent to which the results of a measure correspond to another measure of the same construct. Therefore, it is understandable that concurrent validity would be dependent on the robustness of the alternative measure against

which a measure is being compared (Kline, 1998). The MBI is the most widely used measure of burnout (Maslach et al., 1986) and is, therefore, often used as the point of reference for assessing concurrent validity in other burnout measures. Strong correlations have been found between subscales of the MBI and subscales of other burnout measures, including the OLBI (Demerouti et al., 2003; Halbesleben & Demerouti, 2005). These findings demonstrate some evidence of concurrent validity between different burnout measures. However, it is important to consider the limitations of the MBI, when comparing other burnout measures to it.

Predictive validity: Predictive validity refers to the ability of the measure to predict a future outcome. With this in mind, MBI was not developed as a measure to predict future burnout, but rather as a tool for measuring the current state of burnout. However, the predictive validity of the MBI can be assessed by using it to predict other future outcomes. For example, Sixma et al. (1998) found that high levels of EE predicted general practitioners dropping out of the profession in the next five years. Additionally, burnout has also been associated with various intuitive, theoretically defensible covariates including job performance, turnover intention, actual turnover, physiological ill-health and mental ill-health (Maslach et al., 2001). Moreover, Poghosyan et al. (2010) explored the relationship between burnout and quality of patient care and found that higher levels of burnout, assessed using the MBI, were significantly associated with lower rating of quality of patient care. These findings highlight the utility of the MBI in predicting future outcomes for patient care.

Content validity: Content validity refers to the extent to which a measure represents all facets of a given construct. This form of validity can be difficult to assess with regards to burnout, as a consistent definition of this construct remains absent (Schaufeli, 2003). Additionally, as the

MBI has typically dominated the field of research into burnout, over time, the measure has become equivalent to the definition of burnout itself (Schaufeli, 2003).

Convergent validity: Convergent validity is the extent to which test scores are related to scores on alternative tests or measures of the same attribute. To establish convergent validity, it needs to be proven that measures that should be related are actually related. In the development of the MBI, Maslach et al. (1986) assessed convergent validity in a number of ways. One way was to correlate MBI scores with independent behavioural ratings, assessed by an individual who knew the participant well. For example, Maslach et al. (1986) asked 40 mental health professionals to behaviourally evaluate a colleague who had completed the MBI. Correlations between the independent behaviour ratings and scores on the EE and DP subscales were statistically significant, however, this was not the case for the PA subscale. When undertaking a similar investigation with police officers and their spouses, Maslach et al. (1986) achieved significance within the EE and PA subscales (DP was not assessed). Another way that Maslach et al. (1986) assessed convergent validity was to correlate MBI scores with the presence of job characteristics that were predicted to contribute to burnout.

More recently, Qiao and Schaufeli (2011) investigated the convergent validity of the MBI, by establishing to what degree test scores on the MBI were related to test scores on several other measures of burnout. The convergent validity results confirmed that burnout is best regarded as a multi-dimensional construct consisting of exhaustion and withdrawal, which are two related, but conceptually distinct, aspects. Additionally, the separate factorial analysis of the four different burnout instruments, as well as the simultaneous convergent factorial analysis, suggested that positively phrased items should be dropped from burnout measures, for they constitute a separate factor that is considered to be an artefact.

Discriminant validity: Discriminant validity assess the extent to which concepts that are not supposed to be related are, in fact, unrelated. In differentiating burnout from job dissatisfaction, Maslach et al. (1986) correlated the MBI to aspects of the Job Diagnostic Survey (Hackman & Oldman, 1975) in a sample of social service and mental health workers. Negative correlations were found, which indicates that the constructs of burnout and job dissatisfaction are not related. Comparable results were found in samples of public service employees (Zedeck et al., 1988) and rehabilitation workers (Riggall et al., 1984). Research has also explored the relationship between burnout and depression (Firth et al., 1987; Meier, 1984). However, it appears that, while components of burnout and depression are similar, burnout focuses on problems in an individual's relationship with work, as opposed to a clinically diagnosed syndrome that is evident in every aspect of an individual's life (Maslach et al., 1986).

Construct validity: Construct validity is the degree to which a measure accurately assess the attribute that it intends or claims to assess. There is no single metric that is recommended to quantify the degree of construct validity (Westen & Rosenthal, 2003). Instead, analyses involve interpretations of convergent and discriminant validity. Therefore, the construct validity of the MBI can be assessed by exploring the convergent and discriminant validity of the MBI. The construct validity of the MBI has been assessed by several researchers over the years since its conceptualisation (Hallberg & Sverke, 2004; Helmes et al., 2015; Koeske & Koeske, 1989; Pierce & Molloy, 1989; Powers & Gose, 1986; Schaufeli & Van Dierendonck, 1993). When investigating the construct validity of the MBI, researchers have typically concluded that the MBI can be employed as a reliable and valid multi-dimensional indicator of burnout in people who work in human service professions. However, research has also concluded that the nature of the burnout-construct cannot be determined exclusively in psychometric investigations. In fact, in order to study the construct validity of burnout in greater detail, additional theory-driven

research is needed in which a priori formulated models are tested (Schaufeli & Van Dierendonck, 1993). For instance, Koeske and Koeske (1989) state that the MBI subscales function in different ways within a complex demand-stress-strain-outcome model. Indeed, they found evidence that emotional exhaustion (strain) mediates the relationship between job stress (case load) and outcome (intention to quit), whereas accomplishment was found to moderate the exhaustion-outcome relationship. Unfortunately, these studies typically rely on self-report measures. With this in mind, future attempts to investigate the construct validity of the MBI should include more objective measures, so that method bias can be ruled out.

Clinical validity: Clinical validity refers to the extent to which a measure can provide information about diagnosis, treatment, management or prevention of a disease. Schaufeli et al. (2001) explored the clinical validity of the MBI by examining employees who sought psychological treatment for work-related neurasthenia. Results confirmed the validity of the three-factor structure of the MBI. Results also highlighted that burnout can partly be differentiated from other mental syndromes (for example, anxiety and depression), and the EE and DP scales were able to discriminate between burned out and non-burned out employees.

Appropriate norms:

Normative samples provide scores from people who are presumed to be representative of the target population. This is an important element of psychometric measures, as it provides data against which the sample population can be compared. The MBI manual provides normative data for a variety of professions. Occupational subgroups include education (n = 4,163), social services (n = 1,538), medicine (n = 1,104), mental health (n = 730) and 'other' professions (including attorneys, police officers and probation officers n = 2,897). Normative data are provided for each of the three subscales of the MBI. Cut-off scores for each level of burnout

for each occupational group are also provided. These appropriate norms support the interpretation of the MBI subscales across a broad range of human services profession, as they provide the interpreter with a point of reference with which to compare and interpret findings.

Limitations of the MBI:

As recent research suggests, there is no reason to assume that burnout is limited to human service professions. It is likely that the basic structure of burnout is the same across occupations, namely the combination of EE and DP. In human service work, working closely with people causes exhaustion, resulting in interpersonal strain and withdrawal from recipients. In other professions, the core symptoms of burnout manifest themselves as exhaustion and withdrawal from work in general. However, extending burnout to the entire non-work domain, as suggested by Kristensen et al. (2005) has been criticised by other researchers (Schaufeli & Taris, 2005). In doing so, the term 'burnout' would be used to cover the concept of fatigue. Moreover, it would not concur with the theoretical notion that burnout is a combination of exhaustion and withdrawal. However, it has been argued that the concept of burnout may be applied to work-like activities that, from a psychological perspective, are similar to work. One example is student burnout (Schaufeli et al., 2002). Although students are not employed, their core activities could be considered to be 'work'.

Much controversy remains regarding the number of dimensions that the MBI encompasses. Some researchers argue that three dimensions is not enough and that cognitive deficits should also be included, as poor memory and attention problems are also prominent in employees suffering from burnout (Van Horn et al., 2004; Van der Linden et al., 2005). However, other researchers argue that this would lead to a long list of symptoms that are typical of burnout, rather than symptoms that hold real theoretical meaning. Other researchers debate the inclusion

of the PA dimension. However, before excluding this dimension from the MBI, more research is needed with a scale that measures lack of PA directly, rather than simply reversing the scores.

Furthermore, questions remain regarding whether burnout should be viewed as exhaustion alone (Pines & Aronson, 1981; Kristensen et al., 2005; Shirom & Melamed, 2005) or a multidimensional construct that goes beyond mere exhaustion (Maslach & Jackson, 1981; Schaufeli et al., 2009). Kristensen et al. (2005) argue that three dimensions are too many for characterising burnout and they reduce burnout to a single dimension of exhaustion. This has been suggested before and several single-factor scales can be found in the literature that reduce burnout to mere exhaustion (Pines & Aronson, 1981; Shirom, 2003). Similarly, the MBI exhaustion scale has frequently been used alone as a measure of 'burnout' (Bekker et al., 2005). However, this poses the issue that we are simply equating burnout to fatigue. When burnout is identical to fatigue, the term is redundant and there is no need to develop another instrument. In that case, existing occupational fatigue inventories should be used.

A different perspective is again provided by Schaufeli and Taris (2005), who argue that burnout can be measured using two dimensions. They maintain that burnout is a form of occupational fatigue that is characterised by exhaustion and withdrawal. In their view, inability (exhaustion) and unwillingness (withdrawal) constitute two inseparable parts of the burnout phenomenon. The third MBI component, reduced PA, may either act as a precursor or as a consequence of occupational fatigue, depending on one's perspective.

Another issue considers whether items in the burnout scales should all be positively or negatively phrased, or should the items be mixed (Demerouti et al., 2003). It has been argued that, in order to avoid answering bias, the MBI should include both negatively and positively

phrased items (Demerouti et al., 2003). The EE and DP scales contain only negatively phrased items, which would undermine the validity of these scales. The OLBI was created on the basis of these criticisms (Demerout & Nachreiner, 1996; Halbesleben & Demerouti, 2005).

Additionally, due to their strong wording, some MBI items may trigger dishonest responses (for example, 'I feel I treat some recipients as if they were impersonal objects'). It is possible that this could lead to the violation of the assumption of normality for the more extreme items, with respondents less likely to choose an extreme response, even if this is most representative of how they feel. One final criticism is that the MBI is not widely available in the public domain, as it is protected by copyright and distributed by a commercial publisher. From a scientific point of view, this is an undesirable situation.

Applicability in forensic mental health settings:

Psychometric measures are developed based on a specific population. Therefore, it is important for target populations to be sufficiently similar to the sample populations, in order to increase the reliability of the findings of the measures (Craig & Beech, 2010). In Chapter 4, the MBI-HSS was used to determine the prevalence of burnout in a sample of forensic hospital workers. It is evident that the MBI-HSS has been validated on a sample of mental health workers, as this normative data is provided in the MBI manual. However, it is important to note that the MBI manual does not outline whether forensic mental health staff were included in this sub-group or not. Therefore, this may lead to discrepancies between the normative data and the data presented in Chapter 4. In turn, this may impact on the generalisability of Chapter 4's findings. Indeed, while the normative data for mental health workers is provided in the MBI manual, it is possible that mental health staff working with a forensic client base may be more likely to develop feelings of burnout, as a result of the challenges that they have to face on a daily basis.

Indeed, staff caring for forensic patients are inevitably subject to a greater risk of violence and aggression, compared with those working in any other field of nursing (Bowers, 2002; Mason, 2002). Moreover, being exposed to the perceived threat of violence, as well as actual physical violence, can contribute towards the onset of occupational stress and burnout in forensic mental health staff (Coldwell & Naismith, 1989; Whittington & Richter, 2006). With this in mind, it would perhaps be useful if all research data involving forensic hospital staff could be compiled, in order to provide a normative data sample for this highly unique occupational subgroup.

However, due to the current absence of a normative forensic mental health sample, the internal consistency of the MBI-HSS in a forensic setting was calculated using the data provided in Chapter 4. On the basis of this sample, the MBI-HSS was subsequently found to be of good reliability (22 items, $\alpha = 0.83$). Therefore, going forward, future researchers could potentially consider using the data provided in Chapter 4 as a normative sample for forensic hospital staff.

Conclusion:

The aim of this review was to assess the scientific properties of the MBI, its applicability within occupational settings and its research use. To assess these factors, the validity and reliability of the measure, as well as normative samples, were explored. A large sample of interview and questionnaire data was used to develop the original MBI and the validity and reliability of the MBI have subsequently been explored in large-scale, cross-cultural, meta-analytic studies. There are limitations to the MBI, which have been discussed. However, there is also significant research exploring the use of the MBI in a range of samples, cross-culturally and across different professions, which has regularly demonstrated excellent levels of reliability and validity. It is the most widely used measure of burnout, and numerous studies and meta-analyses have provided support for the reliability and validity of this measure. Indeed, one of

the key strengths of the MBI is the abundance of comparative data available, against which study findings can be compared. Therefore, it would seem appropriate to conclude that the MBI is an effective tool for measuring burnout in a range of occupational settings.

Chapter 3

A systematic review of the risk factors for stress and burnout in forensic hospital workers

Abstract

In this systematic review, the risk factors for burnout in forensic hospital employees were explored. CINAHL, Embase, HMIC, Medline, PsycINFO and Web of Science databases were searched, as well as a number of dissertations and theses. The reference lists of the articles identified were also searched. Specific inclusion and exclusion criteria were applied and data were extracted and synthesised from the resulting studies. A total of 1,313 articles were identified. 379 duplicates were initially removed. Then, following a process of assessing each paper for its relevance, 746 articles were excluded based on their title or abstract being deemed irrelevant to the systematic review question. Articles were screened to ensure that they included at least one outcome measure of either burnout, occupational stress or general/mental health problems. 172 articles were subsequently excluded based on their full text, which left 16 studies to be included in the final review. This review found that the risk factors for burnout identified across the 16 studies could be categorised into four separate sub-categories, these included: organisational and occupational factors (i.e. difficult staff relationships), clinical factors (i.e. working with female patients), personal and individual factors (i.e. being of a younger age) and feeling detached from the outside world (i.e. poor attitudes towards the hospital from the general public). Although some of the risk factors identified were consistent across studies, each study included did appear to identify some unique risk factors for the development of burnout. It is possible that this is attributable to individual differences in organisations and individual differences in people. The findings are considered in relation to study quality and methodological limitations and future research recommendations are also discussed.

Introduction

Burnout has been conceptualised as a syndrome characterised by emotional exhaustion, depersonalisation and a reduced sense of personal accomplishment (Maslach, 1982). Burnout was initially identified within the human services, as it was hypothesised that the emotional demands of working directly with people were highly associated with the development of burnout (Chemiss, 1980; Freudenberger, 1974; Maslach, 1982). However, by the late 1980s, researchers and practitioners began to recognise that burnout occurred outside of human service professions too. It has since become clear that burnout transpires across cultures, occupations and fields (Leiter & Schaufeli, 1996; Stalker & Harvey, 2002).

Job burnout has often been conceptualised within the framework of stress research. However, while burnout and stress are both adverse responses to job stressors, they are not the same concept and they have key differences. Stress is a generic term that refers to the temporary process of dealing with pressures and demands, which is often accompanied by physical and mental symptoms (Schaufeli & Buunk, 1996). In contrast, burnout is the result of experiencing continued stress over a prolonged period of time (Brill, 1984). Therefore, while stress can be caused by daily pressures, demands and adverse circumstances at work, burnout is a specific type of occupational stress that is characterised by its chronic and multi-faceted nature.

Although there are many ways in which stress and burnout differ, they are, in fact, closely related. Research has shown that prolonged exposure to occupational stress is a major risk factor for burnout (Escriba-Aguir et al., 2006; Gosselin et al., 2016; Wang et al., 2015, 2017). Furthermore, excessive occupational stress can also lead to psychological distress, physical health problems, mental health problems, a diminished sense of well-being and a deterioration

in quality of life (Acker, 2010; Ahola, 2007; Ahola & Peterson, 2007; Hakanen & Schaufeli, 2012; Peterson et al., 2008; Schonfeld & Bianchi, 2016; Stalker & Harvey, 2002; Toker & Biron, 2012; Weinberg & Creed, 2000). With this in mind, the current systematic review will incorporate any studies which explore burnout, occupational stress or any related problems.

A range of risk factors for burnout have now been identified, which are evident across occupations in a number of different countries. Six key domains are outlined by the Areas of Worklife (AW) model: workload, control, reward, sense of community, fairness and values (Maslach & Leiter, 2016). Heavy workload diminishes the capacity of employees to meet their job demands. A lack of control can cause employees to feel unable to influence decisions or exercise professional autonomy. Insufficient rewards and recognition makes employees feel under-valued and fails to reinforce positive behaviour at work. When working relationships are characterised by conflict and a lack of support and trust, there is a greater risk of burnout. Burnout is also more likely to arise when employees feel they are not being treated fairly or with respect. Finally, values are the ideals and motivations that originally attracted employees to their job. However, a conflict of values at work can lead to a greater degree of burnout.

Burnout in mental health settings:

A mental health setting can be defined as either an inpatient hospital or a community setting, in which care is provided for individuals diagnosed with a disorder defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the International Statistical Classification of Diseases and Related Health Problems (ICD-11) or their previous editions. With regards to the UK, services may be provided by NHS or independent sector providers. An inpatient service provides 24-hour care for patients who reside there under the conditions of the Mental Health Act (1983, as amended most recently in 2007) with a consultant psychiatrist or another

professional acting as responsible clinician. In this setting, patients would have access to a multi-professional team with a full range of skills. However, not all patients in such a setting will be detained, as some may be on informal sections. Mental health care may also be provided in the form of placements, which are provided by local authorities and independent sector providers and are registered by the CQC. Such placements provide accommodation for people with diagnosed mental health problems, usually a bed in a multiple occupancy facility, and a care/support package funded by health and social services. Finally, a mental health setting may also be a community-based support service, which would generally be provided in a patient's home. Burnout is a particular problem among people who work in these type of mental health settings and considerable literature has focused on staff burnout in such services (e.g. Awa et al., 2010; Morse et al., 2012; Paris & Hoge, 2010). This growing body of literature demonstrates that employees working in such settings tend to experience higher levels of occupational stress and burnout than other professionals (Maslach & Leiter, 2016).

Numerous organisational factors have been found to be associated with burnout in mental health staff, including job role demands (Borrill et al., 1998), role ambiguity (e.g. Carpenter et al., 2003), workload (e.g. Coffey & Coleman, 2001), poor supervision and management (e.g. Sainsbury Centre, 2000) and excessive administrative work (e.g. Priebe et al., 2005). While these risk factors are apparent in other professions, a unique characteristic to the caring profession, particularly in mental health services, is the need to engage with patients and listen to their experiences, which can be distressing (Figley, 1995). Mental health patients have complex needs, a lot of whom have traumatic histories and display challenging behaviours as a result. Their traumatic histories can manifest in ways distressing for staff to witness, for example, self-injurious behaviours or suicide attempts. Mental health staff are, therefore,

within a 'critical occupation' (Paton & Violanti, 1996), where workers are exposed to events that may impact on their psychological well-being.

Individual factors, including external locus of control, low self-esteem, maladaptive coping strategies, perfectionist tendencies and poor resilience have also been linked to burnout (Maslach et al., 2001). Moreover, Purvanova and Muros (2010)'s meta-analysis found that women reported significantly higher levels of emotional exhaustion, while men reported significantly higher levels of de-personalisation. Meta-analytic results have also indicated a negative relationship between age and emotional exhaustion (Brewer & Shapard, 2004). Overall, it appears that burnout in mental health employees may not be simply the result of working long hours in a high-demand environment. Rather, it may be a multi-dimensional response to the interaction of a number of complex factors.

Burnout in forensic mental health hospitals:

Forensic mental health hospitals are designed with secure measures and restrictions and care for individuals diagnosed with a disorder defined in the DSM-5 or ICD-11 and legally detained for treatment and/or their risk of harming others or themselves. Individuals in the criminal justice system have significantly higher rates of mental illness than individuals in the general population (Bebbington et al., 2016; Bradshaw et al., 2016). Those with a mental illness are also more likely to be detained in custody (Short et al., 2012), sentenced to imprisonment (MacPhail & Verdun-Jones, 2013), or to become a victim of crime or violence themselves (Entorf, 2013; Kim et al., 2015; Pettitt et al., 2013). In 2012, an analysis found that the rate of violence over a four-year period among those with severe mental health problems was 2.88%, compared to 0.83% in the general population. However, rather than mental illness causing violence, the two were found to be connected mainly through the accumulation of other risk

factors, such as substance abuse and childhood abuse/neglect (Van Dorn et al., 2012). In addition to this, people with severe mental health problems are much more likely to harm themselves than they are to harm others. In 2013, 1,876 suicides were recorded among mental health inpatients in the UK, compared to 51 homicides (University of Manchester, 2015). However, it is important to note that, while a link does exist between mental illness and violence, most people with mental health problems are not violent and most people who are violent are not mentally ill (Thornicroft et al., 2013).

Overall, it appears that the relationship between mental illness and violence is more complex than initially suspected. However, using the growing repertoire of risk assessment tools, mental health professionals are often expected to predict and manage the violent behaviour of their clients. The current research suggests that a number of risk factors are statistically predictive of violence (Douglas et al., 2013). Indeed, according to the HCR-20 V3, an evidence based structured professional guideline to assessing risk of individual violence, someone's risk rating would increase if certain factors were present. With this in mind, it appears that mental illness and violence are related through the accumulation of risk factors of various kinds, for example, historical (historical problems with violence, substance use or traumatic experiences), clinical (current problems with insight or instability), and risk management factors (future problems with living situation, personal support or stress and coping).

Working within forensic mental health settings exposes oneself to emotionally demanding situations with both staff and patients and greater risk of violence and aggression compared with those working in any other field of nursing (Mason, 2002; Sainsbury Centre, 2000). In turn, this can increase the risk of staff burnout, with research finding that staff in forensic mental health settings experience higher levels of occupational stress and burnout than other

professionals (e.g. Dennis & Leach, 2007; Dickinson & Wright, 2008; Morse et al., 2012). It is also likely that some risk factors associated with caring for individuals with such complex needs are unique. However, despite the growing body of literature, it appears that burnout in forensic mental health workers remains under-researched, with limited concepts generated and many conflicting findings. Therefore, it is evident that further research in this area is necessary, in order to determine which employees may be at highest risk of developing burnout.

Existing reviews:

A scoping exercise took place on the 18th of June 2016 using CINAHL, Cochrane Library, D.A.R.E, Embase, MEDLINE, PsycINFO and Web of Science. The results showed that most of the existing systematic reviews into the risk factors for burnout concentrated on general healthcare professionals (Arora, 2013; Dagrada et al., 2011; Epp, 2012; Gómez-Urquiza et al., 2016; Khamisa et al., 2013; Mikolajewska, 2014; Pereira et al., 2011; Singh et al., 2016). However, two systematic reviews relevant to forensic/psychiatric settings were identified. Moreover, to ensure the research included in the systematic review was up-to-date, another scoping exercise was undertaken on the 11th of July 2018 and two more relevant systematic reviews were identified. Therefore, all four relevant articles will be discussed briefly below.

Melchior et al. (1997) completed a meta-analysis of nine studies into burnout in psychiatric nursing, with the aim of identifying which variables were related to the development of burnout among psychiatric nurses. A meta-analysis of correlations revealed that burnout was negatively correlated with staff support, job satisfaction and involvement with the organisation and positively associated with role conflict. Three typical risk factors of burnout among psychiatric nurses were found: the patient group worked with, the inequity in the exchange process between nurses and patients, and the unrealistic expectations of nurses of the patients' potential

for rehabilitation. The inclusion criteria of Melchior et al.'s (1997) meta-analysis outlined that 'the majority of the sample had to comprise of registered nurses or auxiliary nurses engaged in psychiatric patientcare'. In comparison to this, the inclusion criteria for the current systematic review will be interested in staff burnout in forensic psychiatric populations only.

Freestone et al. (2015) reviewed 27 papers regarding the effects of working with personality disordered offenders. They found that the overall quality of the existing evidence was 'very low', according to the hierarchy proposed by Greenhalgh (1997). Only one adequately powered cohort study was found and 23 studies (85%) were descriptive only. Nevertheless, the negative impacts upon staff identified included: negative attitudes, burnout, stress and negative counter-transference. Two studies also found positive impacts of job excitement and satisfaction. The inclusion criteria for Freestone et al.'s (2015) systematic review outlined that 'the population must have been exposed to individuals diagnosed with either a personality disorder or a psychopathic disorder during the course of their daily work and those individuals must also have committed a crime or be classified as 'forensic' patients'. Additionally, when examining the studies that were included in the systematic review, it is apparent that a number of different 'forensic' settings were explored, including forensic hospitals, outpatient services and prisons. In comparison to this, the inclusion criteria for the current systematic review will be interested in staff burnout in forensic hospital populations only.

Newman (2017) completed a systematic review of the major workplace factors that contribute to burnout among mental health workers. The author outlines that the sample includes social workers, marriage and family therapists, psychiatrists and psychologists. However, does not outline a formal inclusion/exclusion criteria. Ten key articles were included in the systematic review, which yielded three major categories: client specific characteristics (such as working

with individuals diagnosed with personality disorder), individual worker characteristics (such as being younger and less experienced) and organisational/environmental characteristics (such as working in an environment with high demands and limited resources). However, it is worth noting that the author of the systematic review did not assess the quality of the included studies and also did not discuss the limitations of their own work. Additionally, when examining the studies that were included in the systematic review, it is apparent that the population primarily included community mental health teams, eating disorder teams, public mental health teams, public healthcare professionals and social workers and psychologists in the public sector. In comparison to this, the inclusion criteria for the current systematic review will be interested in staff burnout in forensic hospital populations only.

Finally, O'Connor et al. (2018) completed a systematic review and meta-analysis into the prevalence and determinants of burnout in mental health professionals. 62 studies met the systematic review criteria and data from 33 studies was extracted and included in the meta-analysis. The overall estimated pooled prevalence was 40% for high emotional exhaustion, 22% for high depersonalisation and 19% for low personal accomplishment. Increasing age was found to be associated with an increased risk of depersonalisation, but also a heightened sense of personal accomplishment. Work-related factors such as workload and relationships at work, were determinants for burnout, while role clarity, a sense of professional autonomy, a sense of being fairly treated, and access to regular clinical supervision appeared to be protective. O'Connor et al.'s (2018) inclusion criteria outlined that 'the sample population was comprised of mental health professionals (doctors, nurses, social workers, psychologists, occupational therapists and counsellors) working in mental health services'. A wide range of mental health settings were included in the sample and it is apparent that the author included four studies

which contained forensic sub-groups. However, O'Connor et al.'s (2018) review did not focus exclusively on forensic hospital populations, which the current systematic review aims to do.

Methods

Objectives:

This systematic review aims explore the risk factors for burnout in individuals who work in forensic hospital settings, as there have been no previous systematic reviews conducted regarding this topic. Therefore, the systematic review question will be: ‘what are the risk factors for burnout in forensic hospital employees?’.

Search strategy:

The following databases were searched between the 6th and the 10th of February 2017.

- CINAHL
- Embase
- HMIC
- MEDLINE
- PsycInfo
- Web of Science

These databases were searched again on the 1st of November 2018, to update the search results and to explore whether any relevant articles had been published since the date of the initial search. No new articles were found that were considered to be relevant to the review question.

All searches results were limited to references that had been published in the past 30 years (between 1987 and May 2017). The above databases were searched using the following search terms, combined with appropriate Boolean operators and truncations as follows:

staff or nurs* or personnel or worker* or assistant* or professional* or employee*

AND

(mental health / secure / forensic / psychiatric / inpatient) AND (hospital* / ward* / unit* / setting* / service* / institut*) or medium / low / high secure*)

AND

(risk* / stressor* / link* / related factor* / predict* / cause* / correlat* / demograph* / associat*)
or (organi\$ation* factor* / characteristic* feature*) or (personal* factor* / characteristic* / relationship / impact) or (environment* characteristic* / factor) or (staff / individual / patient occupation* AND characteristic* / factor*) or (work* environment)

AND

Burn!out" or (occupational / work / work-related / job / job-related stress)

Grey literature was also searched, this included theses/dissertations, clinical trials, official publications, discussion papers and government reports. This was done in order to identify any studies that were not identified by any of the above databases searches. Sources of grey literature included Google and Google Scholar, Proquest Dissertations and Theses, British Library Ethos, NHS Evidence, The National Institute for Health and Clinical Excellence (NICE) and GOV.UK Publications. The references of selected studies were also scanned for relevant papers. No restrictions on language or country of origin were set.

Study selection (see Figure 1):

All studies were selected based on the inclusion/exclusion criteria (see Table 1). Duplicate references were removed. Initially, the titles of all the search results were screened to exclude clearly irrelevant references. The abstracts of the remaining references were examined to exclude anything that did not meet the inclusion/exclusion criteria. The full text of those considered meeting criteria or needing clarification were obtained and re-examined. Details of the studies excluded at the last stage and the reasons for exclusion are in Appendix B. Reasons for exclusion were predominantly due to the study setting not being a forensic hospital, as the search results included many studies that took place in non-secure psychiatric hospitals, community mental health settings and general health settings. Other reasons for exclusion included review papers, burnout/occupational stress not being an outcome measure and the inclusion of staff in the sample that were not in patient-facing roles (e.g. administration staff).

Figure 1. Study selection process

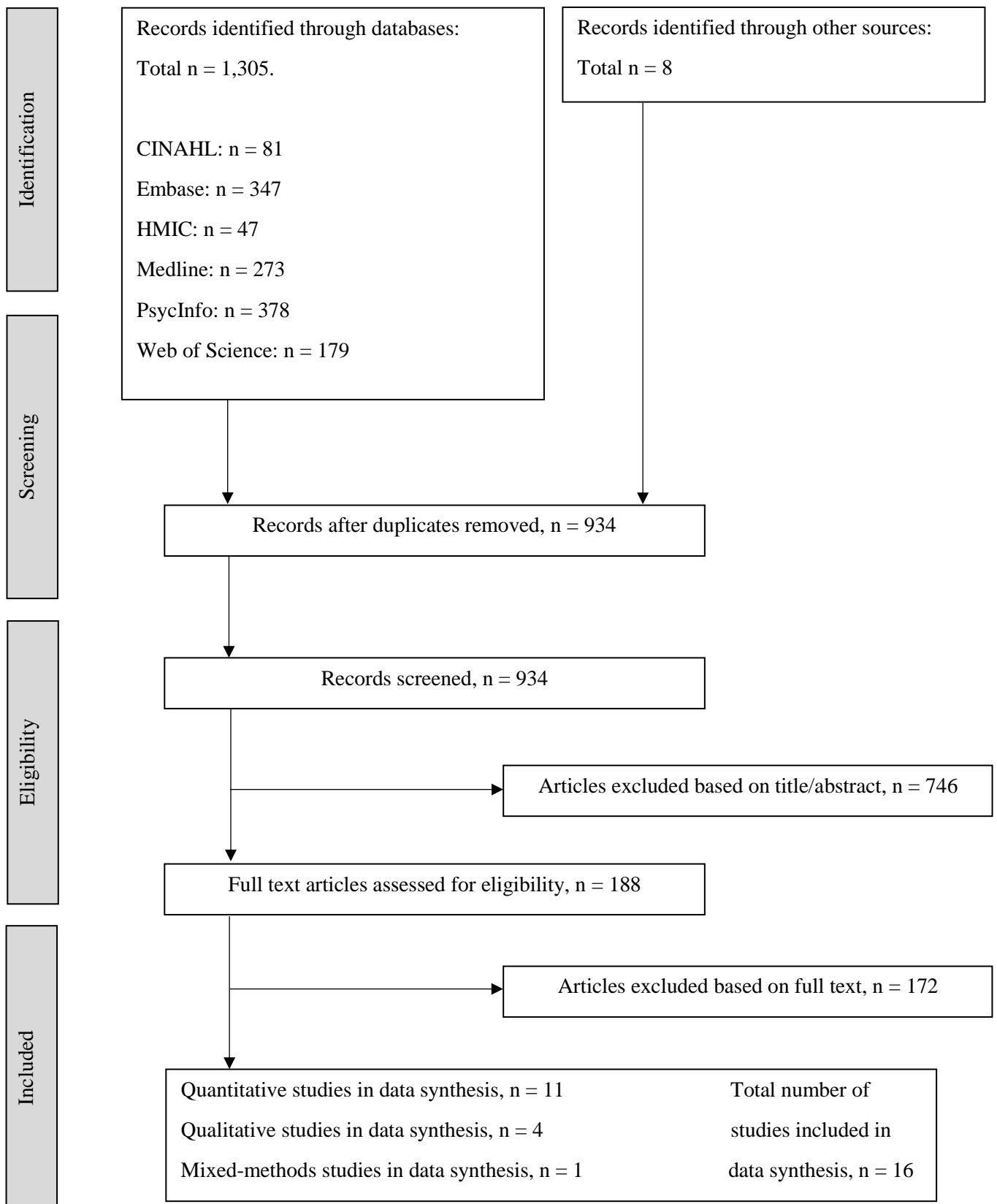


Table 1. Inclusion and exclusion criteria

	Inclusion criteria	Exclusion
Population	Forensic mental health staff who have regular therapeutic contact with patients. This would primarily be qualified nurses and support workers, but could also include other staff such as psychologists, psychiatrists and social workers.	Qualified nurses and support workers in medical/general health settings or community settings. Staff working in forensic mental health settings who do not have regular therapeutic patient contact, such as administration staff.
Exposure	Risk factors or occupational stressors.	Research that does not discuss risk factors for burnout.
Comparison	Relevant sub-group comparisons would include comparisons across wards in the same forensic hospital, staff who work in a general hospital or staff who work in community settings.	Not applicable.
Outcome	Burnout or stress assessed by a standardised measure (quantitative) or explicitly or implicitly explored as part of the lives of forensic hospital staff (qualitative).	No measure or discussion of burnout or stress.
Context	Forensic/secure hospital environment only.	Community, general health setting or non-secure mental health setting.
Study design	Cohort studies, case control studies, cross-sectional studies and qualitative studies.	Review papers, opinion papers, editorials, newspaper articles and popular media.

Quality assessment:

The methodological quality of each included study was assessed using a quality assessment form, adapted from the Critical Appraisal Skills Programme Checklist (CASP, 2004) and the Effective Public Health Practice Project (EPHPP) quality assessment tool for quantitative studies. Two quality assessment forms were created, one for quantitative studies (Appendix D) and the other one for qualitative studies (Appendix E). The aim of assessing study quality was to establish how near the ‘truth’ the research findings are likely to be and whether the findings are relevant in the particular setting or population group studied.

The quality assessment tool for quantitative studies contained 32 items covering screening questions, selection bias, measurement bias, confounding factors, the appropriateness of the analysis, attrition bias, the acknowledgement of any limitations of the research and the justification of the discussion and conclusions. The assessor considered the extent of bias inherent in the design and conduct and rated each of the above areas as high, moderate, low or unclear. Finally, structured judgement was used to combine the overall appraisal of bias and confidence into one of the following categories: strong, moderate, weak or very weak.

The quality assessment tool for the qualitative studies contained 21 items, including: the population selected, the study design, the data collection procedures, the method of data analysis, the researcher’s own role within the study, the reflexivity of the researcher, the credibility of the findings and the contribution of the findings to existing knowledge. Structured judgement was used at the end of the assessment to combine the overall appraisal of credibility and usefulness into one of the following categories: strong, moderate, weak or very weak.

The selected studies were assigned a categorical rating, rather than a numerical score, as empirical research has now shown that quality numbering scores are arbitrary, unreliable and hard to interpret (Juni et al., 1999). It is also against the Cochrane guidelines to assign numerical values when assessing research. Each paper was assessed by the first author and a second assessor then independently assessed 20% of these studies. The second assessor was an Assistant Psychologist, working at the same organisation as the first author. The second assessor had also previously worked as a Research Assistant for a number of years, so was deemed capable with regards to undertaking the quality assessments. Disagreements in ratings were resolved by discussion between the two reviewers. An interrater reliability analysis on the initial ratings was performed, which found Kappa to be 0.643 ($p < 0.001$), indicating a good degree of agreement between reviewers, according to the guidelines outlined by Altman (1991). The Kappa statistic was found to be slightly higher for the quantitative studies (0.653, $p < 0.001$), when compared to qualitative studies (0.622, $p < 0.001$). This is possibly because qualitative studies are more subjective in their nature, which may subsequently result in more discrepancies between researchers. When exploring the ratings of each reviewer in greater depth, it became apparent that one reviewer consistently gave more 'not sure' responses, while the other reviewer was more likely to choose a concrete answer of either 'yes', 'partially' or 'no'. This may have occurred because one reviewer was stricter than the other. Alternatively, this may have occurred if the items were not clear enough, which is something that should be considered upon reflection. The quality ratings of each study can be found in Tables 2 and 3 and the reasons for these quality ratings are explained further in Tables 4 and 5.

Table 2. Characteristics and findings of the included quantitative studies

Author(s), year, location and study design	Research aims	Participants	Measures	Risk factors	Quality
¹ Burdock (2016) U.K. Convergent parallel mixed methods design: The quantitative strand	To explore the relationship between burnout and emotional reaction to challenging behaviour.	N = 43 (14 men and 29 women). Age range was 22-60 years (mean = 35.14 years, SD = 11.12 years).	Maslach Burnout Inventory (MBI, Maslach et al., 1996). General Self-Efficacy Scale (GSE, Schwarzer & Jerusalem, 1995). Emotional Reactions to Challenging Behaviour Scale (ERCBS, Mitchell & Hastings, 1998).	A weak negative correlation between age and the MBI subscale of DP was found ($r = -0.347$, $p = 0.022$).	Moderate.
² Chalder & Nolan (2000) U.K. Cross-sectional comparison	To compare stress at work in forensic mental health nurses and acute mental health nurses.	N = 38 (mental health nurses from two services): - 23 nurses in the forensic mental health service. - 15 nurses in the acute mental health service.	Mental Health Professional Stress Scale (MHPSS, Cushway et al., 1996).	Both groups reported high stress levels, with no significant differences between the two groups. Different causes of stress were identified however: - Forensic nurses scored significantly higher ($U = 90$, $z = 2.478$, $p = 0.013$) on 'relationships and conflicts with other professionals' - Acute nurses scored significantly higher ($U = 81.5$, $z = 2.734$, $p = 0.006$) 'lack of resources'.	Moderate.
³ Dennis & Leach (2007) U.K. Cross-sectional	To examine the level of expressed emotion and burnout in staff caring for people with learning disabilities on a medium secure unit.	N = 10 (six nurses and four support workers). Seven were men and three were women. Ages ranged from: 30-34 ($n=2$), 35-39 ($n=2$), 40-44 ($n=4$) and 45 and over ($n=2$).	Expressed emotion was measured by the Five Minute Speech Sample (FMSS, Magana et al., 1986) Maslach Burnout Inventory (MBI, Maslach et al., 1996).	A significant positive correlation between expressed emotion and the MBI subscale of DP ($\tau = 0.59$, $p = 0.04$, two-tailed). Expressed emotion did not relate significantly to EE or PA. Women had higher EE and PA, while males had higher DP. EE and DP were highest in those that had worked on the	Moderate.

				unit for the longest. However, these results were not significant.	
<p>⁴ Elliot & Daley (2013)</p> <p>U.K.</p> <p>Cross-sectional</p>	<p>To investigate stress, coping and psychological well-being among forensic health care professionals employed within inpatient settings.</p>	<p>N = 135 (64 men and 71 women) from four different medium secure units:</p> <ul style="list-style-type: none"> - 53% from forensic mental health services. - 47% from forensic learning disability services. - Ages ranged from 22-66 (the average was 40 years old). <p>Non-ward-based staff included psychiatrists, occupational therapists, psychologists and social workers.</p>	<p>Maslach Burnout Inventory (MBI, Maslach et al., 1996).</p> <p>The Staff Stressor Questionnaire (SSQ, Hatton et al., 1999).</p> <p>The General Health Questionnaire 12 (GHQ-12, Goldberg & Williams, 1988).</p> <p>The Brief Cope Inventory (BCI, Carver, 1997).</p> <p>The Staff Support and Satisfaction Questionnaire (3SQ, Harris & Rose, 2002).</p>	<ul style="list-style-type: none"> - Those older than 34 experienced more stress in relation to a lack of resources ($F = 3.39, p = 0.03$) and work-home conflicts ($F = 3.17, p = 0.04$) than younger staff members (below 35). - Staff who lived alone found clients' challenging behaviour significantly more stressful ($F = 6.42, p = 0.01$) than those who lived with others. - Staff with children felt significantly more stress in relation to clients' poor skills ($F = 5.62, p = 0.01$) and work home-conflicts ($F = 11.12, p = 0.00$). - Staff who had dependant others living with them experienced significantly less EE ($F = 6.14, p = 0.04$). - The least experienced staff group (less than two years) reported significantly less DP ($F = 3.59, p = 0.04$). - Multi-disciplinary staff experienced significantly higher levels of EE ($F = 4.89, p = 0.02$) than frontline staff. - A high 3SQ score predicts higher PA ($\beta = 0.229, p < 0.01$). - A high SSQ score ($\beta = 0.182, p = 0.45$) and negative coping factor scores on the BCI ($\beta = 0.271, p < 0.003$) predict higher DP. - A high GHQ-12 score ($\beta = 0.234, p < 0.001$), a high SSQ score ($\beta = 0.310, p \leq 0.000$) and negative coping factor scores on the BCI ($\beta = 0.268, p \leq 0.000$) predict higher EE. 	<p>Moderate.</p>
<p>⁵ Hellin (1991)</p> <p>U.K.</p>	<p>To explore the effects of violence on nursing staff in</p>	<p>N = 75 (nurses and nursing assistants across four wards):</p>	<p>Maslach Burnout Inventory (MBI, Maslach et al., 1996).</p>	<ul style="list-style-type: none"> - Negative Affect was positively correlated with EE ($r = 0.49, p < 0.001$) and Positive Affect was 	<p>Moderate.</p>

Cross-sectional	a high security psychiatric service.	<ul style="list-style-type: none"> - 39% men and 61% women - The average age was 38.71 years (SD = 8.58, range 22 to 59 years). - The average length of service was 9.68 years (SD = 6.90, range 0.5 years to 27 years). 	<p>Three vignettes were designed to compare staff emotional responses to three different ward based situations: one in which a patient harmed herself, one in which she harmed a member of staff and one in which she harmed another patient.</p> <p>The Emotional Response Questionnaire (ERQ) was designed to measure emotional reactions of staff.</p>	<p>negatively correlated with EE ($r = -0.28, p < 0.05$).</p> <ul style="list-style-type: none"> - A significant association between the type of vignette and DP ($F = 5.31, p < 0.01$). Post-hoc testing using Tukey's HSD showed that 'attack on patient' was associated with a significantly greater DP than 'attack on staff'. - A significant association between the type of vignette and PA ($F = 4.16, p < 0.05$). Post-hoc testing using Tukey's HSD showed that 'attack on staff' was associated with significantly greater PA than 'self-harm'. - A significant positive association between EE and Negative Affect ($F = 5.81, p < 0.05$) for 'attack on staff'. - For the 'attack on patient' vignette, there was a significant positive association between EE and Negative Affect ($F = 7.69, p < 0.05$), as well as DP and Negative Affect ($F = 11.82, p < 0.001$). - A significant positive correlation between the length of time staff had worked at the hospital and their EE level ($r = 0.38, p = 0.001$). 	
<p>⁶ Johnson, Worthington, Gredecki & Wilks-Riley (2016)</p> <p>U.K.</p> <p>Cross-sectional</p>	To explore the relationship between trust within teams, client boundary violations and burnout among mental health professionals in a forensic	<p>N = 117 (41 men and 76 women) working in an independent forensic psychiatric hospital, including:</p> <ul style="list-style-type: none"> - 66 support workers - 27 nurses - multi-disciplinary team members, including social 	<p>Maslach Burnout Inventory (MBI, Maslach et al., 1996).</p> <p>Measure of trust within teams (Costa & Anderson, 2011).</p> <p>12 vignettes were also designed by the author to assess the frequency and impact of boundary violations by clients. The vignettes were designed to reflect the description of each</p>	<ul style="list-style-type: none"> - The impact of client boundary violations was weakly positively correlated with EE ($r = 0.233, p < 0.05$) and DP ($r = 0.201, p < 0.05$). - A higher frequency of client boundary violations was associated with increased DP ($r = 0.191, p < 0.05$). - Propensity to trust significantly predicts PA ($r = 0.277, p < 0.001$). - Age was weakly negatively correlated with EE ($r = -0.270, p < 0.001$) and 	Moderate.

	psychiatric setting.	workers, activity facilitators, psychologists and occupational therapists.	boundary violation outlined by Elliot and Verdeyen (2002).	DP ($r = -0.301, p < 0.001$) and weakly positively correlated with PA ($r = 0.222, p < 0.05$).	
⁷ Jones, Janman, Payne & Rick (1987) U.K. Cross-sectional	To explore the level of psychological stress experienced by psychiatric nurses employed in a special hospital (defined as a hospital that cares for mentally disturbed patients who are, or have been, dangers to themselves or others).	N = 349 nurses and nursing assistants (73% men and 27% women).	The General Health Questionnaire (GHQ, Goldberg, 1972; Goldberg & Hillier, 1979). Questionnaires were designed by the author to measure perceived level of job demands, support and constraints. Items on the questionnaires were generated by a number of visits to wards and discussions with individuals. The Job Satisfaction Scale (JSS, Warr et al. (1979).	<ul style="list-style-type: none"> - Having a spouse who works at the same hospital is related to higher levels of anxiety ($F = 5.21, p < 0.05$) and psychological distress ($F = 11.18, p < 0.001$). - A marginal difference between males and females, with females scoring higher on psychological distress than males ($F = 3.45, p < 0.06$). - Administrative demands correlate positively with anxiety ($r = 0.13, p < 0.01$) and psychological distress ($r = 0.09, p < 0.05$). - Aversive demands correlate positively with psychological distress ($r = 0.29, p < 0.001$), anxiety ($r = 0.24, p < 0.001$) and depression ($r = 0.16, p < 0.01$). - A significant difference was found between rank and administrative demands ($F = 52.45, p < 0.001$), with higher ranking staff reporting more administrative demands. - Rank is also significant in the case of patient supervisory demands ($F = 12.68, p < 0.001$). - Lower scores on the supports/constraints scale are associated with higher levels of psychological distress. This is particularly evident in the case of 'help with patient care' ($r = -0.25, p < 0.001$). Other factors which are 	Moderate.

				<p>significantly related to psychological distress include: 'communication' ($r = -0.15, p < 0.01$), 'administration' ($r = -0.17, p < 0.01$) and 'social attitudes' ($r = -0.11, p < 0.05$).</p> <ul style="list-style-type: none"> - Job satisfaction correlates highly and negatively with psychological distress ($r = -0.36, p < 0.001$) anxiety ($r = -0.29, p < 0.001$) and depression ($r = -0.18, p < 0.001$). 	
<p>⁸ Kirby & Pollock (1995)</p> <p>U.K.</p> <p>Cross-sectional comparison</p>	<p>To explore the relationship between aspects of the ward environment and occupational stress levels.</p>	<p>N = 38 forensic nursing staff (16 men and 21 women), working across two separate wards (medium secure and high secure).</p> <p>In the previous six months, 80% of the staff had been involved in a serious aggressive incident and 70% had been involved in an incident of self-harm.</p>	<p>Ward Atmosphere Scale (WAS, Moos, 1974).</p> <p>Occupational Stress Indicator (OSI, Cooper et al, 1988).</p> <p>A questionnaire developed by the authors gave an indication of possible perceived stressors in the work place.</p>	<p>There were no demographic or ward atmosphere factors associated with occupational stress. No significant differences were evident between the two wards - the two wards did not differ in terms of unit statistics, demographic variables, dimensions of ward atmosphere or levels of occupational stress.</p>	<p>Low.</p>
<p>⁹ Langdon, Yaguez & Kuipers (2007)</p> <p>U.K.</p> <p>Cross-sectional</p>	<p>To explore the relationship between expressed emotion, burnout, stress and coping strategies.</p>	<p>N = 27 (45% men and 55% women) working within a secure hospital for adults with intellectual disabilities.</p> <ul style="list-style-type: none"> - The mean age was 32.67 years. - The mean length of time working within intellectual disability services was 4.95 years. 	<p>Maslach Burnout Inventory (MBI, Maslach et al., 1996).</p> <p>Expressed emotion was measured by the Five Minute Speech Sample (FMSS).</p> <p>Attitudes to Treatment Questionnaire (ATTQ, Caine et al., 1982).</p> <p>The Cooper Coping Skills Scale (CCSS, Cooper et al., 1988).</p>	<p>63% of the sample showed high expressed emotion, on the basis of one or more critical remarks, a negative initial statement or an overall negative relationship.</p> <p>Participants with high expressed emotion reported significantly higher levels of DP ($z = -2.25, p = 0.02$) and significantly lower levels of PA ($z = -3.00, p = 0.002$).</p>	<p>Moderate.</p>

		<ul style="list-style-type: none"> - The mean length of time working within their current employment was 2.58 years. 	<p>The General Health Questionnaire 28 (GHQ-28, Goldberg, 1987).</p> <p>The Minnesota Job Satisfaction Scale (MJSS, Weiss, 1967).</p>		
<p>¹⁰ Lauvrud, Nonstad & Palmstierna (2009)</p> <p>Norway</p> <p>Cross-sectional</p>	<p>To explore the occurrence of Post-Traumatic Stress Disorder symptoms in nursing staff at a forensic psychiatric security unit.</p>	<p>N = 70. Staff were based on one of four wards at a high secure hospital.</p> <ul style="list-style-type: none"> - 47.1% of participants had over 12 years of experience. - 34.2% had 4-12 years of experience. - 18.6% had less than 4 years of experience. 	<p>The Professional Quality of Life Scale (ProQOL, Stamm, 2009) was used to assess burnout, compassion fatigue and compassion satisfaction.</p> <p>The Post-Traumatic Stress Disorder Checklist Civilian Version (PCL-C, Weathers et al., 1991) assessed participants for symptoms of Post-Traumatic Stress Disorder (PTSD).</p>	<p>Scores on the burnout dimension of the ProQOL were well below average, according to the normative data supplied in the ProQOL manual.</p> <p>Occurrence of any PTSD symptoms was significantly related to two variables, these were: length of psychiatric nursing experience (P = 0.028, HR = 1.76, CI 95% 1.06-2.90) and compassion satisfaction scores (P = 0.027, HR = .90, CI 95% 0.81-0.99).</p>	Moderate.
<p>¹¹ Nathan, Brown, Redhead, Holt & Hill (2007)</p> <p>U.K.</p> <p>Prospective longitudinal cohort</p>	<p>To compare the level of burnout felt by staff who work on male and female wards.</p>	<p>N = 47 nurses participated in the initial assessment (22 on the medium secure male ward and 25 on the medium secure female ward).</p> <p>However, only 14 of the nurses from each ward participated in the follow up assessment (leaving a total of 28).</p>	<p>Maslach Burnout Inventory (MBI, Maslach et al., 1996).</p>	<p>Over 18 months, the burnout score increased more for staff on the female wards (particularly the EE element of burnout), when compared to staff on the male wards. A repeated measures ANOVA for EE showed a significant time × ward interaction (F = 9.07, p = 0.006).</p> <p>A repeated measures ANOVA for DP revealed a similar pattern, but the interaction was not significant (F = 1.95, p = 0.18).</p> <p>Overall, the interaction term arose because of a much larger difference on the female ward than on the male ward. The difference in means at baseline and follow-</p>	Moderate.

				up represented an effect size of 1.70 on the female ward and an effect size of 0.76 on the male ward.	
¹² Oddie & Ousley (2007) U.K. Cross-sectional	To identify occupational stressors and experiences of clinical burnout among mental health nurses and occupational therapists in a medium secure service.	N = 71 (nurses and nine occupational therapists) across three medium secure units. <ul style="list-style-type: none"> - 60% were male. - 40% were female. - The mean age of the sample was 34 years old (range 20-62 years old). - The mean length of time that respondents reported working in the organisation was 4.8 years (range 1-7 years). 	A modified version of the Psychiatric Nurse Occupational Stress Scale (PNOSS, Dawkins et al., 1985). Maslach Burnout Inventory (MBI, Maslach et al., 1996).	EE was significantly positively correlated to the levels of stress reported within four categories: organisational ($r = 0.439$, $p < 0.01$), limited resources ($r = 0.313$, $p < 0.01$), staff conflicts ($r = 0.287$, $p < 0.05$) and patient care ($r = 0.248$, $p < 0.05$). DP was significantly positively correlated to the levels of stress reported within three categories: organisational ($r = 0.419$, $p < 0.01$), limited resources ($r = 0.325$, $p < 0.01$) and staff conflicts ($r = 0.291$, $p < 0.05$). PA was significantly negatively correlated to the levels of stress reported within two categories: organisational ($r = -0.383$, $p < 0.01$) and staff conflicts ($r = -0.337$, $p < 0.01$).	Moderate.

Table 3. Characteristics and findings of the included qualitative studies

Author(s), year, location and study design	Research aims	Participants	Key themes	Summary of findings	Overall quality
<p>¹³Abel (2012)</p> <p>U.K.</p> <p>Interpretive Phenomenological Analysis</p>	<p>To explore the experiences of staff working with patients with a diagnosis of personality disorder in a secure inpatient environment.</p>	<p>N = 8 (3 male and 5 female). This included 3 nurses, 3 student nurses and 2 healthcare assistants. The overall age range was 26-44 years (mean = 35.97 years, SD = 7.46 years).</p>	<p>The diagnosis.</p> <p>Language and communication.</p> <p>Roles on the ward.</p> <p>Difficulties and challenges.</p>	<ul style="list-style-type: none"> - Dealing with patients distress and feelings of hopelessness was challenging. - ‘Subtle’ incidents were just as challenging as aggression. - The challenges of taking control, maintaining boundaries and managing staff relationships. - Complex team dynamics such as a frustrating divide between the ward staff and the wider clinical team. - Low staffing levels, working with clients with personality disorders, high workload, staff fatigue, unachievable job expectations and team splitting were all discussed in relation to burnout. - A desire for training, supervision and support. 	<p>Moderate.</p>
<p>¹Burdock (2016)</p> <p>U.K.</p> <p>Convergent parallel mixed methods design: The qualitative strand</p>	<p>1) To explore the staff experience of occupational stressors and the impact of those stressors.</p> <p>2) To explore the impact of burnout upon staff individually and their relationships with patients.</p> <p>3) To explore the protective factors against negative</p>	<p>10 staff members: 4 nurses, 4 support workers, 1 teacher and 1 occupational therapist.</p>	<p>Thematic analysis yielded seven basic themes, which were clustered into three organising themes:</p> <p>1) Occupational stressors: ‘you want someone you recognise’ and ‘we lack that consistency’.</p> <p>2) The systemic impact of burnout: ‘there could be more consequences’, ‘you don’t get to see any real change’ and ‘young</p>	<p>The qualitative findings of the study revealed a number of occupational stressors related to burnout:</p> <ul style="list-style-type: none"> - Staff and young people feel less safe with agency staff on the ward. In turn, feeling unsafe can lead to the use of restraint or seclusion. - A team struggling to be consistent in terms of: using agency staff, shift patterns, using different approaches and not supporting each other’s decisions. - Staff blame their colleagues for poor communication and lack of support. - Frustrations and a sense of hopelessness regarding a perceived lack of change/progress occurring in the young people. - Desensitised to patient incidents. 	<p>Moderate.</p>

	emotional reactions.		people blame themselves'. 3) Protective factors: 'the opportunity to reflect and gain a wider perspective' and 'you understand where they're coming from'.	<ul style="list-style-type: none"> - Patients receive a lack of consequences for their negative behaviour. - The importance of accessing reflective practice and supervision and working in a psychologically informed way. 	
¹⁴ Kemp (2008) U.K. Interpretive Phenomenological Analysis	To explore the experiences of staff working in forensic child and adolescent mental health services.	9 staff members (3 males and 6 females). Participants were from a range of professional groups: nursing, psychiatry, psychology and education. The overall age range was 26-60.	<p>Powerful internal experiences.</p> <p>Impact of the environment.</p> <p>Negotiating complex staff relationships.</p> <p>Managing complex client dynamics.</p>	<ul style="list-style-type: none"> - The loss of their professional identity following 'undermining' incidents. - Managing a range of difficult feelings at work, labelling it 'a rollercoaster of emotions'. - The physical environment considered physically oppressive, constantly changing and separate to the world outside. - Contradictory teamwork, negative experiences of authority and managers and a fear of openness and being judged. - Being part of a team had positive aspects but working with others was also a source of conflict and stress. - Issues around clients' engagement and disengagement and a challenge focusing on the individual young people within a system. - A reliance on structure/security. - Not always feeling supported and a lack of opportunity for reflection. 	Moderate.
¹⁵ Kurtz & Jeffcote (2011) U.K. Grounded theory and thematic analysis	To explore the experiences of forensic mental health staff working in two contrasting services.	<p>25 staff (10 males and 15 females) working in two forensic mental health services:</p> <ul style="list-style-type: none"> - 13 participants from a medium secure unit 	<p>The two main headings were: 'experience of the clinical task' and 'experience of the organisation'.</p> <p>Key themes under the first heading were: 'motivation to build</p>	<ul style="list-style-type: none"> - Clinical and organisational aspects of experience differed in the type of emotion they evoked. - Staff reported little stress from patient contact and greater stress from relationships with colleagues and the organisation in general. - Ward staff felt isolated from the wider organisation, which was divided into different groups who held contradictory ideas. 	Moderate.

		<ul style="list-style-type: none"> - 12 participants from a medium secure personality disorder unit. <p>The overall age range was 20-60. Years in profession ranged from 2-27 years.</p> <p>Occupations included: nurses, psychiatrists, ward doctors, social workers, probation officers, teachers, psychologists, art therapists and occupational therapists.</p>	<p>relationships, work through difficulty and bring about change', 'minimal sense of risk and anxiety at the centre' and 'difficulty in achieving task integration'</p> <p>Key themes under the second heading were: 'a distant and difficult relationship with outside', 'pre-occupation with staff relationships' and 'feeling unsafe'.</p>	<ul style="list-style-type: none"> - Colleagues outside the ward environment, particularly senior ones, were often described as threatening and undermining. - Managers are seen as commercially driven, whereas staff see themselves as having a more human focus. - Difficulty in addressing issues directly for fear of 'rocking the boat' and feeling unsafe to speak out in meetings. - Support from colleagues was seen as crucial and a sense of crisis accompanied its loss or absence. - Participants discussed the media's negative perception of patients. 	
<p>¹⁶ Kurtz & Turner (2007)</p> <p>U.K.</p> <p>Grounded theory</p>	<p>To explore the needs of staff working in a medium secure unit for offenders with a diagnosis of personality disorder.</p>	<p>13 staff members (6 males and 7 females).</p> <p>The overall age range was 20-60. Years in profession ranged from 2-33 years.</p> <p>Occupations included: nursing, psychiatry, psychology, social work, education, occupational therapy and probation.</p>	<p>The key factors were: 'complexity of the task' and 'tension in the relationship with outside'.</p> <p>The main areas of concern were: 'desire for more meaningful contact', 'contradictory attitude towards openness', 'feeling physically safe but emotionally vulnerable', 'ambivalence towards structure and control' and 'emphasis on staff relationships'.</p>	<ul style="list-style-type: none"> - Ambivalence towards their custodial duties, describing them as less important than the progress of patients. - Satisfaction from their work but frustration in difficult relationships with both patients and colleagues. - When staff were able to address and work through issues with patients, they described feeling a sense of achievement and satisfaction. - Reluctance and the lack of opportunity to discuss differences of opinion with colleagues were described as persistent difficulties. - The inability to address and resolve problems at work was a key frustration. - Feeling connected to others at work was important and feeling isolated was devastating. - The attitudes of external colleagues, society and the media were perceived as hostile and negative. 	<p>Moderate.</p>

			<p>'Risk of isolation' formed a category and described the staff's sense of distance from the outside world.</p>	<ul style="list-style-type: none">- Staff felt that they and their patients were cut-off from the world outside.- Structure and discipline were both deemed important. However, there was some unease regarding the level of control exerted over patients.	
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Results

The search yielded 1,305 hits. A further eight studies were found by manual searching. 379 duplicates were removed and a further 749 irrelevant references were also excluded. A manual search and review of titles and abstracts identified 188 articles relating to burnout or forensic hospitals, or both. Of the remaining 188 references, 11 quantitative studies²⁻¹² met the inclusion criteria. Four qualitative studies¹³⁻¹⁶ were also included, but synthesised separately, as they discussed burnout either explicitly or implicitly in their exploration of the experiences of forensic hospital staff. One mixed-methods study¹ was also included in the data analysis. All included studies were written in English language. The 16 studies included in this systematic review showed variability in population and outcomes. Therefore, meta-analysis was not deemed appropriate and a descriptive data synthesis was utilised. The characteristics and findings of the quantitative studies included in this systematic review are displayed on the previous pages in Table 2, while the characteristics and findings of the qualitative studies included in this systematic review are displayed in Table 3.

Out of all 16 studies included, 15 were conducted in the United Kingdom (UK) and one was conducted in Norway¹⁰. Overall, the total sample size across all the included studies was 1,128 participants, with a range of 8-349 participants per study (mean $n = 70.5$). The total quantitative sample size was 1,073 (range 10-349, mean $n = 97.5$). The total qualitative sample size was 65 (range 8-25, mean $n = 10.8$). Participants held a range of different forensic hospital occupations, including: qualified nurses, student nurses, nursing assistants/support workers, psychologists, psychiatrists, occupational therapists, social workers, teachers/education staff, ward managers, activity facilitators and probation workers. Participants also worked across a range of different forensic hospital environments, including: low secure wards (male and

female), medium secure wards (male and female), high secure wards, locked rehabilitation wards, specialist personality disorder wards, specialist learning/intellectual disability wards, secure forensic mental health services for young people and ‘a special hospital’ (defined by the authors as ‘a hospital that cares for mentally disturbed patients who are, or have been, dangers to themselves or others’).

Eleven of the included studies were quantitative ²⁻¹², four of the included studies were qualitative ¹³⁻¹⁶ and one of the studies utilised a convergent parallel mixed-method design ¹. Of the eleven quantitative studies, ten studies adopted a cross-sectional design, with two of these studies being cross-sectional comparison studies ^{2, 8}. One study ¹¹ adopted a prospective longitudinal design, to compare the level of burnout felt by staff who work on male wards and staff who work on female wards. Of the four qualitative studies, two studies used Interpretive Phenomenological Analysis ^{13, 14} one study used grounded theory ¹⁶ and one study used a combination of grounded theory and thematic analysis ¹⁵.

Regarding the 11 quantitative studies, several measures were used to assess the outcome (the level of work-related stress, burnout and general/mental health problems), these were: the MBI (Maslach et al., 1986), the MHPSS (Cushway et al., 1996), the SSQ (Hatton et al., 1999), the GHQ12 (Goldberg & Williams, 1988), the PNOSS (Dawkins et al., 1985), the ProQOL (Stamm, 2009), the GHQ (Goldberg, 1972; Goldberg & Hillier, 1979), the OSI (Cooper et al., 1974) the GHQ-28 (Goldberg, 1987) and the PCL-C checklist (Weathers et al., 1991).

Several measures were also used to assess the presence of other factors which may be related to the outcome, these included: the BCI (Carver, 1997), the FMSS (Magana et al., 1986), the ERQ (Hellin, 1991), the 3SQ (Harris & Rose, 2002), a measure of trust within teams (Costa &

Anderson, 2011), the WAS (Moos, 1974), the CCSS (Cooper et al., 1988), the MJSS (Weiss, 1967), a questionnaire to measure the perceived level of job demands, support and constraints (Jones et al., 1987), the JSS (Warr et al., 1979), the ATTQ (Caine et al., 1982), the GSE (Schwarzer & Jerusalem, 1995) and the ERCBS (Mitchell & Hastings, 1998). As well as these psychometric tools, other measures were also used to assess the presence of other factors which may be related to the outcome, including vignettes and demographic questionnaires.

The most widely used outcome measure in the reviewed studies was the MBI. Indeed, eight studies ^{1, 3-6, 9, 11, 12} implemented the MBI to assess the experience of burnout in the sample populations. The MBI has demonstrated good psychometric properties with reliability coefficients in the region of 0.81 and 0.92 for EE, 0.57 and 0.82 for DP and 0.50 and 0.86 for PA (Aluja et al., 2005; Kantas & Vassilaki, 1997; Kim & Ji, 2009; Maslach & Jackson, 1981; Richardsen & Martinussen, 2005). However, while the MBI is well-validated and has been used widely in the burnout literature, limitations do exist. Further discussion of the administration, scoring and psychometric properties of the MBI can be found in Chapter 2.

Data synthesis:

The quantitative studies revealed a range of significant risk factors for occupational stress and the three components of burnout (EE, DP and PA) in forensic hospital staff. All except one ¹¹ of the quantitative studies included in this systematic review were of cross-sectional design and reported either correlation or regression analyses, or both. The qualitative studies reported several key themes that transpired from interviews, either explicitly or implicitly, in relation to participants' experiences of occupational stress or burnout at work. Some of these key themes overlapped across studies. The results from all the qualitative studies indicate that the clinical and organisational aspects of work evoked different types of emotions from staff. Participants

typically reported less stress from contact with patients and greater stress from relationships with colleagues, their working environments and their experiences of the organisation in general. The risk factors for burnout identified by the 16 studies in this review will now be discussed in detail and will be classified into four sub-categories to aid this discussion.

Organisational and occupational factors (8 studies):

Three of the quantitative studies included in this review ^{2, 7, 12} highlighted a relationship between organisational factors and staff burnout. Jones et al. (1987) found that administrative demands correlated positively with psychological distress ($p < 0.01$) and anxiety ($p < 0.05$). They found that aversive demands correlated positively with psychological distress ($p < 0.001$), anxiety ($p < 0.001$) and depression ($p < 0.01$). They also found significant negative correlations between psychological distress and communication ($p < 0.01$), administration ($p < 0.01$) and help with patient care ($p < 0.001$).

Similarly, Oddie and Ousley (2007) found that stress and burnout levels primarily stemmed from the organisational aspects of the job. EE was significantly positively correlated to the level of stress reported within four categories: organisational/administrative ($r = 0.439$, $p < 0.01$), limited resources ($r = 0.313$, $p < 0.01$), staff conflicts ($r = 0.287$, $p < 0.05$) and patient care ($r = 0.248$, $p < 0.05$). DP was significantly positively correlated to the level of stress reported within three categories: organisational/administrative ($r = 0.419$, $p < 0.01$), limited resources ($r = 0.325$, $p < 0.01$) and staff conflicts ($r = 0.291$, $p < 0.05$). Moreover, PA was significantly negatively correlated to the levels of stress reported within two categories: organisational/administrative ($r = -0.383$, $p < 0.01$) and staff conflicts ($r = -0.337$, $p < 0.01$). In accordance with Oddie and Ousley's results (2007), Chalder and Nolan (2000) also found that,

when compared to acute mental health nurses, forensic nurses attributed significantly ($p = 0.013$) more stress to relationships and conflicts with other professionals.

All of the qualitative studies included in this review also discussed organisational factors in relation to experiences of occupational stress and burnout. Problems with structure, control, risk management and safety were raised by participants in both Abel's (2012) and Kurtz and Turner's (2007) research, as were issues with language and open and honest communication. Similarly, participants in Burdock's (2016) research highlighted issues with communication and supposed that not having enough opportunities to communicate their thoughts and feelings (such as in reflective practice or supervision) led to the development of occupational stress.

However, difficulties in staff relationships was perhaps the most crucial organisational risk factor that was identified across all of the qualitative studies (Abel, 2012; Burdock, 2016; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). Participants in Kemp's (2008) study described their relationships with colleagues as complex and discussed contradictory experiences of teamwork, negative experiences of authority, power and powerlessness, a fear of openness and a pre-occupation with being judged. Overall, there was a feeling that other staff could be both sources of immense support and strength and sources of disappointment, frustration and anger. Similarly, Kurtz and Jeffcote (2011) found that participants' accounts of relationships with colleagues were full of emotion, both positive and negative. Staff spoke of the extreme importance of support from colleagues, but the absence of such support was felt to result in almost unbearable isolation. Contradictions in Kurtz and Turner's (2007) research suggested that the team image was somewhat idealised and that communication within the staff team was sometimes difficult. Additionally, feeling unsafe in professional relationships was a theme throughout Kurtz and Jeffcote's (2011) research and participants identified that it was

sometimes too risky to speak directly with colleagues about important issues, out of fear of losing a positive team image or vital sources of support. Similarly, Abel (2012) described the challenges of complex team dynamics, team splitting and frustrations in relation to the divide between the ward staff and the wider clinical team. Finally, the qualitative aspect of Burdock's (2016) research identified occupational stressors related to difficulties in staff relationships, which included working with people you don't recognise (typically agency staff) and a lack of consistency in terms of decisions that are made by the team.

Clinical factors (6 studies):

Two of the quantitative studies included in this review ^{6, 11} highlighted a relationship between clinical factors and staff burnout. Nathan et al. (2007) found that staff working with female patients are significantly more likely to develop burnout than staff working with male patients. A repeated measures ANOVA for EE showed a significant time \times ward interaction ($F(1, 26) = 9.07, p = 0.006$). This suggests that patient gender impacted on the level of burnout that staff developed over the 18-month period. Additionally, Johnson et al. (2016) found that the impact of client boundary violations was weakly positively correlated with EE ($r = 0.233, p < 0.05$) and DP ($r = 0.201, p < 0.05$). Furthermore, a higher frequency of client boundary violations reported was associated with increased DP ($r = 0.191, p < 0.05$). This suggests that staff are more likely to feel burned out when they experience boundary violations at work.

All of the qualitative studies included in this review also discussed clinical factors. Abel (2012) highlighted seeing a lack of change/progress in patients, patients blaming themselves for the staffs' frustrations, patient's receiving a lack of consequences for negative behaviours, the diagnosis of patients and difficulties/challenges with boundaries as particularly challenging. Similarly, Kemp (2008) identified that managing complex client dynamics were a source of

stress for staff. Participants in Kemp's (2008) research discussed issues around engagement and disengagement in their relationships with the young people and the challenge of focusing upon the individual young people within the system. Overall, there appeared to be a process of engaging the young people were first admitted and then a process of disengaging with them when they were discharged, as well as tolerating the fluctuations in patients' engagement and disengagement throughout their stay. Finally, participants in Kurtz and Jeffcote's (2011) research discussed experiences of stress in relation task integration, as they felt that the ward staff were considerably more patient-focused than the managers.

Participants in Kurtz and Turner's (2007) research described the complexity of working with offenders with personality disorder, but also discussed the job satisfaction that developed out of this difficulty. The development of a real understanding of patients' problems was seen as a professional duty and a source of considerable personal satisfaction for staff. The participants described change that resulted from working through issues within the therapeutic relationship as particularly gratifying. Job satisfaction derived from hands-on therapeutic work with the patients and participants expressed their displeasure at having to sacrifice their clinical work to focus on other aspects of the job. As a result of this, participants also discussed a desire for more meaningful contact with the patients.

Personal and individual factors (8 studies):

Eight of the quantitative studies included in this review ^{1, 3-7, 9, 10} highlighted a relationship between individual factors and staff burnout. Jones et al. (1987) found that staff who have a spouse working at the same hospital report higher levels of anxiety ($F(1337) = 5.21; p < 0.05$) and psychological distress ($F(1332) = 11.18; p < 0.001$) than those who do not. Jones et al. (1987) also found a gender difference between males and females, with female nurses scoring

slightly higher on psychological distress than male nurses ($F(1,331) = 3.45; p < 0.05$). Job satisfaction also correlated highly and negatively with psychological distress, anxiety and depression ($p < 0.001$).

Dennis and Leach (2007) and Langdon et al. (2007) both found a significant relationship between high expressed emotion and burnout. Dennis and Leach found that there was a significant relationship between the level of expressed emotion and the DP subscale of the MBI ($r = 0.59, p = 0.04$). Similarly, Langdon et al. (2007) found that participants coded as having high expressed emotion reported significantly higher levels of DP ($z = -2.25, p = 0.02$) and significantly lower levels of PA ($z = -3.00, p = 0.002$).

Compassion satisfaction is a measure of pleasure derived from one's ability to work well with clients and be an effective caregiver. Using a binary logistic regression model, Lauvrud et al. (2009) found that low compassion satisfaction scores significantly predicted a higher degree of PTSD symptoms ($p = 0.027, HR = 0.90, CI 95\% 0.81 - 0.99$).

Johnson et al. (2016) found that age was weakly negatively correlated with EE ($r = -0.270, p < 0.001$) and DP ($r = -0.301, p < 0.001$) and weakly positively correlated with PA ($r = 0.222, p < 0.05$). This indicates that younger people are more likely to experience increased levels of EE and DP, whereas older people are more likely to experience increased levels of PA. Similarly, Burdock (2016) found a weak negative correlation between age and DP ($r = -0.347, p = 0.022$), suggesting that younger staff members experienced higher levels of DP.

Elliot and Daley (2013) examined the influence of demographic factors on burnout using a one-way ANOVA and reported that forensic mental health workers with dependant others

experienced lower rates of EE ($F = 6.14$, $p = 0.04$) than those with no dependants. Two-step regression analysis found that living with no dependants ($\beta = 0.225$, $p < 0.008$) and working 9-5 shifts ($\beta = 0.2014$, $p = 0.016$) significantly increased EE, explaining 9% of the variance ($r^2 = 0.086$). They found that older staff members (above age 34) experienced more stress in relation to a lack of resources ($p = 0.03$) and work-home conflicts ($p = 0.04$) than younger staff members (below age 35). Staff who lived alone found clients' challenging behaviour significantly more stressful ($p = 0.01$) than those who lived with others. Staff with children at home reported significantly more stress in relation to clients' poor skills ($p = 0.01$) and work home-conflicts ($p = 0.00$). Multi-disciplinary staff experienced significantly higher levels of EE ($p = 0.02$) than frontline staff. The least experienced group of staff (less than two years) reported significantly less DP ($p = 0.04$), meaning that working at the organisation for a longer period of time was a risk factor for burnout. These findings are corroborated by Hellin (1991), who found a significant positive correlation between the length of time staff had worked at the hospital and their EE level ($r = 0.38$, $p = 0.001$). Similarly, Lauvrud et al. (2009) also found that occurrence of PTSD symptoms was related to length of psychiatric nursing experience ($p = 0.028$).

Feeling disconnected from the outside world (4 studies):

One quantitative study (study 7) included in this review highlighted the views of the outside world as being a significant occupational stressor, leading to staff experiencing psychological distress. Indeed, Jones et al. (1987) found a significant weak negative correlation between social attitudes and psychological distress in staff ($r = -0.11$, $p < 0.05$). Indeed, the participants reported that the image of the hospital created by the media, the reputation of the hospital and their treatment by the local community hindered them in doing their job well.

A number of the qualitative studies included in this review ¹⁴⁻¹⁶ also highlighted feeling distant and isolated from the outside world in relation to the development of occupational stress and burnout. Indeed, both Kurtz and Jeffcote (2011) and Kurtz and Turner (2007) highlighted several areas of concern. Participants in Kurtz and Turner's (2007) study identified that they felt at risk of isolation. The staff described themselves and their patients as both physically and psychologically cut-off from the world outside. Their view was that other mental health colleagues did not understand the nature of the difficulties of patients with a diagnosis of personality disorder or the work carried out by staff in the unit. Outside the hospital, society and the media were repeatedly described as having an unsympathetic attitude towards secure hospital patients. Kurtz and Turner (2007) also identified that participants felt intense emotional vulnerability, particularly in response to critical or hostile behaviour from professional colleagues outside the unit. The type of attack varied in terms of whether it came from professionals within the hospital or a national inquiry into a homicide.

Participants in Kurtz and Jeffcote's (2011) research also discussed tension in the relationship with the outside world. The unit was described as distant from the outside world and the secure hospital environment was described as being cut off from society. The media, in particular, were regarded as hostile towards the patient group, portraying them as monstrous, inhuman and 'not treatable'. Distance from the outside world was mainly ascribed to an ignorance of forensic mental health issues, a general lack of knowledge, and an absence of motivation to learn about working with individuals with a diagnosis of personality disorder. Furthermore, Kemp (2008) identified the impact of the environment as a key theme. Staff described the physical environment as having an impact upon them, as the units were perceived as separate entities and different to the world outside. Indeed, participants described how working within such an intense environment impacted on their relationships with other people.

Study quality:

The quality ratings of each study are in Tables 2 and 3. Specific methodological limitations are presented in Tables 4 and 5. No quantitative studies were rated as strong, mainly due to their cross-sectional designs their small sample sizes and their low rates of participation, which could have potentially led to non-response bias. All but one ⁸ of the quantitative studies were rated as moderate, as this study had a considerable amount of identified limitations. However, due to the limited number of studies available that investigated the review question, all studies were included in this review regardless of their quality ratings. Some studies were at risk of selection bias, as they did not discuss sample size justifications, power calculations or the overall target population. Therefore, for such studies, it was not possible to ascertain the response rate and it was unclear whether the participants who did respond were representative of the target population or not. Other limitations of the studies included using measurements that had not been validated, not acknowledging confounding factors and drawing conclusions without discussing issues with generalisability. With this in mind, consideration was given to the generalisability and applicability of the findings for each study in reference to the quality ratings, as this may have important implications.

All qualitative studies were rated as moderate, as they generated interesting findings and discussed these findings in relation to the existing literature base, as well as identifying areas for further research. However, a number of consistent limitations were identified throughout the qualitative studies. This included the fact that the researchers did not acknowledge the limitations of their own research, nor reflect on their own role within the research and the potential bias this may cause. In one study ¹⁶, the methods chosen were not justified by the researchers. Furthermore, data saturation was not discussed in any of the qualitative studies.

Table 4. Summary of limitations of the included quantitative studies

Author and year	Selection bias	Small sample size	Low rate of participation	Using measures that have not been validated	Analysis unclear	Confounding factors not acknowledged	Potential attrition bias
¹ Burdock (2016) (quantitative part)	■	■				■	
² Chalder & Nolan (2000)	■	■					
³ Dennis & Leach (2007)		■	■			■	
⁴ Elliot & Daley (2013)	■		■				
⁵ Hellin (1991)	■	■		■			
⁶ Johnson, Worthington, Gredecki & Wilks-Riley (2016)	■			■		■	
⁷ Jones, Janman, Payne & Rick (1987)	■			■			
⁸ Kirby & Pollock (1995)	■	■		■	■		
⁹ Langdon, Yaguez & Kuipers (2007)	■	■	■				

¹⁰ Lauvrud, Nonstad & Palmstierna (2009)		■					
¹¹ Nathan, Brown, Redhead, Holt & Hill (2007)	■	■					■
¹² Oddie & Ousley (2007)	■	■					

Table 5. Summary of limitations of the included qualitative studies

Author and year	Potential selection bias	Methods chosen not justified	Data saturation is not discussed	Unclear how the data was collected and analysed	Data to support the findings and conclusions is not sufficient	Limitations are not discussed	Researcher does not examine their own role, relationships and potential bias
¹³ Abel (2012)	■		■				
¹ Burdock (2016) (qualitative part)	■		■				■
¹⁴ Kemp (2008)	■		■				■
¹⁵ Kurtz & Jeffcote (2011)			■			■	■
¹⁶ Kurtz & Turner (2007)		■	■			■	■

Discussion

Summary of main results:

The objective of this systematic review was to explore the empirical literature relating to the risk factors for staff burnout in forensic hospitals. A total of 16 studies were reviewed. The quantitative studies revealed a number of significant risk factors for occupational stress and the three components of burnout (EE, DP and PA) in forensic hospital staff, while the qualitative studies reported several key themes that transpired from interviews, either explicitly or implicitly, in relation to the participants' experiences of occupational stress or burnout at work. Overall, the results suggest that staff burnout in forensic hospitals is associated with a number of risk factors, including: working at the organisation for a longer period of time (Elliot & Daley, 2013; Hellin, 1991; Lauvrud et al., 2009), being of a younger age (Burdock, 2016; Johnson et al., 2016), difficult relationships with other staff (Chalder & Nolan, 2000; Kemp, 2008; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007), high expressed emotion (Dennis & Leach, 2007; Langdon et al., 2007), a difficult relationship with the outside world (Jones et al., 1987; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007), issues with boundaries (Abel, 2012; Johnson et al., 2016), organisational/administrative aspects of the job (Jones et al., 1987; Oddie & Ousley, 2007) and problems with communication (Abel, 2016; Jones et al., 1987).

Interpretation of findings:

The results of the review indicated that working at the organisation for a longer period of time was a significant predictor of EE, DP and PTSD symptoms (Elliot & Daley, 2013; Hellin, 1991; Lauvrud et al., 2009), with those who had worked at the organisation for a longer period of time being significantly more likely to report feelings of burnout than the newer staff. Similar results have been found in those who work in general health nursing (Dimunova et al., 2018)

and educational settings (Montero-Marín et al., 2011). However, findings regarding experience are typically contradictory across studies, with some research into general health nursing finding that burnout rates are higher in newly qualified nurses (Finlayson et al., 2002; Gray & Phillips, 1996; Spinetta et al., 2000). Furthermore, it is apparent that Elliot and Daley (2013) gathered some interesting findings, which they did not explore in their discussion. Indeed, they found that staff with 2-5 years of experience reported significantly higher levels of DP than those with less than 2 years of experience or more than 5 years of experience. Therefore, it appears that the level of burnout experienced by staff increased after 2 years and then decreased after 5 years. It may be assumed that newly recruited staff are less likely to experience DP, particularly as it is described as a domain of burnout typically preceded by EE (Maslach et al., 1996). However, it is more difficult to make a priori assumption with regard to the reporting of decreased DP scores in staff with more than 5 years of experience. In order to explain these results, it is possible that the findings of Elliot and Daley (2013) may have occurred due to an attrition bias, whereby employees have experienced higher levels of burnout up to the point of 5 years, but have then left the organisation. Therefore, it is apparent that this risk factor requires further investigation, in order to be able to better understand the changeable nature of burnout and its sequential progression over time.

The results of the review also indicated that age was a significant predictor of EE and DP (Burdock, 2016; Johnson et al., 2016), with the younger staff being significantly more likely to report feelings of burnout than the older staff. The results of the review appear to support the findings from meta-analyses of mental health professionals (Brewer & Shapard, 2004; Lim et al., 2010), as well as primary research with psychologists (Vredenburgh et al., 1999) and therapists working with sexual offenders (Clarke, 2004). These results all suggest that, as mental health professionals get older, they are less likely to experience EE and DP. With this

in mind, those staff with less professional experience will have had less time to develop effective coping strategies (Bilge, 2006). On the other hand, those staff with more life experience will have greater emotional maturity, which will serve as a coping strategy (Lim et al., 2010). Furthermore, according to Lim et al. (2010), as mental health professionals grow older, they become more adept at dealing with their clients and providing treatment services. However, it is also worth considering the fact that age may be expected to correlate positively with staff experience, as it is likely that the staff with the most experience will be older. Therefore, an alternative hypothesis is that other variables may exist that are related to each other and have a protective effect against burnout, such as experience, having a partner and having children, which are all typically related to age.

Difficult relationships with other staff was highlighted as a risk factor in several studies in the systematic review. Chalder and Nolan (2000) highlighted that, when compared to the acute nurses, forensic nurses reported significantly higher levels of stress with regards to their relationships and conflicts with other professionals. It has been claimed that, in nursing work environments, conflict among colleagues is becoming a significant issue, resulting in job dissatisfaction, absenteeism and turnover (Almost, 2006). Moreover, Trygstad (1986) outlined that difficulties in staff relationships is the most important determinant of occupational stress amongst psychiatric nurses. Indeed, working in a forensic hospital involves working with a complex client group and challenging behaviour may necessitate difficult decision-making regarding their care and management, with inevitable disagreement on occasions between members of staff. Such disagreement may subsequently lead to hostility and resentment. Moreover, it is likely that staff working in forensic settings will have strong personalities and are prepared to be assertive when necessary. On top of this, a forensic hospital may attract

highly trained and very skilled professionals. With this in mind, the combination of strong personalities and high levels of knowledge and skill may, at times, lead to disagreements.

Participants in Kemp's (2008) study described their relationships with colleagues as complex and discussed contradictory experiences of teamwork, negative experiences of authority, power and powerlessness, a fear of openness and a pre-occupation with being judged. Overall, there was a feeling that other staff could be both sources of immense support and strength and sources of disappointment, frustration and anger. Similarly, Kurtz and Jeffcote (2011) found that staff spoke of the extreme importance of support from colleagues, but the absence of such support was felt to result in almost unbearable isolation. Additionally, feeling unsafe in professional relationships was a theme throughout Kurtz and Jeffcote's (2011) research and participants identified that it was sometimes too risky to speak directly with colleagues about important issues, out of fear of losing a positive team image or vital sources of support. With this in mind, research has found that support from colleagues is an important factor in reducing burnout in mental health professionals (Cooper et al., 2001; Demerouti et al., 2001; Karasek & Theorell, 1990; Lim, 1996; Melchior et al., 1997). However, conflict as inevitable within teamwork and has been reported in a range of settings (West & Poulton, 1997). Shared values improves teamwork (Waugaman, 1994), but different professionals are likely to have different values (Wilmott, 1995). This highlights the difficulty faced by professionals who have the task of working together, when their aims and goals may not be entirely compatible.

The results of the review also indicated that staff had a difficult relationship with the outside world (Jones et al., 1987; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). The attitudes of society were significantly related to psychological distress, with the participants reporting that the image of the hospital created by the media, the reputation of the hospital and their treatment

by the local community hindered them in doing their job well. Society and the media were repeatedly described as having an unsympathetic attitude towards forensic patients. The media, in particular, were regarded as hostile towards the patient group, portraying them as monstrous, inhuman and 'not treatable'. Staff also felt emotional vulnerability in response to critical or hostile behaviour from professional colleagues outside the unit, as they felt that other mental health colleagues did not understand the nature of the difficulties of working with forensic patients. The physical environment itself also had an impact on staff, as the units were perceived as separate entities and different to the world outside. It was evident that staff felt at risk of isolation, as they described themselves and their patients as both physically and psychologically cut-off from the world outside and society. Distance from the outside world was mainly ascribed to an ignorance of forensic mental health issues, a general lack of knowledge, and an absence of motivation to learn about working with individuals with a diagnosis of personality disorder. Lavender (2002) reflects these sentiments, suggesting that forensic services face a particular organisational challenge because society is so ambivalent towards offender-patients and confused about what it wants from forensic mental health staff.

The results of the review indicated that staff experienced a number of issues with maintaining patient boundaries (Abel, 2012; Johnson et al., 2016). Indeed, experiencing frequent boundary violations, and the subsequent impact of these boundary violations, was a significant predictor of EE and DP (Johnson et al., 2016). This suggests that both the frequency and impact of boundary violations is related to the development of negative and cynical attitudes and feelings towards clients. This finding is consistent with other research, suggesting that hostile attitudes often develop in response to the challenging behaviours presented by forensic clients (Bowers et al., 2006). Moreover, the finding that the impact, rather than the frequency of boundary violations was associated with EE would seem to suggest that the development of EE is not

related to how often clients violate boundaries, but rather, the individual's perception and interpretation of these violations. This is an interesting finding and further research is clearly needed to explore what boundary violations mean to staff and how they interpret them.

The results of the review also indicated that communication problems were significantly related to psychological distress (Jones et al., 1987), with participants reporting issues with the quality of communication between nursing staff and medical officers, as well as the communication between shifts. It is acknowledged that effective communication and teamwork is essential for the delivery of high quality, safe patient care (Leonard et al., 2004), whilst also contributing to the mental health and well-being of team members (Borrill et al., 2000). When working with patients with a personality disorder, the need for a specialist multi-disciplinary team approach is particularly important (Bateman & Tyrer, 2003). Indeed, it is vital that patients feel that the staff responsible for their care communicate with each other effectively, get on well together and have clear boundaries (Bateman & Tyrer, 2003). Collaboration and consistency within the team is also crucial. However, if issues with communication exist within a team, then problems such as team splitting may occur, which is likely to divide the team even further and impact upon the consistency of decisions made and the standard of patient care provided.

Problems with language and open communication were also raised by participants in Abel's (2016) study, with staff stating that they did not have enough opportunities to communicate their thoughts and feelings, which subsequently led to feelings of stress. Psychoanalytic accounts would indicate that there is potential, in forensic services, for the build-up of both conscious and unconscious anxiety, which is likely to be linked to feelings stirred up by the task of caring for vulnerable and challenging patients, in such a complex and fragmented work environment (Menzies Lyth, 1960; Hinshelwood, 1993). It is hardly surprising, then, that staff

begin to experience stress and burnout, if they have not provided with any opportunities to communicate and reflect on these complicated feelings. Ultimately, communication failures within a team are an extremely common cause of inadvertent patient harm (Leonard et al., 2004). With this in mind, in order to ensure that the highest standard of patient care is being delivered, the quality of communication in forensic health care teams should be considered.

Finally, the results of the review also found that the organisation and administrative aspects of the job were associated with significantly more stress and burnout, when compared to other aspects of the job, such as clinical duties (Jones et al., 1987; Oddie & Ousley, 2007). This finding is consistent with previous research into stress and burnout in other healthcare fields (Cole et al., 2000; Carson et al., 1995; Fagin et al., 1995; Garland, 2004; Schulz et al., 1995; Onyett et al., 1997). Given the emotional demands of caring for mentally unwell patients, added to the increased risk of violence in mental health hospitals (Renwick et al., 2016; Shiao et al., 2010), it is interesting that the stress levels of staff are associated with the organisational aspects of the job, rather than their direct clinical work. However, it is possible that staff directed their frustrations towards their colleagues and the organisation in general, rather than their patients, as the patients are perceived as unwell. As such, they are perhaps considered to less accountable for their behaviour (Markham, 2003). Alternatively, psychoanalytic organisational theory indicates that contact with forensic patients is difficult, and staff are likely to resort to highly defended ways of dealing with it, unless they are highly trained and the working environment is very supportive and containing (Winnicott, 1949; Hinshelwood, 1993, 2004). A degree of organisational dysfunction may, therefore, be attributable to the displacement and projection onto colleagues of what are felt to be unmanageable feelings towards patients. However, despite this possible explanation, it remains imperative that serious consideration is still given to the possibility of a strong and independent influence of organisational difficulties upon staff.

Although a cross-sectional study design has ecological validity, it is limited in that it does not allow for the controlling of variables. In an attempt to include variables outside of the working environment that might also explain a percentage of the variance of an effect, Elliot and Daley (2013) included measures of work-home conflicts, having children at home and living with dependents. They found that forensic mental health workers with dependant others experienced lower rates of EE than those with no dependants. Staff who lived alone found the challenging behaviour of clients significantly more stressful than those who lived with others. Finally, older staff members and staff with children at home experienced more stress in relation to work-home conflicts. Elliot and Daley (2013) do not discuss these findings in detail. However, theories of work-family enrichment (McNall et al., 2010) may explain the link between having dependents and experiencing greater emotional resilience at work. Moreover, a number of other studies have found that being single is a risk factor for burnout in nurses (Cañadas-De la Fuente et al., 2018) and doctors (Amofo et al., 2018). In terms of children, the results of previous research have been mixed. Similar to Elliot and Daley (2013), Moreira et al. (2009) also found that staff with children experience higher levels of burnout, due to the conflict between their work life and family life. However, other studies have found that having children is associated with a lower risk of burnout (Embriaco et al., 2007; Maslach & Jackson, 1985; Shanafelt et al., 2007), possibly due to the emotional resources and the support that having a family provides.

More than one study found relatively low levels of DP with concurrently high levels of EE (Oddie & Ousley, 2007; Elliot & Daley, 2013), which is a positive finding, as it suggests that even when staff feel burnt out, a 'buffer' exists against staff developing cynical and negative attitudes towards their patients (Maslach & Jackson, 1981) and that they are still able to derive a sense of satisfaction from their work. This burnout 'buffer' appears to be common in mental health professionals, irrespective of what type of setting they work in (Morse et al., 2012) and

is thought to relate to the values staff hold regarding working with others. These findings are also supported by Cherniss's (1980) process model of burnout, which outlines the sequential process of burnout development. Furthermore, this also provides an explanation for why this particular population tend to report high scores of PA, in the presence of high levels of EE, and in relation to normative PA scores for other profession (Maslach et al., 1996).

A number of other risk factors were also identified by the systematic review, however, they have not been discussed at length, as they were not identified consistently across studies. However, should future research obtain results which support these findings, then the relevance of these risk factors should be considered in greater depth. The risk factors identified in single studies include: working with female patients (Nathan et al., 2007), being part of the multi-disciplinary team (Elliot & Daley, 2013) and having a spouse who works at the same hospital (Jones et al., 1987). Additionally, it was found that women are more likely to experience higher EE, higher PA (Dennis & Leech, 2007), higher psychological distress and higher anxiety (Jones et al., 1987), while men are more likely to experience higher DP (Dennis & Leech, 2007).

To a certain extent, the findings regarding staff gender are consistent with research in general populations, including Alarcon et al. (2009) and Purvanova and Muros (2010), who both completed meta-analysis studies to investigate gender differences in burnout. Interestingly, both studies found that men reported significantly higher levels of DP, while women reported significantly higher levels of EE. Greenglass (1991) attempts to explain the gender differences in burnout by referring to the masculine gender role, outlining that work sources appear to be the primary precursors of burnout in men, while predictors of women's burnout include both work and family variables, such as work-home conflict. The differential importance of work life and home life as stressors in men and women is sustained by a societal structure, which

continues to assign women primary responsibility for home and family, regardless of their employment status. However, despite this potential explanation, across the board, gender has not yet been established as a consistent predictive factor for burnout (Maccacaro et al., 2011).

The ultimate aim of this systematic review was to be able to prevent and/or intervene to reduce the prevalence of burnout in forensic hospital staff and its harmful effects. With this in mind, further research is seemingly needed, in order to substantiate the findings of the current review. The current findings are undoubtedly useful, as they identify several risk factors for burnout that have been found consistently across studies. However, it is important that the significance of these risk factors is verified by further research, as it is possible that some of these risk factors could be targets for burnout interventions in the future.

Critique of the included studies:

The number of current research studies exploring burnout in secure forensic hospital settings is relatively few, in comparison to the number of studies in community or general mental health settings. Many of the quantitative studies reviewed were found to have small sample sizes or low participation rates, limiting the external validity of their findings. The specialised nature of inpatient forensic mental healthcare is likely to be a limiting factor in the recruitment of large samples and future research should attempt to sample from multiple matched settings, whilst maintaining a strict inclusion criteria to reduce the threat to internal validity. With this in mind, authors must be cautious in reporting their findings, as findings were often discussed without further caution as to their generalisability. Indeed, small sample sizes were issues for many of the studies, increasing the risk of a type II error and limiting external validity.

An obvious weakness in this research field is the prevalent use of cross-sectional designs, as cross-sectional design studies are able to determine neither causality nor direction of an effect. Moreover, many of the studies included in this review reported correlations that were weak. Whilst this is not unusual for social psychological research, it does bring into question the applied value of the findings. The findings from cross-sectional designs are bound to a single moment in time. Longitudinal studies would show increases and decreases in burnout, which might allow for hypotheses regarding maintaining factors.

Several studies included in this review included members of staff in multi-disciplinary team positions, who are typically based off the ward, such as occupational therapists, psychologists, and psychiatrists. However, it is apparent that the majority of the studies did not investigate the different levels of burnout in ward-based staff and multi-disciplinary staff. Kirby and Pollock (1995) included ward managers in their study, who typically only have a small amount of patient contact. This study met the inclusion criteria of this review, as participants were qualified mental health nurses. However, it was not possible to adequately distinguish the impact of differences in the roles of managerial nursing staff and clinical nursing staff.

In one study (Jones et al., 1987), questionnaires were designed by the author to measure perceived level of job demands, support and constraints. Items on the questionnaires were generated by visits to wards and discussions with individual staff. In another study (Kirby & Pollock, 1995), a questionnaire developed by the authors gave an indication of possible perceived stressors in the work place. The authors of both studies commented on the limitations of creating their own questionnaires and, whilst the results indicated good face-validity, the psychometric properties of the instruments had not been formally assessed. Additionally, Hellin (1991) and Johnston et al. (2016) designed vignettes to elicit responses regarding staffs'

feelings. Vignettes can be used to explore a diverse range of issues in social research that could potentially be difficult or sensitive topics. However, as vignettes are fictitious, they cannot completely capture the reality of an individual's life. With this in mind, the extent to which vignettes are generalisable outside of the specific vignette situations is questionable.

Critique of this systematic review:

The strength of this systematic literature review is that there appears to be no previous review investigating the risk factors related to the development of burnout in forensic hospital staff. As such, this review is unique in its aims, and its findings can potentially have considerable impact on the development of future research studies. Future research studies may then continue to inform clinical and professional practice. Another strength of this review is the specificity of the branch of the nursing population included. Due to this specificity, it is increasingly possible to generalise the findings of this review to the forensic mental health nursing population. In turn, this may prove to be useful for clinical practice.

Publication bias in the form of the 'bottom-drawer effect' is where research has a higher likelihood of publication if its findings are significant. This type of publication bias may have negative implications for the synthesis and interpretation of the results in a systematic review. However, another strength of this systematic review is that it also includes unpublished work which was discovered upon searching grey literature. Therefore, in this instance, it has been possible to explore the quantity and quality of unpublished work compared to published work.

Despite these strengths, it is important to acknowledge the limitations of this systematic review. Indeed, a number of studies had to be omitted from this review because their samples included a mixture of participants, some which met the inclusion criteria and some which did not. For

example, Happell et al. (2003) measured stress and burnout levels in 51 nurses employed in various types of forensic in-patient services in Australia. At first, it appeared that this study met the inclusion criteria. However, upon closer inspection, it became apparent that, while the sample did include nurses who worked in forensic in-patient settings, it also included nurses who worked in the community, courts and the prison service. Therefore, while the study may have provided the researcher with some useful information, unfortunately, it had to be omitted, as the participant sample was too broad. As a result of this, it would have been more difficult to generalise the overall findings to a forensic hospital setting. Research by Cacciacarne et al. (1986) was omitted from the current systematic review for similar reasons.

Additionally, while the rest of this thesis concentrates exclusively on burnout, this systematic review explored both stress and burnout. The slightly broader focus of this systematic review was deemed to be necessary, due to the shortage of burnout literature in this specific area of nursing. Therefore, it was felt that slightly widening the search criteria would be beneficial in this instance and would provide a well-balanced overview of what research exists in the field of forensic mental health nursing and where the gaps in the literature base are. Therefore, the inclusion/exclusion criteria was widened to include an outcome of burnout or stress, which had either been assessed by a standardised measure or explicitly or implicitly referred to as part of a qualitative investigation. In the future, it is hoped that the body of literature into staff burnout in forensic hospitals will continue to grow, so that future systematic reviews can be even more focused. Future researchers should consider the methodological limitations identified in the studies included in this review, as addressing these potential biases would surely provide a good foundation for future research endeavours. Indeed, once the literature base has expanded, it would be worthwhile if this systematic review could be reviewed and repeated.

Finally, it remains important to consider the location of each of the included studies, as only one of the 16 studies included was conducted outside the UK. This raises questions regarding the generalisability of the results of this systematic review. However, as the search terms used in this review cover variations across different systems, the shortage of studies outside the UK may not be related to the search strategy, but could be explained by the reform of psychiatric care, particularly in the Western countries. This process is coming to be understood as a more complex process of moving from traditional psychiatric hospitals to supported housing, prisons and, not least, specialist forensic psychiatric units (Chow & Priebe, 2016; Juriloo et al., 2017; Priebe et al., 2005). As a result, authorities in other countries may still in the process of expanding or updating their forensic psychiatric services, in order to respond more effectively to the needs of offenders with mental illness (Allison et al., 2017; Andersson et al., 2013; Hodgins et al., 2006). Forensic hospitals are high-cost, low-volume medical institutions, which are required to provide both therapeutic interventions and a safe and secure environment. These hospitals provide an essential, specialised service for mentally disordered offenders and others with similar needs, both in terms of healthcare and decreasing the risk of re-offending.

However, a major obstacle remains in terms of the lack of knowledge of many culturally different situations, outside of the Western nations. For example, little has been written in English about the Islamic context, which makes it difficult to gain access to information. Furthermore, what might best characterise the African systems is the lack of resources (Bateman, 2005). In addition to the lack of appropriate facilities, most African countries have, on average, one psychiatrist per one million inhabitants. In South Africa, for example, the number of psychiatrists has not increased in the 30 years (Bateman, 2005). Moreover, certain African countries present a forensic problem, in that people often look to witchdoctors for solutions to their psychiatric problems (Abdalla-Filho & Bertolote, 2006). However, it appears

that the quantity of available information regarding the status of forensic psychiatry on the African continent is not sufficient to allow a homogeneous and uniform description (Njenga, 2006). Overall, it seems that it may be difficult to generalise the findings of this systematic review to populations outside of the UK. Nevertheless, it provides a useful synthesis and critique on which to base future exploration and service planning.

Future recommendations:

A number of risk factors were consistently identified across studies and these are documented at length above. Despite this, each study appeared to reveal slightly different risk factors for the development of burnout in forensic hospital staff. This is possibly attributable to individual differences in organisations and individual differences in people. Therefore, the extent to which each factor contributes to the development of burnout remains unclear. With this in mind, it appears that further exploration of this topic is certainly necessary.

While some of the studies included in this review compare risk factors for burnout in staff who work across different settings (Chalder & Nolan, 2000; Kurtz & Jeffcote, 2011) and different wards (Nathan et al., 2007), further emphasis could be put on these types of comparison studies in the future. Comparison group approaches are rated highly because they are an effective way of knowing whether exposure to a particular factor has made a difference or not, which can help attribute an impact to that particular exposure. Future research using comparison groups could include different ward types (low, medium and high secure wards) or different client groups (males, females and adolescents). This way, it could be investigated whether exposure to certain environments or client groups means that an individual is more likely or less likely to develop burnout. However, it is also important to consider the potential ethical implications

of such a study design, as it may be seen as unethical to propose that certain individuals are placed on a ward where they are more likely to develop burnout.

Furthermore, future researchers may benefit from conducting longitudinal research. While one study included in this review used this method (Nathan et al., 2007), only 60% of the original participants were available for follow-up. Therefore, this study is at risk of attrition bias, as 40% of the original sample were lost. Future research may benefit from exploring the long-term effects of burnout and how these can impact on both the individual and the organisation. Burnout is a social and psychological construct that reflects an individual's experiences at that moment in time. Therefore, as burnout is changeable over time and is dependent upon the context in which it occurs, longitudinal research could aim to monitor a group of staff over a certain period of time to explore both the risk factors and the maintenance factors for burnout.

Conclusion:

It appears that there is a growing evidence base linking the unique challenges of working in forensic hospitals to high degree of burnout. In forensic hospital settings, it appears that staff burnout arises through a complex interplay of political, organisational, social and individual factors. However, this evidence base currently remains small, with a number of different hypotheses being generated by different researchers. Based on this systematic review, it is not possible to provide a comprehensive conclusion regarding the specific risk factors for the development of burnout in forensic hospital employees. This is because each study appeared to identify a number of different relevant risk factors. However, some commonalities across the 16 studies were identified, which allowed the studies to be categorised into four separate sub-categories: organisational and occupational factors, clinical factors, personal and individual factors and feeling disconnected from the outside world.

Therefore, further research into this topic may provide information that is beneficial to staff, patients and organisations. Identifying what factors may lead to the development of burnout and which staff are most at risk of developing burnout, as well as implementing practices to reduce burnout, can all contribute towards reducing staff absenteeism. Subsequently, this would reduce the financial implications to the organisation. Furthermore, many of the studies included in this review make clinical and service recommendations, but fail to explore, in detail, the impact of staff burnout on the quality of patient care. Therefore, further research needs to address this gap in the literature. The current body of evidence is dominated by cross-sectional design studies. Longitudinal studies or those using mixed-methods approaches would allow for a broader and deeper understanding of the phenomenon of staff burnout forensic hospitals. Moreover, further research to support evidence-based interventions to limit and reduce burnout is critical to the well-being of mental health professionals, the services within which they operator and the people for whom they provide care.

Chapter 4

A quantitative investigation into the risk factors for burnout in forensic hospital workers

Abstract

Although secure forensic hospitals are recognised as stressful, dangerous and emotionally demanding environments, there has historically been a shortage of research into the phenomena of burnout among forensic mental health staff in the United Kingdom, with research typically focusing on staff burnout in community mental health settings and non-secure mental health settings. With this in mind, the current research study aimed to investigate the risk factors for burnout in forensic hospital workers. 173 participants were recruited from a secure forensic hospital in the North West of England. The study found that over half (52%) of the forensic hospital staff experienced high levels of emotional exhaustion (EE), almost a third (30%) experienced high levels of depersonalisation (DP) and almost half (43%) experienced low levels of personal accomplishment (PA). When these results are compared to the normative data, it appears that participants in the current study reported higher than average levels of EE and DP. Multiple regression analyses identified that burnout may be predicted by being male, being of a younger age, being ward-based, having no children and having university-level qualifications. On the other hand, working on a ward with less stringent levels of relational security (such as locked rehabilitation and low secure wards) predicted lower levels of burnout. Interestingly, working with an adolescent client group predicted a lower level of DP, but a higher level of EE. Possible explanations for this are considered in the discussion chapter. A Mann-Whitney U test revealed that ward-based staff experienced significantly greater levels of EE and DP than staff who were based off the ward. Finally, correlation analyses identified a significant negative correlation between length of time working at the organisation and EE/DP. Overall, the results of the current research appear to support the assertion that working in a forensic hospital setting can lead to employees experiencing marked levels of burnout.

Introduction

Forensic hospitals are typically considered stressful, dangerous and emotionally demanding work environments. On a daily basis, forensic hospital employees face very unique challenges and the pressure to make the right decisions and provide care for extremely vulnerable and unwell people can seriously impact on their health and well-being. Staff caring for mental health patients who have been referred by law-enforcement are inevitably subject to a greater risk of violence and aggression, compared with those working in any other field of nursing (Bowers, 2002; Mason, 2002). Being exposed to the perceived threat of violence, as well as actual physical violence, can contribute towards the onset of occupational stress and burnout in forensic mental health staff (Coldwell & Naismith, 1989; Whittington & Richter, 2006). Both employer and employees have an interest in reducing violence at work. For employers, violence can lead to poor morale and a poor image for the organisation, making it difficult to recruit and keep staff. It can also mean extra cost, with staff absenteeism and compensation payments (Health and Safety Executive, 1996). For employees, violence can cause pain, distress and even disability or death. Physical attacks are obviously dangerous, but persistent verbal abuse and threats can also damage the mental health of employees through anxiety and stress (Health and Safety Executive, 1996). Researchers have also hypothesised that increased levels of violence observed in forensic mental health patients can affect the dynamic of the staff-patient relationship (Archer & Coyne, 2005; Conway, 2005; Leschied et al., 2001). The staff-patient relationship subsequently becomes 'emotionally charged', which increases the EE component of burnout (Nathan et al., 2007). However, there is currently only a small amount of evidence to support these notions, as this area of nursing has historically received little focus.

While occupational risk factors for burnout are apparent across many different professions, an important feature of working in a forensic mental health setting is the role of staff to converse with patients about their life experiences. Forensic mental health patients are often complex individuals, who are typically diagnosed with either mental illnesses, personality disorders or neurodevelopmental disorders, as is reflected in the criteria for admission to secure services (NHS England, 2018a; NHS England, 2018b). They have also sometimes suffered traumatic histories and can demonstrate a wide range of challenging behaviours as a consequence of these experiences. Indeed, it is acknowledged that individuals who have experienced trauma tend to represent the greatest proportion of people accessing mental health, forensic health and drug and alcohol services (Muskett 2014). Issues of attachment are also complex for forensic mental health patients (Pfafflin & Adshead, 2004), as they have often experienced severely disrupted childhoods, through parental neglect, physical, emotional and sexual abuse, institutional care, unemployment, abandonment, poverty and homelessness (Implementing Recovery Through Organisational Change, 2014; Wolf & Shi, 2012). Therefore, at times, learning about the backgrounds of forensic mental health patients can be difficult and upsetting (Figley, 1995).

Additionally, the traumatic histories of forensic mental health patients can sometimes manifest in ways that can be distressing for staff to witness, for example, in the form of self-harming behaviours or suicide attempts. The exposure to these potentially traumatising events may subsequently impact on the psychological well-being of forensic mental health staff (Paton & Violanti, 1996). Completed patient suicides inside secure forensic services are comparatively rare, with an average of 110 occurring in the UK annually (National Confidential Inquiry into Suicide and Homicide, 2016). However, they are more common in mental health services than other healthcare services. When they do happen, the impact on staff is strong and sustained,

linked with loss of self-esteem, feelings of guilt and anger and disturbed relationships with colleagues, friends and family (Chemtob et al., 1988).

Increased incidents of verbal aggression, physical aggression and self-harming behaviours are associated with changes in the ward dynamics, as such incidents often lead to increased levels of therapeutic observations (Power et al., 2003; Senior et al., 2007). This can subsequently cause other patients to experience heightened anxiety, which stems from a reduction in the amount of staff available to meet their needs (Cleary et al., 1999; Kroll, 1988). Additionally, when making decisions regarding the care and management of difficult patients, conflicts of interest between members of the staff team may arise. One such decision that may instigate this type of conflict is assessing whether a patient should be secluded or not. Indeed, managing a person who is behaving in a violent manner is a relatively unusual human experience and this can be a stressful encounter (Whittington & Mason, 1995). These incidents that require some form of physical restraint have been associated with increased emotional demand for both staff (Sequeira & Halstead, 2004) and patients (Wynn, 2004), which may also increase the risk of burnout due to the disruption of staff-patient relationships (Blais, 2004; Johansson & Eklund, 2004; Watts & Morgan, 1994). Moreover, given the litigation regarding seclusion, the constant apprehension and fear as to whether the right decision has been made is also an issue. Fear, however, is rarely discussed within forensic settings and it has been suggested that this could be a result of the culture that exists (Jacob & Holmes, 2011; Morrison, 1990).

Adding to the challenges of working with a complex client group are the competing demands of providing a balance between maintaining security and providing a therapeutic environment, factors inherent in working in forensic hospitals. Individuals who reside in forensic hospitals are detained. As a result, staff are required to care for patients who do not choose to receive

treatment. However, coercive measures, such as restraint and forced medication, are stressful activities for both staff and patients (Bonner et al., 2002). Furthermore, Phillips (1983) illustrates the internal conflict that some staff may experience when working with a mentally ill offender - is the patient a mentally ill person who needs to be diverted within the healthcare system for treatment, or is the patient a criminal who must serve their sentence before their health problems can be attended to?

The inter-related factors discussed above provide the foundations for understanding how burnout may develop uniquely in forensic hospital settings. However, despite these reasons potentially placing these staff at an increased risk of burnout, few studies appear to have focused solely upon the risk factors for burnout in forensic health care professionals. One of the first studies to address this issue was by Cacciabarne et al. (1986), who found that 71% of 133 forensic psychiatric hospital workers felt moderately to greatly burned out. They also found that the lower-ranking staff and the female staff experienced a greater degree of burnout, as did staff who had previously been threatened by a patient. Nurses felt the highest degree of burnout, social workers and psychologists a moderate amount, and psychiatrists the least.

Since the work of Cacciabarne et al. (1986), a handful of studies have explored the concept of burnout in forensic hospital staff. Jones et al. (1987) studied 349 'special' psychiatric hospital employees and found that they experienced higher levels of psychological distress than other health care professionals. Staff found the administrative aspects of the job more stressful than the patient care. Those who had a spouse working at the same hospital reported higher levels of anxiety and psychological distress, and higher rates of psychological distress were reported by females. Van Dierendonck et al. (1996) found that 112 staff from a forensic psychiatric hospital experienced greater burnout on all three dimensions, when compared with 189 staff

from a learning disability service. Additionally, Chalder and Nolan (2000) found that forensic nurses (n = 23) experienced more stress from inter-professional conflicts, when compared to acute care nurses (n = 15). Furthermore, Happell et al. (2003) found that forensic nurses (n = 51) reported lower levels of burnout and higher levels of job satisfaction, when compared to mainstream mental health nurses (n = 78). More specifically, forensic nurses felt more satisfied with regards to their involvement in decision-making and the amount of support they received.

Nathan et al. (2007) found that burnout levels increased more for staff working with forensic female patients (n = 15) than for staff working with forensic male patients (n = 14). Oddie and Ousley (2007) found that 54% of 124 staff on a medium secure ward were experiencing high EE, with organisational issues, limited resources and staff conflicts all being linked to stress and burnout. However, patient care had a small impact on staff burnout levels. Elliot and Daley (2013) recruited 135 participants and found that older staff experienced more stress in relation to a lack of resources and work-home conflict, while staff with children experienced more stress in relation to clients' poor skills and work home-conflicts. Staff who lived alone experienced significantly greater EE than those who lived with others. The least experienced group of staff experienced significantly less DP. Furthermore, MDT members experienced significantly greater EE than frontline staff. Finally, Johnson et al. (2016) recruited 117 participants and found that staff with higher PA had a significantly greater propensity to trust their colleagues. Experiencing boundary violations was positively correlated with EE and DP. Moreover, age was negatively correlated with EE and DP and positively correlated with PA.

To summarise, although it is widely acknowledged that forensic settings can be highly stressful environments to work in, there has been a relative shortage of research into the phenomena of burnout among people employed within such services, with the existing research typically

generating limited concepts and contrasting findings. Moreover, such research is beset with a number of limitations with regards to small sample sizes, single assessment measures and limited demographic data. The conclusions of many of these studies are also limited in their scope for generalisation, as they involve the analysis of a small area of practice only. Therefore, further research in this area is evidently necessary, in order to identify the unique stressors related to working in a forensic hospital setting, which can lead to the development of burnout.

Aims and objectives

Rationale: While a number of previous studies have considered the possible risk factors for burnout in mental health workers, the literature base that has focused specifically on the risk factors for burnout in forensic hospital staff is much smaller. However, as forensic hospital staff typically work with a unique client base, it is possible that there is a unique set of risk factors associated with caring for this complex population. Forensic wards are typically very emotionally demanding places to work for staff, as they care for individuals whose needs are multi-faceted and whose behaviour can often be challenging or risky. In turn, this is likely to increase the risk of burnout in staff (Jones et al., 1987; Nathan et al., 2007). Going forward, if research can identify which staff may be at the highest risk of developing burnout, strategies can subsequently be developed and introduced, to help protect those individuals most at risk.

Aims: This study was aimed to identify the level of burnout experienced in a sample of forensic hospital workers and explore the link between this level of burnout and a number of individual demographic factors. More specifically, it aimed to address the following objectives:

1. What is the level of burnout experienced in a sample of forensic hospital workers and how does this level of burnout compare to the normative data available?
2. Can the level of burnout experienced by individual forensic hospital workers be associated with the presence of any specific risk factors?

Hypotheses:

1. It is hypothesised that the level of burnout (EE, DP and PA) experienced in the current study sample will be higher than the level of burnout experienced in the mental health normative sample and the human service normative sample. It is hypothesised that this will be due to the unique challenges that working in a forensic hospital environment entails. This hypothesis is based on previous research (as discussed in depth in the introduction section of this chapter), which outlines that there are many unique aspects of working in a forensic hospital environment which can contribute towards the onset of occupational stress, burnout, reduced well-being and mental health problems in employees.
2. It is hypothesised that some particular risk factors (namely, individual characteristics) will be associated with burnout scores (EE, DP and PA). This hypothesis is based on the theoretical underpinnings of PEF model (French, 1973), which proposes that the match between a person's individual characteristics and their work environment is essential in influencing their health. This hypothesis is also based on previous research, in which certain demographic factors have been found to predict burnout across a number of previous studies, primarily involving participants who work in human service occupations (as discussed in depth in Chapter 3). As such, this research hypothesises that a number of demographic factors (including age, gender, ethnicity, job role, length of time at current organisation, relationship status, number of dependent children and educational level) will be associated with the level of burnout experienced in the current study sample. Moreover, patient group and ward level of security will also be included in the analysis, as these two factors allow for the exploration of patient characteristics and have also been previously identified as being linked to the development of burnout in healthcare workers.

Method

Design: A quantitative and cross-sectional design was adopted to explore the relationship between a number of demographic factors and overall EE, DP and PA scores.

Setting: This study was conducted in a secure forensic psychiatric hospital in the North West of England. The hospital comprises of 15 wards, including five adolescent wards, three female wards and seven male wards. The security level of the wards includes Psychiatric Intensive Care Units (PICU), locked rehabilitation units, low secure units and medium secure units. Admissions typically arrive from other forensic hospitals, prisons and non-forensic hospitals.

At the time that the current research was being conducted, the host organisation had recently been taken over by a larger healthcare provider, in August 2015. Approval for the research study was then given by the hospital manager in October 2016. In the year prior to the research study receiving approval, organisation changes have taken place. It is understood that a number of employees were made redundant or were asked to re-interview for their positions. While the restructuring of employees did not affect any of staff in patient-facing roles (which is the current study population), the process may have caused unease and discontent in an entire workforce and, in turn, burnout among some workers.

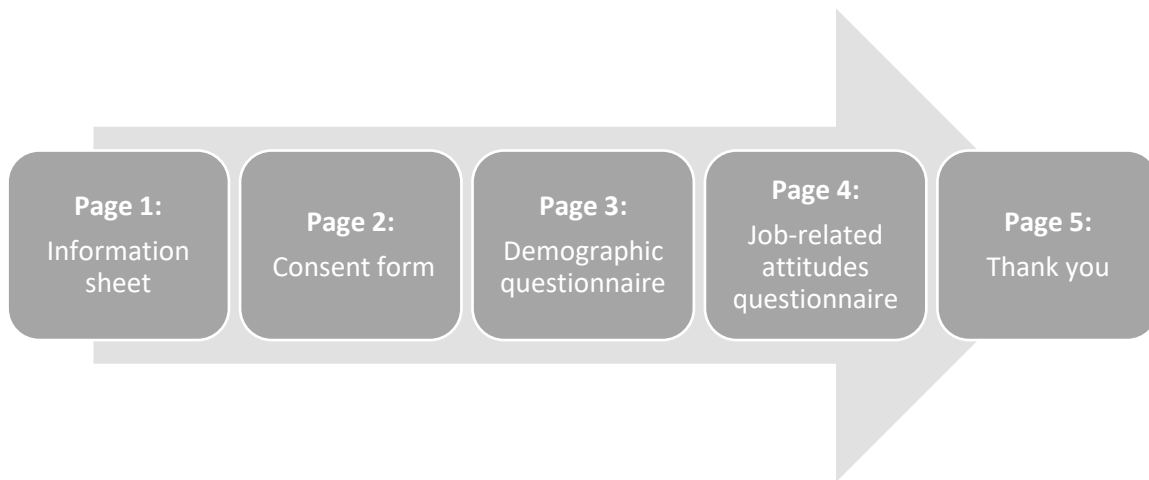
Sampling: Purposive sampling was used to obtain participants, as there was a specific group of the population that the research was targeting, with this group being staff who work in a secure forensic hospital. Out of this group of people, opportunistic volunteer sampling was used and participants were staff who had responded to an initial advertisement via email. Only staff who were in patient-facing roles were invited to participate in the research. These roles

included support workers, qualified nurses, ward managers and multi-disciplinary team members, to name a few. Staff who were not based on the wards, such as staff who worked in human resources, on reception or in administration roles, were not invited to participate.

Power calculations: According to a priori power analysis, the number of participants would need to be at least 172, with a confidence level of 95%, a margin of error of 5% and a medium effect size, as defined by Cohen's (1969) principles. A medium effect size was considered most appropriate in this instance, as a small effect size may be significant in statistical terms, but of little clinical relevance. The final amount of participants included in the research was 173.

Procedure: Email advertisements for participants were sent out by a neutral person, who was independent from the research team. Email advertisements were sent out to all staff who had direct contact with patients on a regular basis. This link was distributed across the hospital email system. This email directed participants to the online link for the research study, which was a questionnaire hosted on the Bristol Online Surveys website. The online questionnaire remained open for around nine months, from January 2017 until September 2017. It included five pages, which are illustrated on the following page in Figure 2, shown in sequential order.

Figure 2. Online survey sequence



Measures: The online survey contained an information sheet, briefly outlining the research study and associated ethical considerations. It also contained a consent form, to ensure that participants had read the information sheet carefully and thoroughly. Finally, the online survey also included the following questionnaires:

- **Demographic questionnaire:** The first questionnaire considered background information and asked a number of questions relating to demographic factors, including: age, gender, ethnicity, job role, length of time at current organisation, relationship status, number of dependent children, educational level, patient group worked with and ward level of security. These latter two factors also allowed for the exploration of patient characteristics. These demographic variables were chosen specifically, as they have all been identified in previous research as being linked to the development of burnout in healthcare workers. Such research studies are discussed in more depth in the introduction sections of Chapter 3 and Chapter 4. However, to summarise, Maslach et al. (2001) collated the past 25 years of burnout research and, from doing this, they outlined that people do not simply respond to

the work setting, rather, they bring their own unique qualities to their work setting. These individual characteristics include demographic variables, such as age, gender, education level and relationship status, which have been found to predict burnout across a number of studies, primarily involving participants who work in human service occupations (Maslach et al., 2001). However, Maslach et al. (2001) also outlined that these findings should be viewed with some caution, as the interpretations of such results have not been studied thoroughly. With this in mind, it was felt that using the demographic variables identified by Maslach et al. (2001) could add some support to the notion that individual characteristics can be used to predict the development of burnout. Moreover, the association of certain demographic variables with burnout has recently gathered more support (Green et al., 2014), through the use of meta-analyses (Brewer & Shapard, 2004; Puranova & Muros, 2010) and systematic reviews (Bria et al., 2012; Elbarazi et al., 2017; McCormack et al., 2018; Newman, 2017; O'Connor et al., 2018; Simionato & Simpson, 2018).

- **The MBI - HSS:** The second questionnaire was the MBI-HSS (Maslach et al., 1996), which identified the level of burnout felt by the staff surveyed. This was presented to participants as a job-related attitudes questionnaire, as is recommended by the authors of the measure (Maslach et al., 1996), who assert that respondents must be unaware that the MBI is a burnout measure and must not be sensitised to the general issue of burnout. The MBI measures burnout in three distinct dimensions: EE, DP and PA. The EE subscale includes nine items (e.g. 'Working with people all day really is a strain for me) ($\alpha = .91$). The DP subscale includes five items (e.g. I've become more callous towards people since I took this job) ($\alpha = .73$). Finally, the PA subscale includes eight items (e.g. 'I feel I'm positively influencing other people's lives through my work) ($\alpha = .68$). All items are scored on a seven-point frequency rating scale ranging from 0 ('never') to 6 ('every day'). The authors

of the MBI do not recommend generating an overall burnout score, rather, they recommend that scores from each subscale are analysed separately. Scores from each subscale can subsequently be categorised as low, moderate or high. High EE and DP scores and low PA scores are indicative of burnout. The MBI is a well-established, valid and reliable measure of burnout (Maslach et al., 1996). Further discussion of the administration, scoring and psychometric properties of the MBI can be found in Chapter 2.

Table 6, as presented on the following page, illustrates the scores that correspond to the different levels of burnout among respondents. These burnout thresholds were chosen based on the guidelines provided in the MBI Instruments and Scoring Guides (Maslach & Jackson, 1981), which outline that the scoring key on the survey should be followed. These scores can subsequently be compared to the normative data for several different occupational subgroups, as provided in the MBI Manual Third Edition (Maslach et al., 1996).

Table 6. Burnout levels and corresponding scores

Emotional exhaustion	Depersonalisation	Personal accomplishment
High (27 or over)	High (13 or over)	High (39 or over)
Moderate (17-26)	Moderate (7-12)	Moderate (32-38)
Low (0-16)	Low (0-6)	Low (0-31)

Participants: The research obtained 186 responses in total. This sample was drawn from a population of approximately 495 employees (as confirmed by the organisation in which the research was completed). However, 13 of these responses were excluded, as either information was missing or the job roles of participants did not meet eligibility criteria (i.e. they were not

in patient-facing roles). Therefore, 173 participants (35 males and 138 females) were included in the analysis. A large proportion of the sample was female (n = 138, 80%), which is typically representative of the standard male to female ratio in healthcare jobs (NHS Digital, 2016). The sample mean age was 32.82 years (SD = 9.21, range = 19-63 years). The majority of participants identified as white British (n = 161, 94%), which is likely to be representative of the location in which the research was conducted. Due to the high proportion of white British participants, the independent variable of ethnicity was dropped from the subsequent analysis, as the analysis would have been neither valid nor reliable. The sample appeared to be experienced in working in the forensic mental health field, as staff members had been employed in this setting for an average of 54.88 months (SD = 46.27). However, there was considerable difference in amount of experience, with a range of two months to 17 years.

Overall, the sample comprised of support workers (41%), senior support workers (13.3%), qualified nurses (17.3%), team leaders (6.4%), ward managers (5.8%) and MDT members (15.6%). Figures regarding the target population are shown in the table on the following page and are based on estimates provided by the host organisation. Based on these figures, it was felt that the study sample was largely representative of population from which it was drawn. This is an important point of consideration in order to permit the generalisability of the findings.

Table 7. Comparison of the study sample and the overall population

Study sample (173)	Overall population (approximately 495)
41% support workers	270 support workers (55%)
13.3% senior support workers	30 senior support workers (6%)
17.3% qualified nurses	90 qualified nurses (18%)

6.4% team leaders	30 team leaders (6%)
5.8% ward managers	15 ward managers (3%)
15.6% MDT members	60 MDT members (12%)

Ethical considerations: Once permission had been granted from the manager of the hospital (Appendix F), the research study was reviewed by the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee and given a favourable opinion. Before commencing the study, participants were provided with an information sheet (Appendix H), detailing the aims of the study what participation would involve. Participants were advised that their contribution was voluntary and they were free to withdraw any time. Participants were informed that their data would remain anonymous and confidential and would be stored securely for 10 years, in a password protected file, before being destroyed. Participants were also advised that the results of the study may be presented at academic conferences and in journals. After reading the information sheet, participants were directed to a consent form (Appendix I). Participants were required to complete the consent form and answer several statements, to establish that they had read the information sheet carefully. Participants were then directed to the demographic questionnaire and the MBI-HSS. Written instructions were provided regarding how to complete each questionnaire. The instructions regarding how to complete the MBI-HSS were taken from the MBI manual, as is advised by the authors.

The MBI-HSS contained potentially sensitive questions relating to burnout, therefore, two precautions were taken. The first precaution was that participants were advised that they could terminate the completion of the study at any time. The second precaution was that participant distress was managed through guiding participants to seek support from their line manager, clinical supervisor or a qualified psychologist at the organisation, should they feel the need to.

Analysis of data: The data were entered into and analysed using IBM SPSS Version 23, a statistical software package. Categorical variables were ‘dummy coded’ and assigned with a value of either ‘0’ or ‘1’. This process of is detailed further in the table below.

Table 8. Dummy coding of variables

Variable name	‘0’ value	‘1’ value
Gender	Male	Female
Job role	Based on ward	Based off-ward
Relationship status	Single	In a relationship
School qualifications	No	Yes
College qualifications	No	Yes
University qualifications	No	Yes
Adolescent clients	No	Yes
Female clients	No	Yes
Male clients	No	Yes
PICU ward	No	Yes
Locked rehab	No	Yes
Low secure	No	Yes
Medium secure	No	Yes

Participants were then categorised on the basis of their burnout scores in each dimension. As outlined previously in Table 6, a high degree of EE is identified by a score of ≥ 27 , high DP by a score of ≥ 13 , and low PA by a score of ≤ 31 . These burnout thresholds were chosen based on

the guidelines provided in the MBI Instruments and Scoring Guides (Maslach & Jackson, 1981), which outline that the scoring key on the survey should be followed.

To investigate the relationship between the independent variables and the level of burnout, a series of statistical analyses were performed, using the burnout dimensions (EE, DP, PA) as dependent variables. However, before commencing any statistical analysis, data screening checks were run, to ensure that the underlying assumptions of parametric testing were not violated. Normal distribution was analysed using the Shapiro-Wilk test. However, the results of the data screening checks revealed that the assumption of normal distribution was violated for all three dependent variables (EE, DP and PA). The presence of outliers was investigated for each dimension of burnout using boxplots and a number of outliers were revealed in the data set. Outliers were subsequently removed, however, the assumption of normal distribution remained violated. Therefore, outliers were retained and the data set was analysed using non-parametric statistical analyses instead.

Results

Prevalence of burnout: The results in Table 9 below highlight the prevalence of burnout in the sample of forensic hospital workers studied. These results show the percentage of staff who were experiencing high, moderate and low levels of burnout in each burnout dimension.

Table 9. The prevalence of burnout in the current sample

Dimension of burnout	Level of Burnout	Number of participants	Percentage of participants
EE	High (27 or over)	90	52%
EE	Moderate (17-26)	36	21%
EE	Low (0-16)	47	27%
DP	High (13 or over)	52	30%
DP	Moderate (7-12)	47	27%
DP	Low (0-6)	74	43%
PA	Low (0-31)	74	43%
PA	Moderate (32 - 38)	61	35%
PA	High (39 or over)	38	22%

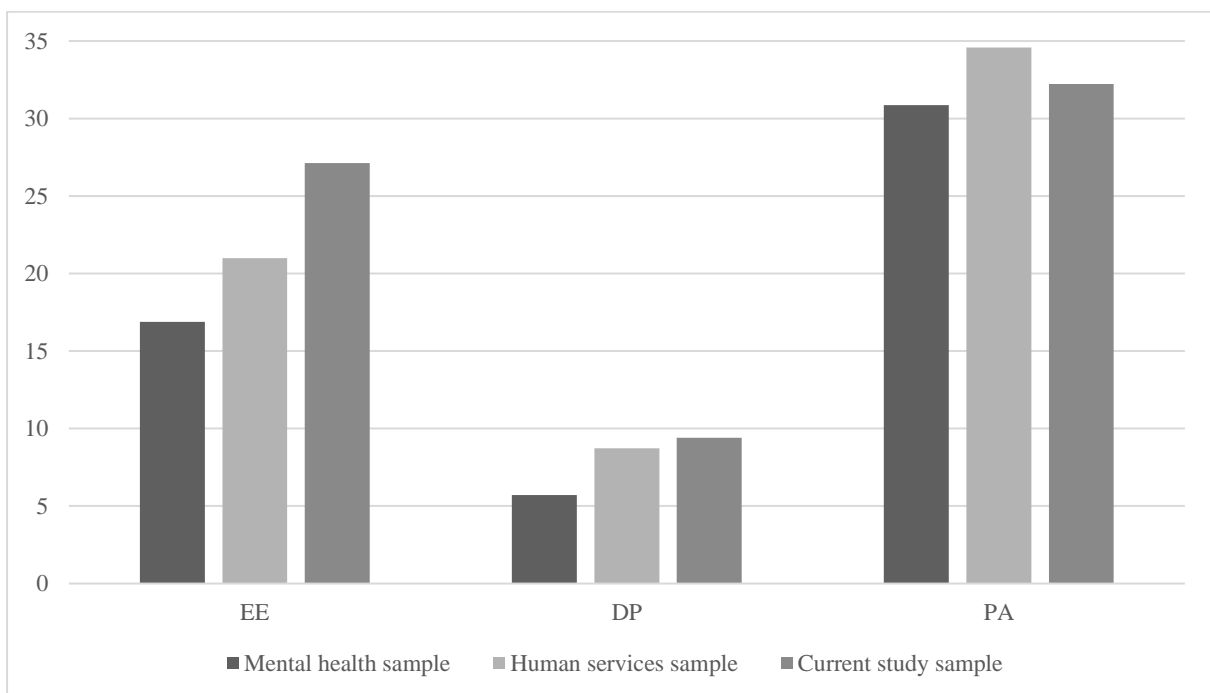
The results demonstrate that over half of the participants (52%) were experiencing high levels of burnout in the EE dimension. These levels of burnout that staff experienced were not as pronounced in the DP dimension, with 30% of participants experiencing high levels of DP. However, almost half of the participants (43%) were experiencing low levels of PA.

When these results are compared to the normative data in the MBI manual (as shown in Table 8 and Figure 3), it appears that participants in the current study experienced higher than average levels of EE (27.13) and DP (9.40), when compared to the mental health sample norms and the human services sample norms. However, participants in the current study achieved a mean PA score of 32.23, which suggests that the PA scores obtained in the current study are average.

Table 10. Normative data taken from the MBI manual

Population	EE	DP	PA
Mental health sample	16.89	5.72	30.87
Human services sample	20.99	8.73	34.58
Current study sample	27.13	9.40	32.23

Figure 3. Graph showing MBI sample means



Risk factors for burnout: Correlational and multiple regression analyses were conducted to examine the relationship between a range of demographic factors and the level of burnout experienced by participants. The results of both types of analyses will be discussed below.

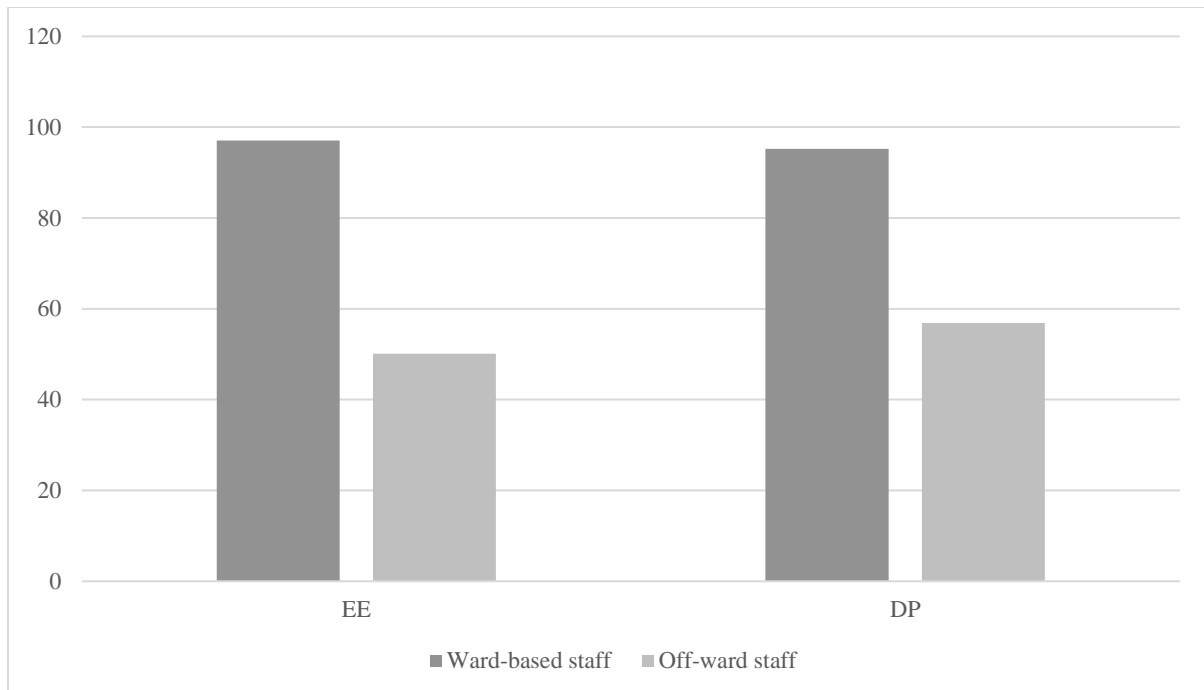
Correlational analysis: The relationships between some of the demographic variables and burnout level were examined using correlational analysis. Correlational analyses were deemed appropriate statistical tests in this instance, as the three demographic variables tested were numerical in nature. Normal distribution of the three dependant variables (EE, DP and PA) was analysed using the Shapiro-Wilk test and the results revealed that the assumption of normal distribution was violated for EE ($p \leq 0.001$), DP ($p \leq 0.001$) and PA ($p = 0.002$). As a result, a Spearman's rank correlation was used. A Spearman's rank correlation applies ranks, and so provides a measure of a monotonic relationship between two continuous random variables. It is useful with ordinal data and is robust to outliers.

The analyses showed a significant negative correlation between age and EE ($r = -0.350$, $p \leq 0.001$) and DP ($r = -0.368$, $p \leq 0.001$), a significant negative correlation between length of time at the organisation and DP ($r = -0.149$, $p \leq 0.05$) and a significant negative correlation between children and DP ($r = -0.168$, $p \leq 0.05$). There were no significant correlations between any of the numerical variables and PA.

Non-parametric tests: To explore differences in burnout score between job roles, a Mann-Whitney U test was performed. Results revealed significant differences in levels of EE ($U = 1,152.00$, $p \leq 0.001$) and DP ($U = 1,401.00$, $p \leq 0.001$) between staff who were based on the ward (support workers, senior support workers, qualified nurses and team leaders) and staff who were based off the ward (ward managers and MDT members). The Mann-Whitney U test

is a rank order test for assessing the distribution of two independent groups when combined into a single sample. With this in mind, the mean ranks of the ward-based staff and the off-ward staff, in relation to their burnout scores, are presented in a graph below.

Figure 4. Graph showing the results of a Mann-Whitney U test



As can be established from the graph presented above, ward-based staff were significantly more likely to report feelings of EE and DP than staff based off the ward. No significant differences in levels of PA were observed between the two groups. Moreover, no significant differences were found in levels of EE, DP or PA between genders or relationship statuses.

Multiple regression analysis: Multiple regression analysis was used to develop a model for predicting an employee’s level of burnout based on a variety of factors, the full results of which are detailed in Tables 9 and 10. As prior tests of normality on the data set had highlighted that

the dependent variables were not normally distributed, bootstrapping was used. Bootstrapping is a nonparametric approach to statistical inference, which allows us to estimate the sampling distribution of a statistic empirically, without making assumptions about the form of the population and without deriving the sampling distribution explicitly (Fox & Weisberg, 2017).

A multiple linear regression was calculated to predict EE based on a number of independent variables. A significant regression equation was found ($F(13,159) = 6.168, p < 0.001$), with an R^2 of 0.335, meaning that the predictors explained 33.5% of the variance. The analysis found that being younger ($\beta = -0.406, p = 0.002$), having a university degree ($\beta = 0.292, p = 0.029$), and working with an adolescent client group ($\beta = 0.665, p = 0.002$) significantly predicted a higher level of EE. On the other hand, being based off-ward ($\beta = -0.330, p = 0.002$) and working on a PICU ward ($\beta = -0.688, p = 0.002$) significantly predicted a lower level of EE.

A multiple linear regression was calculated to predict DP based on the same independent variables. A significant regression equation was found ($F(13,159) = 5.796, p < 0.000$), with an R^2 of 0.322, meaning that the predictors explained 32% of the variance. The analysis found that being male ($\beta = -0.267, p = 0.003$), being younger ($\beta = -0.409, p = 0.002$) and having no children ($\beta = -0.146, p = 0.043$) significantly predicted a higher level of DP. On the other hand, being based off-ward ($\beta = -0.256, p = 0.002$), working with an adolescent client group ($\beta = -0.199, p = 0.045$) and working on a locked rehabilitation ($\beta = -0.116, p = 0.039$) or a low secure ward ($\beta = -0.168, p = 0.015$) significantly predicted a lower level of DP.

A multiple linear regression was also calculated to predict PA based on the same independent variables. In this instance, the regression equation was not significant ($F(13,159) = 1.514, p = 1.118$), with an R^2 of 0.110, meaning that the predictors explained 11% of the variance.

Table 11. Multiple regression analysis with EE as outcome variable

Variables	B	SE B*	β	Sig.*	t	Lower 95% CI*	Upper 95% CI*
Age	-0.570	0.113	-0.406	p = 0.002	-5.158	-0.786	-0.346
Gender	-3.474	2.402	-0.108	n/s	-1.528	-8.088	1.461
Length of time in job	0.018	0.024	0.063	n/s	0.756	-0.032	0.068
Job role	-10.403	1.957	-0.330	p = 0.002	-4.787	-14.186	-6.613
Relationship status	0.948	2.106	0.033	n/s	0.466	-2.879	5.096
Number of children	-0.305	1.207	-0.022	n/s	-0.305	-2.774	2.187
School qualifications	4.549	3.889	0.161	n/s	1.384	-3.662	12.506
College qualifications	-	-	-	-	-	-	-
University qualifications	7.764	3.661	0.292	p = 0.029	2.501	0.80	14.756
Adolescent clients	23.381	2.647	0.665	p = 0.002	2.043	18.179	28.860
Female clients	2.647	2.104	0.102	n/s	1.310	-1.264	7.105
Male clients	-	-	-	-	-	-	-

PICU ward	-24.552	3.297	-0.688	p = 0.002	-2.112	-31.301	-17.886
Locked rehab ward	-6.725	4.176	-0.115	n/s	-1.695	-16.021	1.451
Low secure ward	-1.632	2.135	-0.057	n/s	-0.814	-6.267	2.236
Medium secure ward	-	-	-	-	-	-	-

**Standard error values, significance values and confidence interval values all reported after bootstrapping (based on 621 samples).*

Note: The three independent variables of college qualifications, male clients and medium secure ward were not included in the analysis, as they were held as the constants in the analysis and used as the reference group.

Table 12. Multiple regression analysis with DP as outcome variable

Variables	B	SE B*	β	Sig.*	t	Lower 95% CI*	Upper 95% CI*
Age	-0.298	0.059	-0.409	p = 0.002	-5.142	-0.413	-0.168
Gender	-4.459	1.420	-0.267	p = 0.003	-3.740	-7.169	-1.622
Length of time in job	0.015	0.012	0.102	n/s	1.214	-0.013	0.036
Job role	-4.200	0.885	-0.256	p = 0.002	-3.685	-6.027	-2.530
Relationship status	0.200	1.058	0.013	n/s	0.188	-1.787	2.244
Number of children	-1.193	0.588	-0.146	p = 0.043	-1.984	-2.275	0.046
School qualifications	1.644	1.856	0.112	n/s	0.954	-1.896	5.412
College qualifications	-	-	-	-	-	-	-
University qualifications	2.245	1.684	0.163	n/s	1.379	-0.850	5.665
Adolescent clients	-3.626	1.438	-0.199	p = 0.045	-0.604	-6.626	-0.714
Female clients	0.763	1.015	0.057	n/s	0.720	-1.203	2.854
Male clients	-	-	-	-	-	-	-

PICU ward	2.995	1.936	0.162	n/s	0.491	-0.811	6.648
Locked rehab ward	-3.497	1.748	-0.116	p = 0.039	-1.680	-7.065	-0.169
Low secure ward	-2.495	0.982	-0.168	p = 0.015	-2.374	-4.277	-0.499
Medium secure ward	-	-	-	-	-	-	-

**Standard error values, significance values and confidence interval values all reported after bootstrapping (based on 647 samples).*

Note: The three independent variables of college qualifications, male clients and medium secure ward were not included in the analysis, as they were held as the constants in the analysis and used as the reference group.

Table 13. Multiple regression analysis with PA as outcome variable

Variables	B	SE B*	B	Sig.*	t	Lower 95% CI*	Upper 95% CI*
Age	0.144	0.103	0.168	n/s	1.844	-0.057	0.348
Gender	0.856	1.786	0.043	n/s	0.532	-2.579	4.693
Length of time in job	-0.043	0.020	-0.250	p = 0.031	-2.615	-0.083	-0.005
Job role	2.668	1.445	0.138	n/s	1.737	-0.238	5.549
Relationship status	-0.376	1.481	-0.021	n/s	-0.261	-3.106	2.901
Number of children	1.716	0.869	0.179	p = 0.049	2.117	-0.051	3.362
School qualifications	-0.875	2.715	-0.051	n/s	-0.377	-6.016	4.922
College qualifications	-	-	-	-	-	-	-
University qualifications	-0.302	2.728	-0.019	n/s	-0.138	-5.370	5.088
Adolescent clients	-3.079	2.967	-0.143	n/s	-0.381	-8.605	3.146
Female clients	1.542	1.312	0.097	n/s	1.080	-0.819	3.991
Male clients	-	-	-	-	-	-	-

PICU ward	7.303	3.254	0.335	n/s	0.889	1.432	13.681
Locked rehab ward	1.830	2.032	0.051	n/s	0.652	-2.132	5.767
Low secure ward	1.801	1.298	0.103	n/s	1.272	-0.735	4.479
Medium secure ward	-	-	-	-	-	-	-

**Standard error values, significance values and confidence interval values all reported after bootstrapping (based on 637 samples).*

Note: The three independent variables of college qualifications, male clients and medium secure ward were not included in the analysis, as they were held as the constants in the analysis and used as the reference group.

Discussion

This study aimed to identify the level of burnout in a sample of forensic hospital employees and explore the relationship between the level of burnout and a number of risk factors. The study found that over half (52%) of the sample experienced high EE, 30% of the sample experienced high DP and 43% of the sample experienced low PA. When these results are compared to the normative data, it appears that participants in the current research reported higher than average levels of EE and DP. It possible that these higher than average burnout scores could be due to the added pressures of working in a forensic environment. Statistical analyses were computed to determine if there were any links between the independent variables and the dependent variables of EE, DP and PA. Overall, the quantitative outcome measures yielded some statistically significant results and some interesting observations can be made.

Multicollinearity:

Before discussing any of the findings, it is important to consider the multicollinearity of the variables. The term collinearity implies that two variables are near perfect linear combinations of one another. Indeed, when there is a perfect linear relationship among the predictors, the estimates for a regression model cannot be uniquely computed. The primary concern is that as the degree of multicollinearity increases, the regression model estimates of the coefficients become unstable. The tolerance and variance inflation factor (VIF) values for each predictor can be used to check for multicollinearity. O'Brien (2007) suggests that a tolerance of less than 0.2 or 0.1 or a VIF of 5 or 10 and above indicates a multicollinearity problem (O'Brien, 2007). Other researchers have proposed that either 5 (Ringle et al., 2015) or 10 (Hair et al., 1995) are the maximum levels of VIF (Hair et al., 1995). Additionally, Hair et al. (2010) suggest that if the VIF value exceeds 4 or the tolerance is less than 0.2, then there is a problem with

multicollinearity. As outlined in the results section, the three independent variables of college qualifications, male clients and medium secure ward were not included in the analysis, as they were held as the constants in the analysis and used as the reference group. Therefore, after excluding these variables, tests were run to see if the data met the assumption of collinearity. The results of these tests indicated that multicollinearity was not a concern for this data set. Indeed, all the VAF values fell below 5, and no values of tolerance fell below 0.2.

Age: Correlational analysis and multiple regression analysis both indicated that age was a significant predictor of EE and DP, with the younger staff being significantly more likely to report feelings of burnout than the older staff. The results of the current study appear to support the findings from previous meta-analysis (Brewer & Shapard, 2004) and primary research (Burdock 2016; Johnson et al., 2016), suggesting that younger staff experience significantly greater levels of burnout. This may be due to having less professional experience and, therefore, less time to develop effective coping strategies (Bilge, 2006).

Job role: Mann-Whitney U test results showed that ward-based staff were significantly more likely to experience EE and DP than staff who were based off the ward. These results are in contrast with the results of Elliot and Daley (2013), who found that MDT members experienced significantly higher levels of EE than frontline staff. However, the results of the current study may be explained by the fact that staff who are based off the ward have substantially less patient contact than ward-based staff. With this in mind, it is possible that a greater amount of patient contact may contribute to the higher burnout levels in ward-based staff. Indeed, it is nearly always the ward-based staff who are the primary responders to incidents on the ward, are present when patients are behaving aggressively and are present when patients are self-harming. Therefore, it is possible that witnessing such events cause the ward-based staff to

experience a greater amount of distress, which, in turn, increases their feelings of EE and DP. However, it is also apparent that a person's job role is directly related to the type of shifts that they work, as ward-based staff in this organisation work twelve-hour shifts (7-7s) on a rota system, while the MDT members work standard 9-5 shifts, five days a week. Therefore, this may have been what has contributed to the increased level of burnout in ward-based staff, as they may find the long shifts difficult and they may also dislike working on weekends, as it impacts upon their home lives. Moreover, it is also apparent that a person's job role is directly linked to their income, and the ward-based staff typically receive lower incomes than the MDT members, as all positions in the MDT require employees to have a university degree. Therefore, it is possible that ward-based staff may experience fewer financial rewards from their jobs, which subsequently impacts upon the level of burnout they experience.

Children: Correlational analysis and multiple regression analysis both indicated that having no children was a significant predictor of DP. Similar results have been found in public contact employees in a federal service agency (Maslach & Jackson, 1985), surgeons (Shanafelt et al., 2007) and professionals working in intensive care units (Embriaco et al., 2007). In each of these studies, MBI results showed that having children was associated with a lower risk of burnout. However, these results do not appear to have been replicated across mental health settings. It is likely that having a family provides a person with emotional resilience and a support network (Walsh, 2003). Additionally, people who have children are more likely to be more stable and more emotionally mature (Maslach, 2003). On the other hand, Elliot and Daley (2013), found that forensic health care professionals with children reported significantly more stress. Moreover, other studies have found that staff with children experience higher levels of burnout (Moreira et al., 2009) due to the conflict between their work life and family life.

Length of time at organisation: Correlational analysis revealed that there was a significant negative correlation between length of time at the organisation and DP, with the least experienced staff experiencing the highest levels of DP. Similar results have been found in general health nursing, where burnout rates are higher in newly qualified nurses (Finlayson et al., 2002; Gray & Phillips, 1996; Spinetta et al., 2000). However, these results are in contrast to the results of Elliot and Daley (2013), who found that the least experienced group of staff reported significantly less DP. Nevertheless, the results of the current study could be explained by the fact that staff who have worked at the organisation for a shorter period of time have not yet got to know the patients very well, so they may be more likely to experience DP. On the other hand, staff who have worked with the same patients for years have developed strong therapeutic relationships with them, so they are less likely to depersonalise them. However, such findings should be interpreted cautiously, due to the possibility of a correlation between this variable and the variable of age. Indeed, this variable was not found to be significant in the multiple regression analysis, whereas age was found predict both EE and DP. Therefore, it is possible that this variable is a confounding variable, which has produced a false association.

Education level: Multiple regression analysis indicated that education level was a significant predictor of EE, with a university-level qualification predicting a significantly higher level of EE. Staff who have been to university are more likely to be in higher-ranking jobs, which subsequently come with more responsibility, demands and stress. On the other hand, those who have been to university, but are in lower-ranking jobs due to the lack of opportunities for progression, may become frustrated with their working situation, which may lead to burnout. Indeed, similar results have been found in general health nursing, where educated individuals are more likely to quit their jobs in order to seek career advancement, especially if there are limited opportunities in their organisation (Tai et al., 1998; Yin & Yang, 2002).

Gender: Multiple regression analysis indicated that gender was a significant predictor of DP, with males more likely to experience significantly higher levels of DP than females. These results are supported by the findings of Dennis and Leach (2007), who found that female staff experience higher PA and EE, while males experience higher DP. Similarly, Alarcon et al. (2009) and Purvanova and Muros (2010) both completed meta-analysis studies to investigate gender differences in burnout. Interestingly, both studies found that men reported significantly higher levels of DP, while women reported significantly higher levels of EE.

Type of ward: Multiple regression analysis indicated that ward security level was a significant predictor of EE and DP. Working on a PICU ward predicted lower EE, while working on a locked rehabilitation ward or a low secure ward predicted lower DP. These results may be explained by the fact that patients on PICU wards typically only reside there for the short-term. Indeed, on PICU wards, the admission, assessment, treatment and discharge process is much shorter, when compared to secure wards. Therefore, it is possible that staff on PICU wards may be less likely to experience burnout, due to their regularly changing client base. A regularly changing client base may mean that staff are less likely to become overwhelmed by the same patients and the relentlessness of their behaviours. Moreover, the reward of seeing patients progress on a PICU may be more imminent, which may increase job satisfaction.

With regards to the locked rehabilitation and low secure wards, lower DP levels may be explained by the fact that these wards are typically seen as the less difficult wards to work on, with more settled patients and less incidents. Indeed, due to the gate-keeping assessment criteria to be placed on such wards, patients on locked rehabilitation and low secure wards typically present with lower risks and display fewer challenging behaviours, when compared to patients residing on medium secure wards. The difference in service specifications are

outlined at length by NHS England, who state that medium secure services ‘provide care and treatment to adults who present a serious risk of harm to others and whose escape should be prevented’ (NHS England, 2018b) while low secure services ‘provide care and treatment to adults who present a significant risk of harm to others and whose escape from hospital should be impeded’ (NHS England, 2018a).

As well as patient characteristics differing across wards, environmental characteristics also differ across wards. For example, a medium secure environment must implement certain procedural and relational security measures, which may not be deemed necessary on a low secure or locked rehabilitation ward. Subsequently, working in a more restrictive environment may lead to staff experiencing increased levels of burnout, as they may feel that they have less control over the restrictive environment and less autonomy to make their own clinical decisions. The JDC model (Karasek & Theorell, 1990) has made the case for the enabling role of control. This area includes employees’ perceived capacity to influence decisions and to exercise professional autonomy. Control problems may occur when workers have insufficient authority over their work or are unable to shape the work environment to be consistent with their values. A sense of efficacy is unlikely to occur when workers are feeling buffeted by circumstances or powerful people within the organisation (Leiter & Maslach, 2003).

Patient group: Multiple regression analysis indicated that patient group was a significant predictor of EE and DP. Interestingly, working with an adolescent client group predicted a lower level of DP, but a higher level of EE. Although working with an adolescent group is obviously emotionally exhausting, results showed that staff were less likely to depersonalise the adolescent clients and less likely to develop negative and cynical attitudes towards them. This is possibly due to staff seeing the adolescent patients as having poorer judgement and less

control over their actions when compared to the adult patients, as they have not yet fully matured (Steinberg & Scott, 2003; Steinberg et al., 2009). This is also possible due to staff believing that the patients are not at fault for their behaviour, given their young ages and their often traumatic backgrounds. Indeed, experiencing significant adversity in childhood, such as being exposed to violence and victimization, has damaging effects on a child's general well-being and lifelong health (Chapman et al., 2004; Felitti et al., 1998; Finkelhor et al., 2007; Flaherty et al., 2013; Turner et al., 2006). Furthermore, developmental, behavioural and biological research has clearly demonstrated the link between early exposure to stressful events and impaired neurological, physiological and psychosocial systems, which contribute to a wide array of mental and physical health problems (Shonkoff et al., 2009). As a result of this, staff working with young patients may see it as their responsibility to protect them and provide them with a safe, stable and nurturing environment, as it is something which they may never have had in their home lives.

Limitations: There are limitations of the cross-sectional design of the current study, in that it offers retrospective information only and the findings are bound to a single moment in time. Therefore, the findings of such studies often remain speculative, as cross-sectional studies are able to determine neither causality nor direction of an effect. Future research could employ a longitudinal design and collecting data from numerous time points, in order to robustly represent data. This type of design would show increases and decreases in burnout over time, which may allow for exploration into maintaining factors.

Further limitations relate to the measure utilised. While the MBI-HSS is a widely used and validated psychometric tool, a number of limitations of self-report measures do exist. These limitations are discussed at length in Chapter 2 and include issues such as: introspective ability, socially desirable responding and response bias. The effects of social desirability and response

bias can be detrimental to the outcome of a test and can affect the validity of the findings, which can subsequently have implications on the generalisability of the findings.

It is important to consider the reasons why staff may or may not have decided to participate in the study, as it is likely that the free-will and pre-existing attitudes of staff will have influenced their decisions. Staff may not have participated due to experiencing high levels of burnout and, therefore, they lacked the motivation to participate. On the other hand, staff may not have been experiencing any extreme emotions about their work and, therefore, they did not perceive the study to be relevant. Finally, experiencing high levels of stress or burnout may have increased the desire of some people to participate in the study, as they wanted their opinions to be heard. Consequently, these motives may have impacted on the response rates and findings.

Administering psychometric measures requires close monitoring, as is outlined in the MBI manual, which provides guidelines to minimise response bias. The authors of the MBI-HSS advise that respondents should ideally complete the MBI-HSS in private. The MBI-HSS can be completed at home, but there are drawbacks to this procedure. In the current study, a link to the MBI-HSS questionnaire was sent to participants via email. Therefore, the researcher did not have any control over the environment in which participants completed the questionnaire in. With this in mind, it is important to consider the possibility that some of the participants' answers may have been influenced by other people. However, in the essence of time and due to the relatively large sample size needed, it was considered to be unfeasible to monitor and supervise the environment that participants completed the questionnaire in.

Additionally, interpreting psychometric measures also requires close monitoring, as such measures are developed based on a specific population. Consequently, it is important for target

populations to be sufficiently similar to the sample populations, in order to increase the reliability of the findings of the measures (Craig & Beech, 2010). In the current study, the MBI-HSS was implemented, as this measure has been validated on a sample of individuals who work in mental health services. While forensic hospital employees fall within this category, it is important to note that the MBI manual does not outline whether forensic hospital employees were included in the normative mental health sample or not. Therefore, this may account for some discrepancies between the data from the current sample and normative data. In response to this limitation, the internal consistency of the MBI-HSS was calculated using the current study sample and the MBI-HSS was subsequently found to be of good reliability (22 items, $\alpha = 0.83$). Therefore, going forward, future researchers could potentially use the current study sample as a normative sample for forensic hospital employees.

Additional limitations relate to the generalisability of the findings. While the current study explored the risk factors for burnout in one organisation, it is likely that each forensic hospital employs their own practices and philosophies. This may create difficulties in comparing data across organisations. Moreover, the forensic hospital where the research was conducted is a privately-run company. Therefore, it is possible that the findings may have differed slightly, had the research been conducted in an NHS hospital. This is due to the fact that private sector hospitals are, in their nature, profit driven. Therefore, it is possible that staff working in private sector hospitals may be more likely to develop feelings of stress and burnout, as their patient-focused goals do not resonate with the commercially driven goals of the organisation. However, due to the current challenges faced by the NHS (Smith et al., 2014), especially with regards to NHS mental health services (Care Quality Commission, CQC, 2017; Mental Health Taskforce Strategy, 2016; Parliamentary and Health Service Ombudsman, 2018), it is possible that feelings of stress and burnout may be present across both private and public sector services.

Clinical implications: An important finding is the higher than average levels of EE and DP found in the current sample, when compared to the normative samples. These results would suggest that forensic hospital managers need to increase their awareness of staff well-being and consider the fact that their staff may be particularly susceptible to burnout, due to the forensic environment that they are working in. Overall, these findings are cause for concern, not only for the forensic hospital employees, their services and their organisation, but also because of the potential detrimental implications on the standard of care offered to the patients.

Based on these findings, preliminary strategies can be developed to target the staff who are at the highest risk of burnout (including younger staff, male staff, ward-based staff and staff with no children), by providing appropriate support and actively encouraging uptake. While all staff should undoubtedly be given the opportunities to access support, managers should perhaps emphasise, to certain staff members, the importance of having effective support networks in place in order to cope with the demands of the job. The support on offer to staff should include effective clinical supervision, which aims to allow staff to reflect on their experiences and work through their emotions within a safe environment (CQC, 2013). In turn, this opportunity to reflect would allow staff to feel supported, which subsequently maintains morale and job satisfaction and, ultimately, leads to enhanced well-being and staff retention. Feeling motivated and successful may also lead to reduced levels of burnout, by increasing levels of PA. Good quality clinical supervision has been found to reduce burnout across a number of healthcare settings, including mental health/psychiatric nurses (Arvidsson et al., 2001; Bowles & Young, 1999; Hyrkas, 2005; Magnusson et al., 2002), community mental health nurses (Edwards et al., 2006; Walsh et al., 2003), general nurses (Jones, 2003; Severinsson & Kamaker, 1999; Teasdale et al., 2000), intensive care unit nurses (Lantz & Severinsson, 2001; Magnusson et al., 2002) and dementia care nurses (Berg & Welander-Hansson, 2000). Therefore, greater use

of clinical supervision in forensic hospital settings may reduce staff absenteeism and staff turnover and, subsequently, minimise spending costs for the organisation (CQC, 2013). Moreover, there also appears to be a need for the routine monitoring of staff well-being, as nothing exists within the current organisation to support this. This could include ongoing discussions with staff regarding the emotions they experience as a result of their jobs. Again, when completing routine monitoring of staff well-being, managers should consider the staff who have been identified as being at the highest risk of developing burnout.

In terms of the impact of DP upon client outcome and therapeutic milieu, forensic service managers could consider adopting a psychologically informed environment (PIE), similar to the models of care that have recently been employed in homelessness services (Keats, 2012). A PIE is a therapeutic model of care that aims to provide a theoretical underpinning to the work of the unit and provide guidance for staff to work in a psychologically informed manner. PIEs take the psychological makeup of the patients into consideration in the way they operate, whilst also making an allowance for the psychological needs of the staff who work there (Johnson & Haigh, 2010). Ultimately, adopting a PIE approach can be beneficial and therapeutic for both the staff and patients on a ward (Breedvelt, 2016; Cockersell, 2011; Haigh et al., 2012; Johnson, 2014, 2015; Keats, 2012; Stronge & Williamson, 2014). If a PIE is encouraged by hospital managers and ward managers and the implementation of such an environment is supported by ward psychologists, then the DP levels of staff may decrease as a result of this.

Future individual-level interventions aimed at promoting the well-being of staff working in forensic services could include the use of educational interventions to enhance the capacity of employees to cope with the demands of their job. At the root of this approach would be teaching staff new ways of coping and strengthening their resilience. At the organisation involved in the

current research, it is apparent that no specific training to either combat burnout or improve staff well-being exists. Therefore, the introduction of a range of intervention strategies, which have been proven to reduce burnout across a range of healthcare settings, could be considered. Such intervention strategies could include: stress management training (De Vente et al., 2008), coping skills training (Awa et al., 2010; Halbesleben & Buckley, 2004; Van Dierendonck et al., 1998), assertiveness training (Scarnera et al., 2009), cognitive restructuring (Scarnera et al., 2009; Van Dierendonck et al., 1998), relaxation training (Van Dierendonck et al., 1998), cognitive behavioural therapy (Heiden et al., 2007; Rowe, 1999; Stenlund et al., 2009), group therapy (Salmela-Aro et al., 2004), meditation sessions (Murphy, 1996; Salyers et al., 2011; Saganha et al., 2012), mindfulness (Krasner et al., 2009; Salyers et al., 2011) and interventions to increase employees' sense of meaning and purpose (Robey et al., 1991; Salyers et al., 2011). Moreover, research also suggests that training forensic nurses in psychosocial interventions also significantly reduces their levels of burnout (Doyle et al., 2007; Ewers et al., 2002).

It has been suggested that the most effective mode of intervention is to combine changes in organisational practice with individual-level interventions (Maslach et al., 2001). However, making observations about the organisational structure are beyond the scope of this research. Nevertheless, a useful suggestion may be staff rotation, which would ensure that staff do not work on the same ward indefinitely and, subsequently, do not develop DP due to working with the same patients every day. Staff rotation would also ensure that staff have a break from their current environment and are given the opportunity to develop new skills with a different client group. Other ways to reduce staff exposure to stressful situations is to offer staff off-ward duties or the opportunity to become involved in other departments. Indeed, giving staff opportunities to develop their knowledge and learn new skills in different environments may allow staff to feel that they are progressing, which may subsequently protect against burnout. Strategies such

as this may be especially valuable with the staff who have university level qualifications, who may have become frustrated with their working situations, due to a lack of career advancement.

In addition to these suggestions offered by the current author, prior researchers have proposed a number of possible changes in organisational practices that may help decrease or prevent burnout, these include: increasing social support for employees, by teaching communication and social skills to supervisors (Burke & Richardsen, 1993; Halbesleben & Buckley, 2004), increasing employee autonomy and involvement in decision-making (Burke & Richardsen, 1993), reducing role ambiguity and role conflicts (Stalker & Harvey, 2002) and promoting self-care (Feingold, 2008). However, not all of these recommendations have been evaluated.

This study contributes to the evidence base in this highly specialised care area and is valuable to the forensic hospital in which it was conducted, as the results generated provide information regarding the level of burnout experienced by staff across the hospital. Going forward, it is hoped that ongoing staff training and supervision will increase knowledge, understanding and clinical skills, encourage reflection, develop support networks and coping strategies, enhance staff communication and working environment, promote collaborative working between teams and improve the psychosocial climate on the wards. In turn, it is hoped that this will improve both the experiences of staff and the experiences of patients.

Research implications: It appears that there is a gradually growing evidence base linking the unique challenges of working in forensic hospitals to a higher degree of burnout. Some of the risk factors for burnout identified in the current research corroborate the findings of other studies, while some contradict the findings of other studies. Therefore, there is evidently a strong need to continue to explore the phenomenon of burnout among staff who work in

forensic hospitals, as further research into this topic may provide further information that is beneficial to staff, patients and organisations.

Other areas of interest for future research include a greater exploration of the factors that may protect against burnout. It is now well-established that there are a range of risk factors for burnout, which are evident across occupations in a range of different countries (Maslach & Leiter, 2016). However, it has also been discovered that there are certain individuals who remain resilient to the phenomenon of burnout. Whilst these individuals are not immune to the impact of prolonged, job-related stress, they possess characteristics that serve as protective factors. A protective factor can be defined as characteristics or attributes that help people deal more effectively with stressful events and mitigate or eliminate risk. As a result of this, protective factors are associated with a lower likelihood of problem outcomes. Unfortunately, despite this acknowledgement, there remains a dearth of research on the factors that may protect mental health professionals from the experience of burnout. However, according to research into general healthcare professionals, there are a number of protective factors that future research into burnout in mental health workers could explore, these include: personality traits (Cooper et al., 2016; O'Boyle et al., 2011), social support (Cooper et al., 2001; Demerouti et al., 2001; Karasek & Theorell, 1990; Lim, 1996), autonomy (Kandelman et al., 2015; Karasek, 1979), optimism (Huang et al., 2016), emotional intelligence (del Mar Molero Jurado et al., 2018; Nightingale et al., 2018), coping strategies (Cañadas-De la Fuente, 2015; Gómez-Urquiza, 2017) and self-efficacy (Huang et al., 2016; Shoji et al., 2016; Ventura et al., 2015).

Moreover, the use of more qualitative methods to study burnout in forensic hospitals would also be advantageous. This approach may provide insight into the daily experiences of forensic hospital staff and may also enable a wider understanding about the meaning that certain events

have for individuals. With this in mind, the next study in this thesis will utilise a qualitative methodology to explore the experiences of stress and burnout in forensic hospital employees.

Conclusion: The current research supplements the growing body of literature into burnout in forensic hospital employees. In particular, this study adds weight to the notion that forensic hospital staff may experience particularly high burnout levels, as participants in the current study reported higher than average levels of EE and DP, when compared to the normative data. The percentage of participants experiencing heightened EE levels was particularly high. This study also provides evidence that certain risk factors may be associated with the development of burnout in this unique population. Overall, these results appear to support the commonly held assertion that working in a forensic hospital is an inherently stressful experience, which can lead to staff experiencing marked levels of burnout. However, further research is necessary, to determine the extent to which each individual risk factor contributes to the development of burnout. Further research is also necessary to consider the impact of other variables on the development of burnout, such as organisational factors and clinical factors. Furthermore, in the future, the use of qualitative methods to study burnout would be worthwhile, as this approach would provide greater insight into the daily experiences of forensic hospital workers.

Chapter 5

**'It's just a case of getting from one day to the next
without anyone dying': A qualitative exploration of the
experiences of forensic hospital workers**

Abstract

Using a qualitative methodology, this study aimed to explore the day-to-day experiences of forensic hospital workers. More specifically, this study aimed to explore how forensic hospital workers may come to develop feelings of burnout and which occupational stressors influence how they feel about their jobs. Twelve participants were recruited from a private forensic hospital in the North West of England. They took part in semi-structured interviews and the content was analysed using thematic analysis. Participants described both positive and negative experiences within their work. The data analysis yielded ten sub-themes, grouped under five superordinate themes, which were all perceived to contribute to feelings of stress and burnout at work. The themes identified included: inadequate resources (difficulty accessing support and training needs), the daily chaos (the nature of working with forensic patients and running the ward), no sense of community (problematic relationships with colleagues and a fractured team), consequences of the job (impact on my personal life and impact on my health) and rewarding our efforts (limited recognition and why I still do it. It was clear that participants felt passionate about the clinical aspects of the job and valued their work with the patients, which they found both rewarding and challenging at the same time. On the other hand, greater stress appeared to come from organisational aspects of the job, including negotiating complex relationships with colleagues and the organisation hierarchy. Participants typically saw the management as detached from the front-line staff, with a more commercially-driven agenda. Participants expressed a desire for further support, training and recognition. In conclusion, it is clear that forensic hospital workers experience a range of challenges within their work and they require appropriate support and resources to manage the demands of such.

Introduction

On a daily basis, forensic hospital employees face unique challenges and the pressures of providing care for extremely complex individuals can have a considerable impact on their health and well-being (Paton & Violanti, 1996). As discussed previously, working in a forensic environment means that staff working with offenders with a diagnosis of mental illness or personality disorder are likely to experience distressing and traumatic events and witness a variety of challenging behaviours, including verbal aggression, physical aggression, self-harming behaviours and suicide attempts. Working with offenders with a diagnosis of mental illness or personality disorder can therefore be difficult and maintaining a therapeutic but secure environment can be challenging. Moreover, the care of complex patients and the use of coercive measures to manage their risk is likely to be a stressful experience. Such demands may contribute to the onset of occupational stress and burnout.

Some studies have revealed, however, that organisational factors, such as a lack of support, rather than the nature of the patient group or contact with the patients, may be more strongly associated with stress and burnout for forensic mental health staff (Carson et al., 1995; Fagin et al., 1995; Schulz et al., 1995; Onyett et al., 1997). These can include the difficulty in achieving MDT working (Shaw et al., 2007), as well as the problematic divide between the different professional groups in the organisation (Davies et al., 2006). Similar findings were also obtained in a qualitative study by Kurtz and Jeffcote (2011), who explored the experiences of forensic hospital staff in two contrasting services. Overall, they found a difference between the clinical and organisational aspects of the job, with the latter reported to be more stressful. Additionally, Kurtz and Turner (2007) also employed a qualitative methodology, to explore the experiences of staff who care for people with personality disorder. The participants

appeared to derive considerable satisfaction from their work, whilst also experiencing intense frustration and difficulty in relationships with both the patients and their colleagues. However, the most significant negative pressures described by staff arose from the organisational context, rather than as a result of direct clinical work.

Lavender (2002) has suggested that forensic services face a particular challenge because society is so wary of offender-patients, and unsure of the role of forensic mental health staff. So, in addition to considering the impact of patients on staff, it is important to reflect on the dynamics of the wider environment as well. Indeed, government inquiries into malpractice at Broadmoor and Ashworth have highlighted systemic difficulties within these organisations, suggesting that mistakes can result from the general impact of work-setting on groups of staff, rather than the failures of particular individuals (Blom-Cooper, 1999; Fallon et al., 1999). To summarise, prior to 1990, it was reported that Ashworth had operated a harsh and repressive regime. Following this, the Blom-Cooper inquiry (Blom-Cooper, 1992) recommended a more liberal approach. However, these recommendations were implemented without proper consideration of their impact. As a result, the patients subsequently enjoyed most personal freedom and reduced security. The Fallon enquiry (Fallon et al., 1999) concluded that because of the failure of top management to lay down and enforce clear rules for both patients and staff, security became less and less important. As a result, more and more problems arose, but nobody attended to them. Nobody was seen to be in charge of the personality disorder unit: the senior management were out of touch, psychiatrists were deemed incapable, members of the board did not know what was going on and management decisions, if known, were frequently ignored by both staff and patients. Events within Ashworth were not reported to senior officials of the NHS or the Department of Health. Moreover, reports into serious incidents were suppressed. Therefore, the Fallon report concluded that the whole system was at fault.

In general occupational research, quantitative methodologies have long been used to identify the risk factors associated with employee burnout. However, risk factors alone tell us little about why employees experience certain feelings and how the symptoms of burnout can impact on them personally. Moreover, there is an apparent lack of qualitative literature that examines this phenomenon from the perspective of the individual worker. In fact, caring for clients with a forensic history is a unique experience. Therefore, it is clearly worth exploring the day-to-day experiences of forensic mental health workers, in order to learn more about staff experiences of occupational stressors and the effect of those stressors, as well as investigate the impact of burnout upon staff individually, their relationships with the patients and in the context of the wider organisation. Furthermore, using quantitative methodologies to determine who might be prone to burnout is clearly only the first step in a long process of understanding. The next step should perhaps be a more in depth exploration of the meaning that certain events have for individual employees. Therefore, it appears reasonable to suggest that quantitative risk-focused research should be supported by routine qualitative discussions.

Aims: This exploratory study aims to build on the existing body of literature regarding staff burnout in forensic hospitals, by supplementing the quantitative findings of the primary research study and developing a greater insight into the day-to-day experiences of in forensic hospital workers. More specifically, this study aims to address the following objectives:

1. Give a voice to the individual forensic hospital workers and develop a greater insight into their day-to-day experiences and what the job role constitutes.
2. Develop an understanding of how forensic hospital workers feel about their jobs and how they may come to develop feelings of burnout.

3. Explore if there are any occupational stressors or aspects of the forensic environment which may have influenced how the forensic hospital workers feel about their jobs.

Method

Design and methodology: Qualitative research is an interpretative, contextual and naturalistic mode of enquiry (Henwood & Pidgeon, 1996). In this instance, a qualitative methodology was deemed to be most helpful in aiding the collection of in-depth information from interviews and ensuring a thorough and detailed explanation of participants' views. Qualitative methods also aimed to bridge the gap between the existing literature, which consists of a small amount of quantitative results, and the real-life experiences of forensic hospital staff.

Epistemology: The epistemological stance adopted by the researcher was most closely aligned to a critical realist position. Critical realism is a meta-theory for social sciences. It is concerned with aspects of the philosophy of science, ontology (the study of being), epistemology (the study of human knowledge), and aetiology (the study of causes), along with conceptions of what constitutes an explanation or a prediction (Fleetwood, 2013). The critical realist paradigm entails a belief in an independent reality, but it does not commit one to an absolute knowledge of that reality (Scott, 2005). Rather, critical realists argue that the world is 'layered' into different domains of reality. Critical realists believe that there are unobservable events which cause the observable ones. Therefore, the social world can be understood if people go beyond the observable and investigate the mechanisms behind an event. Taking this into consideration, the researcher believed that what was said by participants during their interviews had some significance and reality for them beyond the bounds of the interview situation and that it represented a manifestation of their own psychological world, whilst also being connected to the external world (Smith, 1995).

When considering the epistemology of this study in relation to the data analysis, it is apparent that thematic analysis is not aligned to any pre-existing theoretical framework, so it can be used within different theoretical frameworks and can be used to do different things within such frameworks (Braun & Clarke, 2006). Thematic analysis can be an essentialist/realist method, which describes experiences, meanings and the reality of participants, or it can be a constructionist method, which investigates the ways in which events, realities, meanings and experiences are the effects of a range of discourses operating within society (Braun & Clarke, 2006). It can also be a 'contextualist' method, acting as a middle ground between the two extremes of essentialism and constructionism, which is characterised by theories such as critical realism (Willig, 1999). Such theories acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material (Braun & Clarke, 2006).

For this research study, a data-driven 'bottom-up' inductive method of thematic analysis was employed to reduce the impact of personal theoretic interest. For an inductive study, the researcher carefully reads and rereads the data, looking for key words, trends, themes, or ideas in the data that will help outline the analysis, before any analysis takes place. Inductive analyses are exploratory in their nature and, as such, they are commonly used to generate hypotheses for further study. In an inductive approach, specific codes will not be pre-determined, rather, they will be derived from the data. This means that the process of coding occurs without trying to fit the data into a pre-existing model or frame. The themes identified will, therefore, be strongly linked to the data, because assumptions are data-driven.

Research team and reflexivity: Reflexivity represents a continuous process of researchers reflecting on their values (Parahoo, 2006) and recognising, examining and understanding how

their social background, location and assumptions may affect their research practice (Hesse-Biber, 2007). Through reflexivity, researchers acknowledge the changes brought about in themselves as a result of the research process and consider how these changes may have affected the research process. Therefore, the researcher needed to reflect on the nature of her own involvement in the research process and the way in which this may have shaped the research outcomes. Arber (2006) suggests that one way to do this is to keep a reflective journal. Therefore, in the current study, this has acted as a reflective diary, as well as providing an audit trail. An extract from the researcher's reflective journal is presented in Appendix J.

It is also possible that knowing about the researcher's professional background could have impacted on the participants' willingness to talk openly about experiences. Indeed, participants were aware that the researcher was a Trainee Forensic Psychologist, who had previously worked at the organisation in a support worker role. On the other hand, it is also possible that knowing this information facilitated open communication, as the fact that the researcher had previously worked at the organisation allowed a level of familiarity and trust to be established.

Setting: This study was conducted in a private forensic psychiatric hospital in the North West of England. The hospital comprises of 15 different wards, including five adolescent wards, three female wards and seven male wards. The security level of the wards includes PICU, locked rehabilitation, low secure and medium secure. Admissions typically arrive from other forensic hospitals, prisons and non-forensic hospitals.

Sampling: Purposive sampling was used to obtain participants, as there was a specific group of the population that the research was targeting, with this group being staff who work in a secure forensic hospital. Out of this group of people, opportunistic volunteer sampling was

used and participants were staff who had responded to an initial advertisement via email. Only staff who had regular direct contact with the patients were invited to participate in the research.

Procedure: Email advertisements for participants were sent out by a neutral person, who was independent from the research team. This email asked those who were interested to make contact with the researcher, in order to organise an interview date and time. Each employee that contacted the researcher was interviewed at their place of work, in a suitable room, at a pre-arranged convenient time. Each interview was recorded for transcription after basic demographic information had been collected and consent had been obtained. The interviews lasted between 30-60 minutes. Following each interview, participants were asked how they found the interview, in order to ascertain whether the participant was distressed and required any further support. Participants were also asked if they would like to receive feedback after completion of the research and reminded of how to contact the researcher, should they wish to. Recruitment for participants finally ceased after twelve interviews had taken place, as this is when the researcher believed that data saturation had been reached.

Participants: Participants were from several different forensic wards across one hospital site, these wards included: a locked rehabilitation female ward, a low secure female ward, a medium secure female ward, a medium secure male ward and a mixed adolescent PICU ward. Twelve participants (ten females and two males) took part in the research and were all selected on a voluntary basis. The age of participants ranged from 23-63 years old. The participants included: six support workers, three senior support workers, one qualified nurse, one team leader and one member of the MDT. Overall, participants were considered to be experienced forensic hospital employees, having worked at the organisation for between three years and 15 years. However,

further details about individual participants cannot be provided, as staff would be identifiable by such details and confidentiality would be breached.

Development of the interview schedule: Two pilot interviews were carried out and the final interview schedule used was the third version. The two pilot interviews seemed to lack depth and appeared to elicit more general concepts, rather than emotional experiences. Due to this, the interviews were shorter than predicted. Therefore, more prompts were included in the real interviews, to encourage participants to expand on their responses. Additionally, during the pilot interviews, it became apparent that some of the questions were leading to overlapping responses. Therefore, these questions were merged together in the real interviews. The two pilot interviews were used only for the development of the interview schedule and were not included in the main study sample.

A semi-structured interview format was used to allow for flexibility to follow up relevant areas of interest that emerged during the interview (Smith, 1995). The benefit of this interview format was that it encouraged the participants to discuss their experiences, but in a fairly focused way. The interview schedule (see Appendix K) was designed so participants felt like they were having a collaborative conversation with the researcher, rather than being asked a series of questions. A set of topics to discuss with participants was prepared beforehand, loosely based around areas that previous research (as highlighted in Chapter 3) and psychological models (as highlighted in Chapter 1) have identified that may be related to the development of stress and burnout at work. The chosen topics were designed to give participants the opportunity to discuss issues which may resonate with them. A selection of prompts were also prepared beforehand, in order to supplement the topics chosen and to give participants other ideas to consider, if they did not raise them personally. Prompts were not formally scripted, as every

interview was different and covered a variety of different issues. Therefore, prompts were not always deemed necessary, but were typically used if participant's answers to questions needed further clarity or explanation. Informal prompts were also used, such as reassuring noises to show the participants that they were being listened to.

Ethical considerations: Once permission had been granted from the manager of the hospital (Appendix F), the research study was reviewed by the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee and given a favourable opinion. Before commencing the study, participants were provided with an information sheet (Appendix M), detailing the aims of the research study and what participation would involve. Participants were advised that their contribution was entirely voluntary and they were free to withdraw any time. Participants were informed that they would be audio-recorded on a Dictaphone and this was solely for the purposes of transcription. They were informed that their interviews would be anonymised in the resulting transcripts. Moreover, all data would be stored securely, in a password protected file, and would be kept securely for ten years, before being destroyed. Participants were also advised that the results of the study may be presented at academic conferences and in journals. After reading the information sheet, participants were given a consent form (Appendix N). They were then required to sign the consent form and answer several statements, to establish that they had read the information sheet carefully.

Participant distress: The interview contained potentially sensitive questions relating to the experiences of stress and burnout, therefore, two precautions were taken. The first precaution was that participants were advised that they could terminate the interview at any time. The second precaution was that participant distress was managed through guiding participants to seek support from their line manager or clinical supervisor, should they feel the need to.

Moreover, a number of qualified clinical psychologists and forensic psychologists who worked in the organisation were also able to offer support to participants, if necessary.

Transcription and analysis of interview data: The interviews were transcribed, including each word spoken by the researcher and the participant, pauses, laughs and hesitations. An example of one of the transcribed interviews is provided in Appendix L. The researcher approached the analysis of the interview data with the aim of understanding the content and complexity of the psychological world of each participant. The interview data was analysed through the process of thematic analysis, following Braun and Clarke's (2006) six-step framework. Thematic analysis is a method for 'identifying, analysing and reporting patterns or themes within qualitative data' (Braun & Clarke, 2006). The overall aim of thematic analysis is to identify patterns within the data that are important or interesting and use these themes to make a statement about an issue. Thematic analysis was selected specifically as it is a 'flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data' (Braun & Clarke, 2006). Moreover, it is a 'highly versatile' method of analysis, and it can be 'adapted to several kinds of research aim' (Coolican, 2009). Indeed, as thematic analysis is essentially independent of theory and epistemology it can be applied across a range of theoretical and epistemological approaches. As thematic analysis is not wed to any pre-existing theoretical framework, it can be used within different theoretical frameworks and is compatible with both the essentialist and constructionist paradigms within psychology. Due to its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data.

Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways

in which events, realities, meanings and experiences are the effects of a range of discourses operating within society. It can also be a contextualist method, sitting between the two poles of essentialism and constructionism, and characterised by theories such as critical realism, which acknowledge the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings (Braun & Clarke, 2006). As discussed previously, the epistemological stance adopted by the researcher for this analysis was most closely aligned to a critical realist position. The critical realist paradigm entails a belief in an independent reality, but it does not commit one to an absolute knowledge of that reality (Scott, 2005). Rather, critical realists argue that the world is 'layered' into different domains of reality. Six stages were undertaken in order to complete the process of thematic analysis:

1. Familiarisation with the data, including the transcription of the data.
2. Generating initial codes.
3. Searching for themes.
4. Reviewing themes.
5. Defining and naming themes.
6. Report write-up.

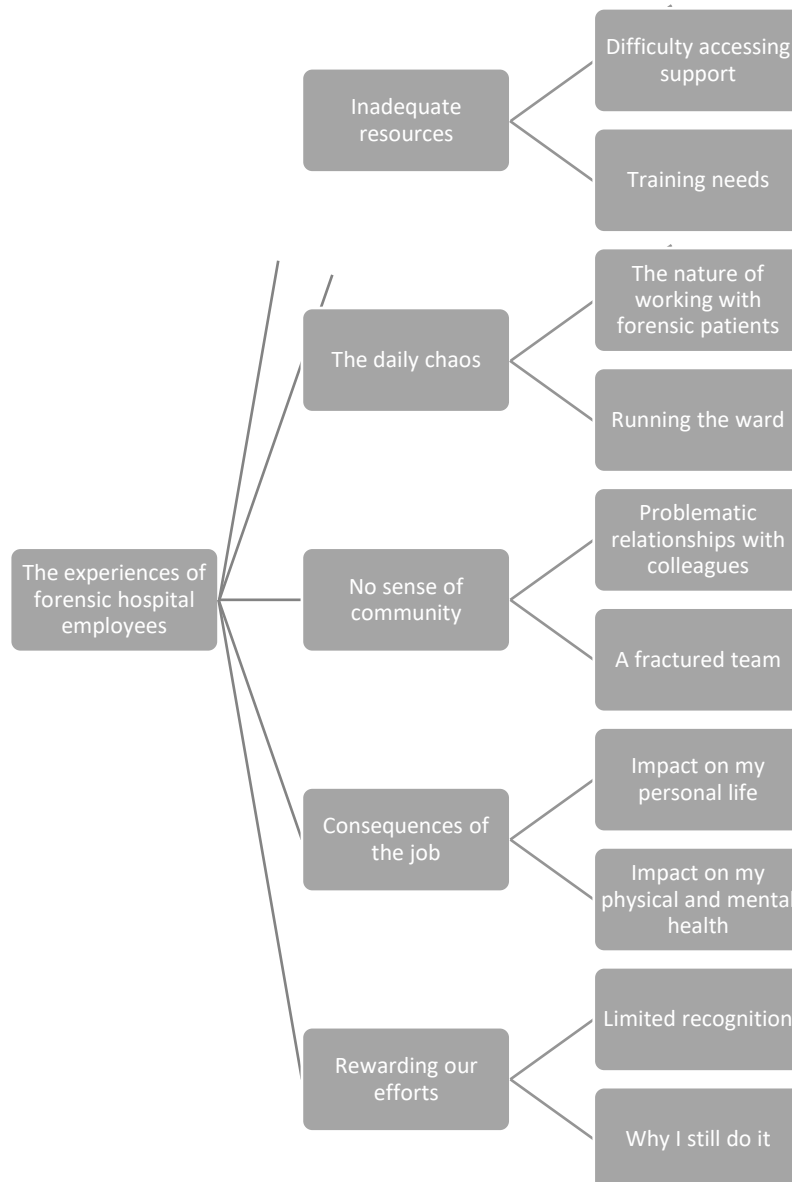
A data-driven 'bottom-up' inductive method of thematic analysis was employed (see Frith & Gleeson, 2004), to reduce the impact of personal theoretic interest. This inductive approach meant that the themes identified were strongly linked to the data that was collected through interviews. Inductive analysis is, therefore, a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven. Another necessary decision considers the level at which themes are to be identified. This method of thematic analysis took a semantic approach,

as the themes identified within the data were explicit/surface meanings of the data, as the researcher did not look for anything beyond what the participants said. However, the analytic process did also involve a progression from mere description, where the data was organised into patterns based on semantic content, to interpretation, where the significance of patterns were theorised, and their broader implications were considered in relation to previous literature.

Initially, interviews were transcribed by the researcher herself and, upon completion of this, transcripts were read and re-read, to aid familiarisation with the data. Preliminary ideas about codes were subsequently generated. Transcripts were then examined again and every segment of the text that was deemed to be relevant to the research question was coded. This was done by hand, working through hard copies of the transcripts with highlighter pens. When all the transcripts had been coded, the researcher explored if there was any overlap between the codes and, if so, which of the codes could be collated into preliminary themes. The themes identified represented some pattern or meaning within the data. The themes were then reviewed, modified and developed, to ensure that they were coherent and clearly distinct from each other. Finally, the themes were refined one last time, in order to identify the essence of what each theme was about and ascertain how all the themes related to each other, including how the sub-themes interacted with the main themes. Further analysis continued throughout the write-up stage and the themes continued to evolve, as the researcher developed her thinking about the material. A final thematic map was generated, which is displayed on the following page.

Results

The data analysis yielded ten sub-themes, which have been grouped under five superordinate themes. Superordinate themes, sub-themes and all their interactions are shown in the figure below. Each theme was labelled based upon interview quotes. While staff discussed some unique matters in their interviews which were personal to them, considerable homogeneity was observed across the twelve interviews. In the following section, the themes extracted from the data are explored and contextualised with the use of a number of participant quotes.



Superordinate theme: 'Inadequate resources'

Sub-themes: 'Difficulty accessing support' and 'training needs'

Difficulty accessing support: Participants identified a number of issues with regards to being able to access good quality, effective and confidential support at work. Participants typically painted a picture of a very demanding job, however, with a lack of support options available alleviate the stress associated with the demands of the job. The general consensus throughout the interviews appeared to be that participants did not feel supported by the wider organisation and those in more senior positions. Participants typically expressed that support was either not available at all, or inadequate. Therefore, when participants felt like they needed support, they typically reached out to people in similar roles to themselves, rather than reaching out to their managers or supervisors, who they felt very detached from. Indeed, the general feeling that came across throughout the interviews was that those in more senior positions are very detached from the ward-based staff and, as such, they are not in a position to provide effective support, as they are unable to truly empathise with what the ward-based staff may be feeling.

"If you have got the same break as someone, you can sit in the staff room and let it off there. But then sometimes, that isn't appropriate because of confidentiality, but sometimes you need to get it off your chest, because you then don't want to go back in off your break, still feeling so wound up, because then it's going to affect how you do your job. But, obviously it's all very well out letting to your friends, but they are in the same position as you, so they can't do anything" (participant 5 - support worker).

“You do get support from the support workers and the nurses, but anything higher up than that, you are just seen as like the bottom of the barrel because you’re a support worker and it doesn’t matter if you get punched or spat at” (participant 5 - support worker).

“If you have a problem or if you have an issue with the management or something or you try to raise an issue, then the support ends, if you know what I mean? The only people I feel I could turn to are the support workers and the people who actually work on the ward... the support workers, the nurses, the senior support workers” (participant 8 - support worker).

It also became apparent that many participants did not feel comfortable with their allocated supervisors and did not trust them enough to discuss their private lives with them. This was primarily due to not being able to choose supervisors from their own ward and their allocated supervisors subsequently being strangers. However, a number of participants also spoke about times when their own private information had been leaked outside the supervision room.

“They allocate it to certain people that you wouldn’t feel comfortable divulging certain information to, because you don’t know where that information is going to go. They say it’s confidential, but, I think the idea of it is to go and really let off steam, but I would feel more comfortable doing it to people that know the environment and work on that ward... someone you can trust and can say exactly what you need to say and you know it’s not going to go any further and you’re not going to be bit in the arse for it. But you’re not allowed a clinical supervisor who is on the same ward as you apparently, and I don’t know anyone that works on another ward that I would completely trust” (participant 5 - support worker).

“Nothing is private there. I mean, you can speak about something and you can have an issue with somebody... you’re not necessarily complaining, but you’re just putting it out there and saying... listen, this is happening. Then it gets back to people who you have issues with and then, obviously, people are looking at you as if then you’re this monster for raising this issue that nobody else wants to raise” (participant 8 - support worker).

“It was only the other day, somebody I was talking to... they’ve been struggling, having a bad time with work and outside of work at the moment. They had clinical supervision with a ward manager and they said they would never have it again because they told them some information about home life what they are struggling with and apparently it went round everywhere. So, it wasn’t confidential” (participant 9 - senior support worker).

It also became apparent that participants felt clinical supervision and line management were simply ‘tick box exercises’ put in place due to the requirements of the organisation, rather than effective ways of maintaining staff well-being. In addition, a number of participants expressed that they were not accessing line management or clinical supervision as they did not typically have any free time, due to their heavy work load, or their supervisors could not fit them in.

“You’re supposed to have supervisions monthly, but if you try and make an appointment with your supervisor, nine times out of ten, they’re too busy to fit you in. But then, your ward manager will check at the end of the month if you’ve had your supervision. And, if not, and you explain why not, it still always seems to be your fault” (participant 4 - support worker).

“We used to just get threw a piece of paper and were told, just sign it... and that was our supervision, that was it. Because, obviously, they like to dot the I's and cross the T's... so that

they want people looking in to think... oh, everything is done thoroughly, but it's actually not" (participant 8 - support worker).

"I've not had clinical supervision for, I don't know, probably a very long time. It's just basically, there's not enough time, you've got to have time off the ward and, you know, you've not got enough time to access that. And when you do line management, they just take you to one side for ten minutes, type up your line management and then get you to sign it. It's just an exercise, it's just a tick box exercise" (participant 10 - qualified nurse).

Unfortunately, it seemed that some staff had given up on seeking support entirely, believing that their concerns had never been taken seriously in the past, so there was little point in trying to confide in someone again. A number of participants expressed the belief that when they tried to access support at work, their problems were typically overlooked, their feelings were disregarded and their managers attempted to 'brush things under the carpet' or attempted to implement solutions which did not provide the staff with any resolution to their problem.

"There is no de-brief, there is no 'how do you feel'... all that happens is you do is get shipped to another ward" (participant 3 - senior support worker).

"It's very rare that you can get support. I didn't have any support when I was having a bit of a meltdown, until I'd had the actual breakdown on the ward, and that's when the support comes to you. Even though I'd been sending various emails to people saying I'm feeling down... but they just try and brush things under the carpet" (participant 6 - support worker).

“You’re talking and there’s still nothing happening... so you’re just going in there saying, sign that piece of paper for me please and I’ll walk away” (participant 6 - support worker).

Training needs: Participants typically painted a picture of a very challenging job, requiring a very unique set of skills and a considerable amount of specialist knowledge regarding mental illnesses and forensic services. However, unfortunately, participants also highlighted that there were a lack of training resources available for them to do their job to the best of their ability. Participants typically referred to the training sessions as inadequate, feeling that there had been recent reductions in the quality of training provided by the organisation. Moreover, participants expressed that they would like more in-depth training in a range of different areas, in order to improve the standard of patient care that they could offer, but the opportunities were not there.

“It’s a business, rather than a care-setting, so the training has fallen a little on the way side. The training that we used to have access to, we can’t have anymore. I’m a senior support worker and I’ve worked there for three and a half years. I’ve been doing immediate life support for all the time I’ve been there. I’ve just been on training today for basic life support. Because now, I’m not allowed to do certain things because I’m not qualified, so I’m not legible to do that anymore. So, if you do that, you know, you’re going to be liable in court. So, right now, currently, I feel that the training is getting thin. It’s not good enough. Because I don’t care whether you are qualified or not... if I have to save someone’s life, I have to save someone’s life” (participant 2 - senior support worker).

“We got offered PD training, but I don’t think it was effective, because it was only like 9-5 training and I feel like you need a lot more than that. And they said it was substantial. But it was just someone talking on a power point. But I found it hard to work with PD patients,

especially then, that's why I wanted to get more information about that. Because I feel like I could manage PD service users better than I am doing now... I feel like I could give them a lot more than what I am giving them now" (participant 6 - support worker).

"Yeah, I think the training... it's basically, mostly just regarding policies, you know, about 90% of the training is policies and paperwork and things like that. Whereas they don't actually do practical training with you, which I think people learn better by doing practical stuff rather than... do you know what I mean?" (participant 10 - qualified nurse).

Participants also highlighted that the needs of the ward on a daily basis typically outweighed the training needs of staff, so training sessions would be cancelled if the ward was under-staffed on that particular day. This led to staff becoming frustrated, as they had been looking forward to attending particular training sessions, which were being regularly cancelled.

"But there have been times where you have been on the training and then you get taken off that training last minute... you're told that you cannot go on that training because of staff shortages, so you're then not benefitting from that, because it's like specific training to like personality disorder or DBT, stuff like that, that could help you be a better support worker. You're then missing out on that" (participant 5 - support worker).

The lack of adequate training was also reflected in the new staff coming into the organisation, who many participants believed lacked the necessary knowledge and skills in order to work in a forensic hospital. Indeed, a number of participants expressed the belief that the new staff being recruited by the organisation were 'out of their depth' and were not being provided with the necessary information that you need when working with such a complex client group.

“They have changed their style of training now, it’s not as in depth and it’s less educational and when people come through to the wards they have no idea about mental illness, they don’t really understand what the forensic service means or why people are there and, you know, it really shows in the standard of staff we get, from what we used to get to what we get now. So, for me, I have worked in different services within the hospital and had better training in the past, so I feel like I’m quite well educated... but it really shows on the new starters, that they are just not getting good enough training” (participant 10 - team leader).

“Five years in, I feel like I know my job like the back of my hand. But, I do think now that, the new staff that are coming in, I don’t think that... I think the training should be more in depth, from seeing them come onto the ward. And then I think... you’ve just done two weeks of training, how do you not know this? Kind of thing” (participant 4 - support worker).

“I’ve had about four new starters who I have spoken to and they really don’t get what different mental illnesses are and that’s quite scary” (participant 11 - team leader).

“It’s a ridiculous training system, because it’s two weeks and it just isn’t long enough and that’s part of the problem with the people that work there that are coming through without any experience” (participant 12 - MDT member).

For some staff, the lack of training opportunities at work had subsequently resulted in them seeking out those opportunities themselves, signing up to college courses and participating in training in their own free time, in order to provide a better standard of care to their patients.

“Personally, for me, well I have gone and done it myself, I’ve gone and paid privately. I would still only be a level two if I stayed within the hospital, so I think the hospital, if they are calling themselves a specialist in deaf mental illness then they should provide the right training, which shouldn’t just be three weeks long. You can’t learn anything in three weeks, in my opinion, I think it’s absolutely not going to happen” (participant 4 - support worker).

Superordinate theme: 'The daily chaos'

Sub-themes: 'The nature of working with forensic patients' and 'running the ward'

The nature of working with forensic patients: Participants identified a number of concerns related to the nature of working with forensic patients, which primarily centred on managing patients who were presenting as a risk to themselves or others. Staff identified that they spent a considerable proportion of their working lives dealing with patient incidents, such as self-harming behaviours, damage to property, verbal aggression and physical aggression.

"I've been hit, kicked, head-butted... I've actually got permanent tissue damage on my chest from being head-butted by one of the patients" (participant 4 - support worker).

"Today, I didn't get assaulted. Prior to my last shift, I've been assaulted quite a few times. I've been, punched, bitten, I've had quite a bad bite recently... I've been kicked, head-butted, I had my breasts exposed the other week, strangled..." (participant 10 - qualified nurse).

"Verbal abuse and aggression is a constant battle. I think, if I don't get verbally abused once within the day then, you know, I think it's a very rare day. I can't remember the last time that I went to work and didn't get verbally abused in some way. Physical aggression, that's a constant risk for every single staff member on the ward. For me personally, last weekend I got kicked into the door and thought I had broken my elbow. Two weeks before that, I was off work for three weeks because one of the patients nearly broke my ankle. So constant physical aggression towards staff members is a daily thing" (participant 11 - team leader).

“We have got two patients at the minute who are extremely high profile and I think they are the ones that kind of burn the staff out, due to their relentlessness... the challenging behaviours we have got are continual self-harming... by insertion, choking, ligaturing, cutting constantly throughout the day” (participant 11 - team leader).

Throughout the interviews, participants often referred to the ‘dangerous’ environment that they worked in and it became apparent that managing risky behaviour was a key part of the job. Despite this, staff did not typically express that they felt unsafe on the ward.

“I never felt unsafe at all. Obviously, you know, it gets your adrenaline going, because you think... woah, what’s coming next? You know, what’s going to happen now? Why are they angry at me? What have I done? I’ll be honest with you... it’s questioning yourself... have I done something wrong in my job? Have I said something that I shouldn’t say? Is it actually my fault? Because, in this job... you’ve got to question yourself, you’ve got to make sure you’re doing the right thing. Because, otherwise, you wouldn’t be a good worker. So, it made me feel unsettled, unsettled I’d say... but not unsafe, no” (participant 2 - senior support worker).

However, despite never feeling acutely unsafe, staff did express that they felt that they were always ‘on their toes’, due to the unpredictable nature of the environment. Staff described the need to be alert and vigilant, which sometimes led to them feeling uneasy. Staff also expressed that they could never truly relax in such an environment, as they were always attempting to be ‘on the ball’, anticipating what may happen next. Staff outlined that they often consider the worst case scenario, as they never really know what situation they could be walking into.

“I’m not scared of any of them and I don’t feel intimidated by any of them, but it’s that fear of not knowing... it’s like when [name] is blood-letting in the bathroom, obviously you open the bathroom it’s like... what you going to see? Like, it could be something out the chainsaw massacre or she can just be sat on the toilet” (participant 3 - senior support worker).

“They are vulnerable people and at any point, if they wanted to, they could kill themselves and that’s always in the back of your head, all the time. No matter what, how they’re presenting or whatever, you don’t know what is going to happen. You’re always on your toes, all the time” (participant 6 - support worker).

However, it appeared that staff had grown ‘used to’ to this aspect of the job. Although such challenges were to be ‘expected’ in a forensic setting, this did not excuse violent behaviour.

“It’s part and parcel of the job, isn’t it? At the time, I didn’t feel that, obviously. I was really upset, angry... but, now, you just live with it, don’t you?” (participant 4 - support worker).

“Obviously we know it comes as part of the job and people are going to be unwell, but that’s not what we go there for. We are not there to be fighting with people or be getting punched and kicked and getting called every name under the sun, but most of the time that’s what you are there for and it’s not a nice environment to be in” (participant 5 - support worker).

“I think unfortunately, again, it’s one of the things... when there are serious incidents like self-harm, you kind of get used to it, don’t you? Because you see it every day. Some of the girls are pretty unwell, so I expect it” (participant 11 - team leader).

Despite the frequent comments that participants made about managing patient incidents on the ward, on the whole, the participants did not appear to have any ill-feelings towards the patients and did not feel that their relationships with the patients were problematic. In fact, participants typically spoke fondly of the patients and consistently outlined that the most enjoyable and rewarding aspect of the job was their direct clinical work.

“We are all there for the patients... as much as it is sometimes a horrendous environment to work in, we all want the best for the patients” (participant 8 - support worker).

“The therapeutic time we do get with the patients... that’s my favourite part of the job, because you feel like you’re actually... you’re spending time with them, you’re helping them, you’re just normalising their life a little bit, you know?” (participant 10 - qualified nurse).

It seems that staff in this type of setting may have become somewhat hardened and desensitised to dealing with patient incidents, as they see such matters as simply ‘part of the job’. This was particularly evident in the blasé manner that some participants spoke about patient incidents. This could be due to the fact that staff see patients as less in control of their behaviour, due to their mental health problems. However, it is also possible that this blasé manner may have been a defence mechanism, to cover up their true feelings, as they do not want to appear weak.

“I don’t think I feel unsafe, in that sense, because I just think... I’ve been punched in the face, so, that’s out the way now” (participant 5 - support worker).

“I got punched in the face once off a patient. It did hurt. I knew it was coming and I just didn’t move quick enough” (participant 6 - support worker).

Running the ward: Participants identified a number of issues with regards to how the wards are run on a daily basis. The types of issues centred around the fact that the wards were not particularly organised and the fast-paced environment often felt hectic and chaotic.

“It’s very busy, there is a lot going on all of the time” (participant 4 - support worker).

“Unorganised is a good word, like running around like headless chickens, especially on day shifts because there is so much going on” (participant 5 - support worker).

“An appointment could come up, someone could be ringing saying your solicitor is here, and then you’re like... what’s just happened? Where is everyone? How can we get this patient to go and see their solicitor or how are we going to get the solicitor over here with no staff? It’s just... in them situations, it’s chaos” (participant 6 - support worker).

“A lot of people are very unclear on what to do, they don’t know how to manage... simple things like not understanding why they need to change round on observations and stuff so, I think that it is unorganised as a whole” (participant 11 - team leader).

Staff also expressed that the job expectations were high and the work load was substantial, with not enough hours in the day to get everything done. On top of the patient-care aspect of the job, the work load of staff was increased significantly by the added pressures of paperwork. In their interviews, participants typically expressed that they found it difficult to maintain an effective balance between their clinical duties and the paperwork side of the job.

“You’re chasing your tail all the time. Always chasing. You’re always catching up. Every single shift, you’re catching up from the last shift” (participant 2 - senior support worker).

“If we work 10.75 hours... ten of those hours, I will be on observations. Which gives me that tiny little bit to do paperwork, which, in reality, that is not enough time. So, you’re spending your breaks catching up with paperwork. So, I feel like, if you’re expected to do ten hours of obs, how can you also be expected to do paperwork and sessions and stuff like that? You’re only one person, you can’t split yourself in half” (participant 4 - support worker).

“On the days you’re overloaded with work, it’s a nightmare. Like, you’re expected to do all the paperwork and things, as well as deal with all the incidents... that’s if incidents are going on. And then, if you’re dealing with the incidents and the paperwork isn’t done, then they ask you why that paperwork isn’t done” (participant 6 - support worker).

“Expectations of the job role that you’ve got, in the time frame you’ve got, it’s just basically unmanageable... it’s unrealistic... it’s a high work load we’ve got and minimal time to complete” (participant 10 - qualified nurse).

“It’s hectic, very hectic... too much work and not enough hours in the day. I’ve got a huge work load at the minute. There is literally not enough time to do what needs to be done in my job at the minute... it’s just crazy” (participant 12 - MDT member).

Due to the heavy work load and the regular patient incidents, participants outlined that they were often having to act outside their job role, or ask other staff to act outside their job roles, to ensure that all the necessary tasks were completed by the end of the working day.

“You just have to delegate the responsibility of everything, aside from medication, down to them, so we can make sure that we are getting the paper done. You just have to enforce a delegation and ensure that everyone is getting stuff done, like they should be doing. You have got no choice really and that means that, not only are we under a lot of pressure, we are putting pressure on people who aren’t really qualified to take that pressure, but they have to take it whether they like it or not to make sure that things are getting done. Because obviously we’ve got patient care side, but then you have got the paperwork side of things as well”
(participant 11 - team leader).

“It’s not just doing a nursing role, it’s doing like... a support worker role as well and then obviously you’ve got to contact the parents, so it’s a social work role, so you just basically... it’s like you been put in a blender” *(participant 10 - qualified nurse).*

The issues discussed above are then further exacerbated by staffing issues, which participants described as being a regular occurrence. Participants outlined that the wards are often running on low staffing levels and this can leave the wards feeling unsafe. This also impacts on the ability of the ward staff to deliver a good standard of patient care and facilitate activities for the patients, in terms of visits, section 17 leave and therapeutic sessions. Staffing can also be problematic when the staff on a ward are under-skilled or are unfamiliar with the ward, which has a knock-on effect on the patients, as they do not know or trust any of the staff members.

“So you’re left with two permanent staff and six bank staff. Not saying anything about bank staff, but they don’t know the ward, they don’t know the patients, right? So, then there are problems... the patients don’t like it” *(participant 2 - senior support worker).*

“So, if we work off seven... we probably have five every day. You know, someone is always sick, or there is always someone doing a drive, or say one of our patients has got a home leave... the management will never look at that beforehand and think ‘oh, we need an extra two staff on that shift because they are going to be out all day from seven to seven’ ... they will actually take it out the core numbers, which will leave only five staff on the ward, which is absolutely ridiculous. So every day it’s either sickness, staff out on leaves or they are being moved wards or they have got to do favours like driving for others wards, so you have never got a full staff team... it’s ridiculous” (participant 4 - support worker).

“If you have got an agency nurse that has never worked there, you know you are going to have thirteen girls all at you, because you are the only one that knows them... you are the only one they trust” (participant 4 - support worker).

“It’s the biggest issue that we have in that place, because they are never increasing numbers, it’s always decreasing numbers. So, most of the time, you are just sat around watching people, because you don’t actually have the resources to do anything therapeutic with them. It kind of just makes you think, well why am I even here?” (participant 5 - support worker).

“There’s just not enough staff. And, maybe, it’s not even more staff that they need, it’s just more skilled, trained, experienced staff. Because you could have 50 staff members on that ward some days and it would make no difference what so ever. Whereas you could have a team of seven or eight staff that knew what they were doing and I think that would make the team’s job a hell of a lot easier” (participant 12 - MDT member).

Participants also raised issues with frequently finishing late and not getting their breaks, with this having a knock-on effect on their personal lives and their mental and physical health.

“At quarter past seven, you should be walking out the door... but, actually, you are clock-watching still. Then half seven comes and quarter to eight comes and it’s just like... you are just there for another hour, before you know it” (participant 4 - support worker).

“On day shifts I find sometimes you don’t get your full break or you don’t get a break at all and it’s expected. It’s kind of... well, what do you expect? But it’s like... I wouldn’t even be bothered if I didn’t have my full break, but half an hour to get away from it, go and have a brew or something to eat in peace would be nice” (participant 5 - support worker).

“There was a period over the summer from May to August where I didn’t have a single break barely anytime. So that’s like four months without a break, or you get like half hour just to have a minute, but never leave on time. Shifts finish at quarter past seven and I get out about twenty-five to eight most nights, it’s a bonus if I get out at quarter past seven... never ever have I ever finished at my designated end of shift time. I think it was getting to a point where I was getting pretty burnt out and stressed” (participant 11 - team leader).

“I think I’m owed nearly a week in time in lieu, because I’ve had to stay late so many times and I don’t get chance to have a dinner break” (participant 12 - MDT member).

However, the issue which appeared to cause participants the most stress and frustration was the 'allocation sheet' and the distribution of observations. To summarise, the allocation sheet was described by the participants as basically being the 'plan for the day', which details where staff will need to be at all times, to ensure that the shift runs smoothly. The allocation sheet incorporates patient observations, sessions, visits, section 17 leaves and staff breaks. However,

many staff disagreements were related to the allocation sheet, with disputes typically focused on an unfair distribution of observations and staff not helping each other out.

“The senior support worker each morning will do the allocation shift for where the staff should be every hour, which obs... obviously we have communal area obs, corridor obs, seclusion obs most days, one to ones, two to ones... and the staff that are taking over you, they don't come on time, so that means you're not at your next obs on time, so it's just like dominos really” (participant 4 - support worker).

“I'm always stuck on obs, I never get to go on my break on time because I'm covering other people's obs. I could be down the corridor for four hours before someone actually comes to take over. That means I'm not going to the toilet, I'm not eating, I'm on my feet for four hours walking up and down the corridor, it's not healthy” (participant 4 - support worker).

“Like... they do an allocation sheet and it's not always... people aren't always there to cover that allocation... and you get people whinging 'oh, they're not coming covering' or 'I've been here two hours' or whatever” (participant 6 - support worker).

“They complain about the observations that they're doing, so they will come up to me after I've done the allocation and they will say 'I've got seven hours of obs' or 'I've got this many hours of obs' and I'm thinking, you know what, come in the office and do the handovers and do the notes and free me up, you know what I mean? (participant 10 - qualified nurse).

Moreover, the poor running of the ward was further exacerbated when unplanned patient incidents materialised and had to be dealt with. These unplanned incidents subsequently had a knock-on effect on the daily planner, such as patient visits, appointments and section 17 leaves.

“You do work a twelve-hour shift and patients do go to bed, but on the frequent occasion when patients will not go to bed and they are causing incidents, things don’t get done. And when the things that are not done that the management asks for, then they start coming down on us and say well you have enough staff, you have enough time to be doing it. But we don’t... not when incidents are arising” (participant 8 - support worker).

“I have got the responsibility to ensure the basic things like medication is done, that everyone is getting foods and drinks in seclusions, that everyone is where they should be on the allocation sheet, that staff are getting breaks, that I am getting a break... but then, obviously, if you’re have got incidents thrown into that, that throws the allocation sheet off, it throws staff stress levels up, it means that staff don’t get breaks” (participant 11 - team leader).

Superordinate theme: 'No sense of community'

Sub-themes: 'Problematic relationships with colleagues' and 'a fractured team'

Problematic relationships with colleagues: Participants identified a number of issues in their relationships with the other staff members on the ward, the people who they must work closely with on a daily basis. Accounts of relationships with ward-based colleagues were often full of emotion, both positive and negative. On one hand, relationships with ward-based colleagues provided necessary support in a difficult, often risky, working environment.

“If you're on the shop floor and the patients kick off, I feel really supported, because I know that within seconds the rest of the team are going to be there and we can deal with it as a team together. I don't feel scared of the patients, because if they do kick off or assault me, I know that the team will be there to handle and manage that situation, as fast as I can pull my alarm” (participant 4 - support worker).

On the other hand, spending twelve hours a day with some colleagues often led to an unpleasant and hostile atmosphere. Problems with colleagues typically centred around issues such as bitching, disagreements, some staff not working as hard as others and personality clashes.

“The relationships I have with them, some of them, they're a little bit up their own arses. So, at the moment, it's a little bit problematic. Some of them, you know, they're refusing to do stuff. Refusing to go to a ward. Now, I can't accept that, because we're just all in the same job, nobody is better than anybody else” (participant 2 - senior support worker).

“There are people that grid my gears because they either do nothing and sit in the office... and then you’ve got people there who haven’t been there as long as you and they’re trying to tell you how to do your job. And you’re just thinking... don’t tell me what to do. I mean, you can ask me to do something, I don’t mind, but don’t come out and start dictating what I should and shouldn’t be doing or where I should be. Or you’ve got people that think they know everything or you’ve got people that take the job a little bit too far. And then you’ve got people there who can be quite intimidating as well” (participant 5 - support worker).

“All the support workers bicker amongst each other and all they do is they slag each other off. So, you’re trying to, like... manage the way the dynamics of the ward all the time, so you feel like a bit of a counsellor as well” (participant 10 - qualified nurse).

There was an acknowledgement that close support networks were often built in this type of environment, due to the nature of the work bringing staff closer together. However, this was typically dependent upon the staff team that was working on that particular shift, and it was evident that relationships were stronger with some colleagues and more distant with others.

“I love the way the teams... when you get a full established team... the way they support one another, you know, when times are bad, you just get through the shift, just because the staff support you (participant 10 - qualified nurse)”.

“We’re not just colleagues, we’re friends as well. We weren’t at first, we were just colleagues... but then we work so close to each other that you become you become friends. So, the people that I work with as colleagues, are now extremely good friends of mine” (participant 8 - support worker).

At times, relationships with colleagues became so intense that ‘cliques’ formed, which subsequently impacted on the team dynamics. Consequently, when intense relationships with others at work were formed, this often led to some staff not working as hard, as they were more concerned with spending time with their friends and less concerned with patient care.

“If they have been out on the Saturday, they will sit in the office on Monday morning and discuss what happened on the Saturday... which means that they are not actually on the shop floor. So you’re doing double work, because the staff member that should be with you is actually talking to their friend in the office” (participant 4 - support worker).

Feelings of inequality and unfairness between ward-based staff were also evident throughout the interviews, with a number of participants expressing that favouritism was common in the organisation, with certain staff having access to more opportunities for progression than others. Moreover, participants expressed that certain staff were frequently given a ‘nicer’ day, whereas other staff would be allocated more duties and would typically be much busier. In addition to this, some participants expressed concerns that their breaks were shorter than others. Instances such as this appeared to cause much friction in the relationships between staff members.

“You always get favouritism wherever you go, I guess. But... you see people who get to do all the nice section 17s and they’re not on as many obs as other people, when certain people do the allocation sheet” (participant 5 - support worker).

“It’s not what you know, it’s who you know. You could be working your butt off and some people just sit on their arse all day and get what they want (participant 6 - support worker).

“In some situations, people can go for an hour and a half break... but then they come and tell you that you can only go for half an hour. And you think... why am I only going for half an hour, when you’ve had your full hour and a half?” (participant 6 - support worker).

“I guess there are some [opportunities for progression], but it’s kind of... if your face fits... it’s a certain exclusive club, to which I’ve never been a part of” (participant 8 - support worker).

A fractured team: Participants typically painted a picture of a fractured staff team, with splits apparent throughout the organisation, all the way up from the bottom of the hierarchy to the top. Participants identified a number of issues in their relationships with the management of the organisation and, throughout the interviews, frequently referred to the divide between the ward-based staff and the management of the organisation. Participants expressed that they wished there could be more integration between the ward-based teams and the management. However, they felt that the two teams were very detached and separate from each other.

“The hierarchy... they’re all living on fifty grand a year... driving in in BMs and Lexuses and... I’m not saying that none of them don’t deserve their jobs or whatever... but I just think, the difference between them and us... it shouldn’t be them and us... it should be a complete and utter joint team effort” (participant 2 - senior support worker).

In order to give account for this separation, participants typically presented themselves as very patient-focused, while they saw the organisation hierarchy as very detached from the front-line staff and the patients, with a more commercially-driven agenda.

“You know, people who are traumatised, who are there for them? The fifty grand a year people with the Lexuses and the BMs aren’t there for them, because they don’t give a shit, they don’t know what their names are” (participant 2 - senior support worker).

Participants also expressed that another one of their main issues with the management of the organisation was that they were never present on the wards, which subsequently meant that they did not understand what working in a patient-facing role actually entailed. Therefore, they could not truly appreciate the difficulties that ward-based staff faced on a daily basis.

“They’re never on the ward... they’re just sat in offices all day. And I just feel that, you know, take a step in our shoes, work a twelve-hour shift” (participant 3 - senior support worker).

“Management don’t realise how much we actually do and what we actually do. Because the amount of times we get emails from higher management asking what we’ve done and they literally want half an hour snippets from a week, just so they can justify why they’ve got you on site... and I don’t think they quite realise” (participant 12 - MDT member).

Participants also outlined another issue with the organisation management was that they do not communicate properly with the ward-based staff. As a result of this poor communication, the management often make decisions without considering the repercussions of those decisions on the ward-based staff. Indeed, participants typically felt that the management did not listen to their opinions and, therefore, decisions were being made that were not working in practice. Participants also felt that sometimes, management did not even acknowledge who they were. This was particularly disheartening for the participants, as they are the people who spend twelve hours a day with the patients, so they felt strongly that their opinions should be heard.

“There needs to be more of a connection with the hierarchy... just more connection with the actual people who are on the front line, because none of them are on the front line. Not just telling us what to do and changing things and making us do things. They need to listen to us... we’re working with these patients all the time, not them. So, to make it better, they need to sit down with us on a regular basis and discuss things. Not saying we will be right, not saying they will, but at least compromise, you know, at least give us the time of day or the acknowledgement of, you know, who we are” (participant 2 - senior support worker).

“They make up these rules, but I don’t even think they have worked a day on the ward, where it is intense. They make up these rules and then, obviously, we have to deal with the backlash from it and we don’t even get so much as a ‘so what do you think would be better’ or ‘how do you think it’s working so far’. They don’t take your opinion into account. They just do what they want to do, because it costs less, most of the time” (participant 5 - support worker).

As well as a divide between the management and the ward-based staff, another commonality present throughout the interviews was that of a divide between the different disciplines.

“Nursing and social work never really get on, because we just have completely separate opinions on everything. But, we make the best of it” (participant 12 - MDT member).

As well as a divide between some of the disciplines, the ward-based staff expressed that they had differing opinions on patient care when compared to members of the MDT. Indeed, the ward-based staff felt that the communication between the MDT and themselves was poor, with the MDT rarely taking their points of view into consideration.

“You speak up about it to the MDT and they basically... they basically just shoot you down, without the gun” (participant 2 - senior support worker).

“It’s the communication between the MDT and us. Between psychology and us. It doesn’t seem to, you know, just gel. It really doesn’t. Even though we say what we’re supposed to do and we ask them for advice and we give them our opinions, we write in the notes and they tell us to do these things and we do them... pfft... and then, most of the time, they either override us or ignore us and that’s my honest opinion” (participant 2 - senior support worker).

Similarly, members of the MDT also felt that they had different opinions on patient care when compared to the ward-based staff. The MDT blamed this on a lack of understanding from the ward-based staff, claiming that ward-based staff did not know the patients’ histories as well and, subsequently, did not understand the rationale behind decisions. However, the ward-based staff would often question or attempt to override the decisions made by the MDT. These differences in opinions subsequently led to the patients being able to split the team.

“We’ve had incidents where the MDT have decided really low thresholds for patients to go to seclusion and there’s been a really strong rationale for that. But then, obviously, the ward staff are questioning it, saying... well, it’s not the MDT who are having to get into holds with these patients, it’s us. So, there’s definitely a split there. And, also, the ward staff don’t see the rationale behind the decisions. And there’s definitely a lack of understanding from the support staff, but I think part of that comes from the inexperience of them and not knowing the patients properly and not knowing all the histories of the patients, so I think that’s where that comes from. I don’t think it’s helped by the nursing staff... I think the nursing staff can fuel that kind of split as well” (participant 12 - MDT member).

“The patients are getting really inconsistent care. From one aspect, you’ve got seniors or really experienced staff who know the patients well and they don’t necessarily listen to the decisions made by the MDT or are questioning the decisions that are made and they think ‘it’ll be alright, I’ll just give her this to keep her calm for the minute’. And then the patients can see and pick where things are weaker... and the patients tend to pick on the complacent staff and also the newer staff and the patients are then able to split the teams massively, to the point where they’re even splitting the nurses (participant 12 - MDT member).

Superordinate theme: 'Consequences of the job'

Sub-themes: 'Impact on my personal life' and 'impact on my physical and mental health'

Impact on my personal life: Participants often spoke about the difficulty of maintaining a healthy work-life balance, with their work life often spilling into their personal life. Participants disclosed that their job often impacted upon their personal relationships, as their partners and families did not understand the stresses of working in a mental health setting.

"I do come home and I do take it out on the people I love the most. I feel like they don't understand. They just think that you should just go into your job, do your job and come home... it's not as easy as that. You're not only dealing with your own problems... you're dealing with the patients' problems as well" (participant 8 - support worker).

"I feel like coming home to my personal life, my work just overflows into it. And you can have a really rubbish shift and you come home and you just can't switch off. You're thinking... I could have done this better, I could have done that better... and the people that we love, don't understand that, so it causes friction in the relationship (participant 8 - support worker).

"My partner isn't from a mental health background and he doesn't understand it. He doesn't understand the fact that you're staying later or you're coming home anxious and stuff. He doesn't understand, you know, even though you leave there, you are still responsible. If you did something wrong that day, you didn't document something or you didn't hand something over... it could potentially impact on your career (participant 10 - qualified nurse).

Participants also spoke about the impact that shift work had on their lives and outlined that getting up early, working twelve hours and getting home late impacted on their physical and mental health, with staff often feeling exhausted and drained at the end of a twelve hour day. Participants painted a picture of being isolated from the outside world, due to being at work for twelve hours, often never leaving the building throughout the entire day, and then going home and going straight to bed, in anticipation for tomorrow's shift. Furthermore, participants also highlighted that shift work affected their social lives, as being exhausted on their days off impacted on their ability to maintain their personal relationships. Indeed, participants typically felt that their days off work were wasted, as they typically spent those days recuperating in bed.

“The shift patterns to me are just absolutely diabolical. We're there early, we finish late, sometimes you don't get a break, you know... you're getting up at half five and you don't get home until nine. It has a bad impact on your life, it really does. And you're doing overtime as well... you're doing overtime to get more money because of the shit pay... well, then you've got no life at all” (participant 2 - senior support worker).

“I don't want to talk to people after work really, for a good couple of hours. I don't want to speak to no one, not even my best friends in the world. I want to get home, not speak to no one, have a shower, have a few drinks and then, that's it... by the time you've done all that, it's eleven o'clock anyway, so you're in bo-bos, because you're getting up for half five the next day. So it's a bad impact on your personal life” (participant 2 - senior support worker).

“You don't ever get time at home as it is... you're up at five o'clock and not getting home until eight, half eight, sometimes even later, so you have got to force your tea down, have a

shower and force yourself to bed, because you're up again at five o'clock for your next shift. You might as well have never spoken to the outside world" (participant 4 - support worker).

"You're off Monday and Tuesday, but you had the worst weekend in work ever, so you spend Monday just lazing around, so you've lost a day already" (participant 4 - support worker).

Participants also outlined that, even when they had left work, they would sometimes struggle to 'switch off' at home and would continue to question themselves over the decisions that they had made throughout the day, wondering whether they had done the right thing. Participants also expressed that they struggled to switch off when they had been involved in incidents, as this caused their adrenaline to kick in, which has subsequently meant that they were physically unable to relax for some time afterwards. Furthermore, participants also struggled to switch off when they were feeling anxious about their next day in work, apprehensive about what they would be walking into and worrying whether any of their colleagues would have been hurt.

"I couldn't switch off when I went home. And I used to be worried and I couldn't sleep. And I used to be thinking... did I do that right? Did I say that right? Or maybe... could I have done that a bit different?" (participant 1 - support worker).

"If something is affecting me at work, like, I will either not sleep well because I will have been so wound up that I can't shut down. That's my worst issue, like, I wish I could be one of them people that think, right, I walk out of the door and all my problems are left behind... but I can't, like, it follows me home" (participant 5 - support worker).

“So, you have just finished a day shift, then one of your friends is starting the night shift, you will spend the night worrying what is going to happen to them, especially if they’re not on with a really good team. Then you are just up all night thinking ‘oh my god, they could be in A&E because they have been battered’, or something” (participant 5 - support worker).

“The majority of the time, I switch off. But sometimes, recently, it is getting harder and harder to switch off. So, even though you feel like you’ve switched off... your body, you feel anxious, you’ve got your adrenals going, you’ve had about 50 coffees just to get through the shift... you know? So, like, your mind has sort of switched off, but then sometimes your body doesn’t switch off, your adrenaline is still going” (participant 10 - qualified nurse).

Impact on my physical and mental health: A key theme which was apparent throughout all the interviews, was how the job impacted upon the physical and mental health of the staff at the organisation. Participants spoke about the job affected their lives and outlined a number of aspects of the job in particular, including the physically exhausting shifts and the emotionally draining patients, which impacted on both their physical and mental health. Moreover, worries about going into work sometimes led to staff experiencing anxiety. Furthermore, participants expressed that when both their personal and professional lives were causing them to feel stressed, this had the potential to be an overwhelming combination.

“I had time off for stress. But, that was not only to do with work, but that was to do with home as well. So, it just had a bit of like... combined” (participant 1 - support worker).

“Feeling exhausted all the time, even if I do get a good night sleep, I wake up and I still feel exhausted, like your whole body just feels drained. You can’t enjoy anything because you are always thinking about work and stressing about that” (participant 5 - support worker).

*“It just gets on top of you, I think working there for three years is enough for me. I think working there too long can affect your mental health as well, because it is a tough job”
(participant 6 - support worker).*

“I don’t want to go into work. I just feel emotional all the time, like, everything just upsets you and, whenever anyone says anything, you just get upset by the littlest thing. I suppose, you can’t describe it, because you don’t know until you’re there at that point. So, building up to it, you haven’t got a clue until you’re like... boom...” (participant 6 - support worker).

“Low mood, you know, sometimes I don’t even want to get up... it’s just, I don’t want to get up, I don’t want to go to work. On my days off, I’m doing nothing but sleeping and staying in bed. So it’s taking its toll on my personal life as well” (participant 8 - support worker).

“Just being anxious about going to work, you know, taking your stress home, being snappy, not enjoying normal situations that you usually would” (participant 10 - qualified nurse).

As well as describing the impact that the job had on both their physical and mental health, some participants even suggested that they, or their colleagues, may have been experiencing burnout.

“I have definitely witnessed burnout, I have been doing this job for five years. There was a unit I worked on and it was a specialist women’s PD unit. I experienced burnout on there and

I did end up leaving to go to the unit where I work now, purely for the fact that I was just tired, fed up and burnt out” (participant 3 - senior support worker).

“I do think I am burnt out, even little things get to me a lot more now” (participant 4 - support worker).

“I’ve felt burnt out quite a lot actually. Erm... over the years, but I’ve always ended up moving to a different ward and then, you know, starting a fresh and then it slowly starts creeping in again, you know?” (participant 10 - qualified nurse).

“You can quite easily become burnt out and I think a lot of people do get burnt out pretty quickly. I have definitely been burnt out before, to the point where I have had to have time off work for it, so it’s a reoccurring thing for a lot of people” (participant 11 - team leader).

“It was a couple of years ago and... it was just constant massive incidents every day, four or five of the same sort of incidents every day, for nine months... so I guess nine months of intense stress and pressure leads up to burning out so... I’m quite surprised I lasted that long, to be honest, because it was intense” (participant 11 - team leader).

“Every time I look at my diary for the week after, I just think... I’m not entirely sure how I’m going to manage this week. So... I don’t feel burnt out at the minute and I haven’t felt burnt out for the last year or so, but, I wouldn’t be surprised if very soon I was like... I’m not going back. Because it’s just getting ridiculous” (participant 12 - MDT member).

Participants also outlined that, when the physical and mental health of staff begun to deteriorate and staff started to experience some of the symptoms of burnout, it subsequently impacted upon the standard of patient care that was being delivered on the ward.

“Some of my colleagues... because they just feel depressed and they don’t want to do their job properly as well... I can’t be arsed with this, I can’t be arsed with that... so then, it reflects on everyone, it’s like a domino effect, isn’t it?” (participant 6 - support worker).

“A lot of people have got the ‘really don’t want to be there’ attitude. And you can tell, because it’s written all over their face and it’s written in the way they interact with the patients and it’s evident in the care that the patients are getting, because it’s not up to the standard that it should be” (participant 12 - MDT member).

“The patients know when the staff have low morale, because they are not as engaging with them. Like, obviously, they will do their job, but they are not... I think the patients prefer it when it feels more like they are not staff. Like, not their friends, I know that’s not the right word but, you know, you can just sit there and have a laugh with them. Then obviously it doesn’t feel like such a closed environment, then it feels more natural and then that’s more comfortable for everyone, not just the patients (participant 5 - support worker).

As well as impacting upon the standard patient care delivered, participants also recognised that the impact of the job could ultimately lead to people leaving the organisation, with a high staff turnover typically being seen by the participants as a common feature of working in a forensic hospital and something which they witnessed regularly. Indeed, a number of the participants

expressed their desire to leave the organisation and join alternative mental health organisations, while some of the participants expressed their desire to pursue alternative careers entirely.

“I am looking towards doing something else. Because, yeah, I don’t think I could continue to cope with those sorts of wages for much longer” (participant 9 - senior support worker).

“Morale is very, very low at the moment... so I’m quite stressed with it and I’m actively looking for new work” (participant 10 - qualified nurse).

“I think that’s a constant battle with the forensic services isn’t it, because it is an environment where people get burnt out quite easily, so I think it means the high turnovers of staff, so when people start to feel that way, the morale dips. And I think that really, on a whole, throughout the hospital the morale is not good and that’s what makes people leave, so it ends up just all the new staff all the time” (participant 11 - team leader).

“I have made my decision that I don’t want to be a nurse anymore. I think I am satisfied to an extent, but, for me personally, there is more to life than where I work at the minute. I feel as a job, it is pretty unsatisfying, and we have to suffer a lot of verbal, emotional and physical abuse... when I can be a big man and get fifty grand a year” (participant 11 - team leader).

“As a long-term thing, I wouldn’t stay in it, because I think you will be grey by the age of thirty. I feel like it is a highly intense and stressful job and it’s not a job I would stay in for a long period of time. But I do like it when I am there and I do like helping people... but it’s not something I will be staying in for a long period of time” (participant 11 - team leader).

Superordinate theme: 'Rewarding our efforts'

Sub-themes: 'Limited recognition' and 'why I still do it'

Limited recognition: Throughout the interviews, participants frequently referred to feeling unappreciated and typically expressed the belief that there was a distinct lack of rewards for doing the job that they do. This lack of rewards included both a lack of financial rewards and simply a lack of recognition for all their hard work. In terms of financial rewards, the general consensus across the interviews was that the job was incredibly under-paid, considering what the job role entails and how challenging the job is. Indeed, it became apparent that participants felt that they were doing a very important job, as they were working with very complex and unpredictable clients, they encountered dangerous situations at work on a regular basis and they always had to be 'on the ball', ready to react, anticipating what could happen next. With this in mind, participants felt that they were extremely under-paid, especially when they compared themselves to other people in jobs, such as those who worked in shops or fast-food outlets, as they believed such jobs to be considerably less challenging and less dangerous. Participants also expressed that they felt demoralised, as they were unable to access pay rises, even when they had worked at the organisation for a substantial length of time.

"Any job like this... to me, you're looking after people, you're dealing with people's lives, you're actually looking after humans... human beings, you're in charge of their lives. So, if I don't do something right, somebody dies. It's a person's life. Why are you not paid more money? I don't know why. You should be paid danger money as well, you know, they kick off and it does get a bit scary. I don't know why you're not paid enough. But we're not paid at all adequately" (participant 2 - senior support worker).

“People in McDonalds, right, get paid danger pay for working nights... and I think, danger pay, what is the worst they’re going to get? And then, sometimes, on some of the wards, we’re dealing with people that have committed awful crimes and wouldn’t think twice about stabbing you in the eye or whatever. I do not think the pay reflects the job at all, it is extremely underpaid, not even just a little bit” (participant 5 - support worker).

“To be brutally honest, it’s crap. Fourteen grand a year. I think that is a kick in the teeth, basically. But they don’t care, they just won’t put it up, because people will still go to their jobs and do it, won’t they? So... that’s staff morale as well, with the pay. They’re asking for pay rises because they’ve been there so long and they’re still not getting them. And they’ve got all this experience! And then you get all these other little rewards, but accessing them is hard. They don’t make it easy for you to get rewards” (participant 6 - support worker).

“The one part of the job I don’t like is the pay, because it’s rubbish and it doesn’t reflect the responsibility and how challenging the work can be” (participant 9 - senior support worker).

“It’s shocking! And especially for support workers it is, because, you know, people that are stacking shelves at Aldi get paid a lot more than what the support workers do. You know, it’s minimum wage, you know, and it’s not even like you get danger money and it is a dangerous job” (participant 10 - qualified nurse).

As well as issues with the low pay, participants also wanted recognition for the hard work that they put in each day, as they were doing a very demanding job and were typically getting no acknowledgement in return. The general consensus throughout the interviews appeared to be that participants did not feel valued by their employers, as they were never thanked for their

efforts. In such a challenging work environment, participants felt strongly that a little bit of recognition would make a big difference, in terms of boosting staff morale and letting staff know that their efforts were appreciated. However, participants typically felt that all their hard work went unnoticed by those in more senior positions. Furthermore, participants expressed that when people were being recognised, it was the wrong people who were being recognised, with those in management receiving awards and the ward-based staff receiving nothing.

“Getting the recognition for it would be a start. Like, when you do a good job. Most of the time you are only picked up on if you have done something wrong, never for when you have done anything right. There is no praise or appreciation for things, even when you do go above and beyond” (participant 5 - support worker).

“You’re not valued there, like, you’re just a number” (participant 6 - support worker).

“Even just like a thank you email, you know, when we’ve had a typical horrendous night... when you have 3, 4, 5, 6 patients having an incident, you know, you don’t get anything. It’s not like we want to be praised constantly, but when we do a good job, we want the management to acknowledge that, you know, that you’ve done a good job and you’ve managed the situation (participant 8 - support worker).

“It’s like... they’ve just said that’s there are some recognition awards at the [name] hotel, but the only people that are going to it are the management. But they’ve not done anything to manage all this stuff, they’re just the ones that are reaping the rewards and I think it’s a bit of a piss take” (participant 10 - qualified nurse).

Why I still do it: A key theme present throughout the majority of the interviews was that, despite all the issues that participants raised about their jobs, they all still had their reasons for why they continued to work there. In the majority of cases, this reason was the patients. Indeed, despite having to manage a wide range of challenging behaviours from the patients, participants typically spoke fondly of the patients and frequently stated that their time with the patients was their favourite aspect of the job. It was also clear that their therapeutic relationships with the patients meant a great deal to the staff, who had put a lot of effort into building them up.

“I love it really. I love being able to make a difference in someone’s every day. I love... even if it’s only making something to eat with them or having a game of scrabble... if I can make their day a better day, by just even having a chat and a brew... you know, it makes me feel better that I’ve helped somebody through the day” (participant 1 - support worker).

“The therapeutic time we do get with the patients... that’s my favourite part of the job, because you feel like you’re actually, you know, you’re spending time with them, you’re helping them, you’re just normalising their life a little bit” (participant 10 - qualified nurse).

Moreover, seeing the patients progress and feeling that they had ‘made a difference’ in the lives of the patients were typically cited as being the most rewarding aspects of the job.

“As much as it gets to you, and it does get to you some days, but as much as it does, the rewards are better. When you see patients leave and go home or go to a supported accommodation... you feel like you’ve done a good job” (participant 1 - support worker).

“I find my job quite rewarding in a sense that, if feel like you put the input and you put the effort into someone’s care, they will give a bit of gratitude back. And that, you know, it is quite rewarding, especially when you see them get discharged after so long of being in services. So, that’s a positive note” (participant 3 - senior support worker).

“I like going home with the patients, it’s really nice to see them with their families again and, you know, just that bit of normality that they have, for that day. It’s really nice knowing that you’ve took them there and if it wasn’t for you, then they wouldn’t have had that day. And it’s really, really nice seeing them discharged as well, because then, actually, all your hard work really has paid off (participant 4 - support worker).

“There’s one patient in mind... like, she’s like a completely different person now. And you feel like you’ve been part of that, because you’ve been there to support her through things and you’ve had a good relationship, which is why, you know, you’ve had a part of that, because she’s trusted you at times when she hasn’t trusted other people. So, that’s a good feeling” (participant 5 - support worker).

“When a patient is self-harming and you go in and you kind of talk them down from doing it... you bring them like distraction techniques and they go away and they will go to the bed and go to sleep, and they wake in the morning and be thankful and you go home and you think... this is why I do this job” (participant 8 - support worker).

“I do like making a difference... I do like seeing people recover and discharged... that is rewarding. Just recently, somebody got discharged and they wrote me a nice letter before they got discharged and I was quite touched by that” (participant 9 - senior support worker).

Finally, participants also conveyed a strong duty of care towards the patients, especially after the difficult upbringings that many of the patients had experienced. Participants expressed a great deal of empathy and compassion towards the patients and, due to their traumatic histories, the staff typically felt a sense of protectiveness over them too.

“People who’ve been through life, people who are traumatised, who are there for them? Somebody’s got to be there for them, somebody’s got to help them, who is it? Somebody’s got to do it... and, to be honest, I’m good with people. You know, I’ve not a had a perfect life myself. So, that is the reason that I’m staying at it... because somebody needs to help these people” (participant 2 - senior support worker).

“I get to know the patients and I get to see the good side of them. And, not only that... I see the families and the history... I see what they’ve been through and why they’re behaving like this. A lot of the support workers and even some of the nurses don’t quite understand where some of these behaviours have come from. To be honest, I think I’d feel pretty shit as well, if my mum had picked my rapist father over me. Whereas a lot of the nursing team that are getting abused every day, they don’t understand where these behaviours are coming from. And then I get links with families and I get to go and have a brew with grandma [name] and get brought biscuits and... it’s the patients that I stay for” (participant 12 - MDT member).

Discussion

Overview of findings: Using a qualitative methodology, the current study aimed to develop a greater insight into the day-to-day experiences of forensic hospital workers. More specifically, the current study aimed explore how forensic hospital workers may come to develop feelings of burnout and which occupational stressors may have influenced how they feel about their jobs. Staff outlined which aspects of the job they enjoyed and which aspects they found the most difficult. The qualitative findings of this study provide the context for the quantitative findings of the primary research study contained in this thesis. The qualitative findings provide an insight into the experiences of forensic hospital staff, as they encounter situations and live through them. The qualitative findings also reveal a number of distinct occupational stressors, which may be linked to the development of burnout in forensic hospital workers.

As can be established from the identified themes, participants described a number of both ward-level issues and organisation-level issues. Ward-level issues included problematic relationships with colleagues, the nature of working with forensic patients and difficulty running the ward, while organisational-level issues included training needs, difficulty accessing support, a lack of recognition and a fractured team. Staff also expressed a number of individual concerns, including worries over their work-life balance and the way in which the job impacts upon both their physical and mental health. Participants expressed a desire for further support, supervision and training, as they typically feel that are simply surviving and not thriving in their jobs. Staff also expressed a desire for greater recognition and rewards, as they only reward they currently have is spending therapeutic time with the patients, with this being cited as the main reason why the staff continue to do the jobs that they do. Finally, participants expressed that the demands of the job were impacting upon both their physical health and mental health, with

some participants referring to feelings of burnout. When the physical and mental health of staff begun to deteriorate, it subsequently impacted upon the standard of patient care that was being delivered and, ultimately, led to an increased number of staff leaving the organisation.

The clinical and organisational aspects of the job evoked different types of emotion in staff. Staff appeared motivated by the desire to generate positive change in the lives of patients, often highlighting their direct clinical work as the most enjoyable and rewarding aspect of the job. Despite reporting many patient incidents, sometimes on a daily basis, staff did not appear to experience a considerable amount of stress directly as a result of these incidents. Indeed, staff appeared to accept the fact that managing patient distress and challenging behaviour was an integral part of the job. Instead, stress seemed to stem from the organisation's response to such situations, such as not having enough staff to manage an incident safely or not receiving adequate support after an incident. In some cases, participants even attributed the cause of incidents to organisational issues, such as a lack of therapeutic activities available or not enough staff to facilitate section 17 leaves, rather than to the patients themselves. Moreover, participants attributed greater stress to difficult relationships with their colleagues and their experience of the organisation in general, especially with regards to the management. They depicted an organisation which was divided into different groups based on hierarchy, with contradictory ideas about the nature of the work being undertaken. Participants described the agenda of their managers as different from their own, seeing managers as commercially-driven and themselves as patient-focused. Participants typically found this split in ideologies difficult to comprehend, as they saw their role as, first and foremost, caring for the patients.

Relation to existing literature: This research suggests that organisational-related issues can present considerably more of a problem for forensic hospital employees than contact with their

patients, which is consistent with previous research into stress and burnout in healthcare staff (Carson et al., 1995; Schulz et al., 1995; Onyett et al., 1997) as well as forensic healthcare staff (Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007). Given the emotional demands of caring for mentally unwell patients, added to the increased risk of violence in mental health hospitals (Renwick et al., 2016; Shiao et al., 2010), it is interesting that participants typically attributed their stress levels to the organisational aspects of the job, rather than their direct clinical work. However, it is possible that participants directed their frustrations towards their colleagues and the organisation in general, rather than their patients, as the patients are perceived as ill. As such, they are perhaps considered to less accountable for their behaviour (Markham, 2003).

To explain the findings discussed above, psychoanalytic organisational theory suggests that working in forensic hospitals can lead to the build-up of both conscious and unconscious anxiety, as regular contact with forensic patients can be complicated and traumatic (Dartington, 1994; Hinshelwood, 1993). Staff may find it hard to acknowledge the difficult feelings which contact with serious offenders arouses, out of concern as to whether they will be able to cope with such feelings (Kurtz, 2002). As a result of this, staff are likely to resort to defended ways of dealing with their distress, unless they are highly trained and the working environment is very supportive (Cherniss, 1995; Hinshelwood, 1993, 2004; Winnicott, 1949). With this in mind, it is possible that staff's unmanageable feelings towards the patients may be displaced and projected onto their colleagues instead. This may have occurred in the current research, as it is less acceptable for staff to feel anger and resentment towards the patients, due to their mental health problems and their seeming lack of control over their behaviours. However, this is just one explanation, and serious consideration should still be given to the strong influence of organisational factors on staff burnout. Furthermore, it is also important to remember that the method of thematic analysis utilised in the current study took a semantic approach and the

researcher did not look for anything beyond what the participants said. Therefore, to go beyond the explicit/surface meanings of the data is beyond the scope of this method of analysis.

In the current research, staff had to negotiate complex relationships with their colleagues on the ward, the wider MDT and the management of the organisation. Participants spoke about being part of a team as a positive experience in one sense, but there was also a strong sense that working with other professionals represented a source of conflict and potential stress. This supports findings from previous research in forensic mental health settings (Chalder & Nolan, 2000; Kurtz & Jeffcote, 2011; Kurtz & Turner, 2007; Oddie & Ousley, 2007), as well as working in an MDT in general (Atwal & Caldwell, 2006; Brown et al., 2008; Jones, 2006; Madge & Khair, 2000). Research has found that support from colleagues is an important factor in reducing burnout in mental health settings (Jenkins & Elliot, 2004; Melchior et al., 1997; Stewart & Terry, 2014). However, conflict within teams continues to be reported across studies in this field. Indeed, Davies et al. (2006) found a range of different perspectives contained within a single forensic organisation and attributed this to the formal and informal structures that divide staff into different professional groups. Similarly, Shaw et al. (2007) concluded that true MDT working is hard to achieve in secure forensic services, as they are characterised by perceived power differences between staff and patients on one hand and medical and non-medical staff on the other. Ultimately, the findings of the current study, in conjunction with the findings from previous research, highlight the difficulty faced by professionals who have the task of working together, when their aims and goals may not be entirely compatible.

In the current study, participants also expressed concerns over talking openly with colleagues, due to a lack of trust and a fear of negative reprisals. This fear of openness has previously been reported by Kurtz and Turner (2007). The issue of power differences was also reported by

participants in this study and was outlined by Stokes (1994) as an aspect of working within psychiatric settings. Stokes (1994) suggests that a focus upon power and powerlessness is a defensive shift away from the real powerlessness the whole team shares in its relative inability to 'cure' the patients. In the current study, issues with staff relationships were a prominent theme and it is possible that these dynamics could have a significant impact upon staff in such settings, due to the closed environment and the need to work closely with colleagues and rely on them in certain situations. With this in mind, further research considering the wider systemic issues that operate and impact upon staff relationships would be interesting.

The conceptual framework: There are many different psychological models of occupational stress and burnout, which are important in guiding research and practice. The underpinnings of a number of these models are substantiated by the findings of the current research. As discussed in more detail previously, the AW model proposes a structured framework for considering six areas of work-life that have resonated through the literature on burnout over the previous two decades, including: workload, control, reward, sense of community, fairness and values (Leiter & Maslach, 1999). It is apparent that a number of the themes identified through thematic analysis in the current study resonate with a number of the areas outlined by the AW model. The ways in which they resonate with certain areas of the AW model will be discussed below.

The most commonly discussed area of the AW model is work overload, when job demands exceed human limits. Increasing workload is related to burnout, especially with the exhaustion dimension (Cordes & Dougherty, 1993; Maslach et al., 2001; Schaufeli & Enzmann, 1998). In the current research, while workload was not identified as a theme in its own right, it was referred to by participants numerous times throughout the theme of superordinate 'the daily chaos' and the sub-theme of 'running the ward'. As is discussed in more depth in the results

section, staff expressed that the job expectations were unrealistic and unmanageable, and that the work load was substantial, with not enough hours in the day to get everything done. On top of the patient-care aspect of the job, the work load of staff was increased significantly by the added pressures of paperwork, and participants typically expressed that they found it difficult to maintain an effective balance between their clinical duties and the paperwork side of the job.

The control aspect of the AW model addresses the extent to which staff are able to influence decisions that affect their work and to exercise professional autonomy. Control problems occur when staff have insufficient authority or are unable to shape the work environment to be consistent with their values. In the current research, while control was not identified as a theme in its own right, issues were discussed regarding a lack of control over the environment as a whole. Staff reported a lack of control over their working environment, with the wards being run in a particularly unorganised, chaotic and hectic way. This often led to staff not getting their breaks and finishing late, again, which they had no control over. Staff also identified a lack of control over their working day, with the distribution of duties on the 'allocation sheet' causing the most problems, due to an unfair distribution of observations. Staff also sometimes felt out of control when managing patients who were presenting as a risk to themselves or others. While staff did not typically express that they felt unsafe on the ward, they did express that were always 'on their toes' and could never truly relax, due to the unpredictable nature of the forensic patients, which also demonstrates a lack of control in their working environment.

The reward aspect of the AW model addresses the extent to which rewards, including monetary, social and intrinsic rewards, are consistent with expectations. Lack of recognition from colleagues, managers and service users and external stakeholders can devalue staff and is closely associated with feelings of inefficacy (Cordes & Dougherty, 1993; Maslach et al.,

1996). In contrast, consistency in the reward dimension between the person and the job means that there are both material rewards and opportunities for intrinsic satisfaction (Richardson et al., 1992). Intrinsic rewards, such as pride, can be just as critical as extrinsic rewards, if not more so (Leiter, 1992). Links to this aspect of the AW model are apparent in the current research, as highlighted by the superordinate theme of ‘rewarding our efforts’ and the sub-themes of ‘limited recognition’ and ‘why I still do it’. Staff referred to feeling unappreciated and expressed that there was a distinct lack of rewards for doing the job that they do. This lack of rewards included both a lack of financial rewards and simply a lack of recognition, especially considering what the job role entails and how challenging the job can be. However, it became apparent that the overriding reason why staff continued to stay in their jobs was due to the intrinsic rewards of seeing the patients progress and feeling that they had ‘made a difference’.

The community aspect of the AW model refers to the overall quality of social interaction at work, including issues of conflict, mutual support, closeness and the capacity to work as a team. People thrive in a community and function best when they share praise, comfort, happiness, values and humour with people they like and respect. However, what is most destructive of community is chronic and unresolved conflict with others on the job (Leiter & Maslach, 2003). Such conflict produces constant negative feelings of frustration and hostility and reduces the likelihood of social support. A sense of community has been found to buffer the impact of feelings of inequity at work (Truchot & Derogard, 2001). Links to this aspect of the AW model are apparent in the current research, as highlighted by the superordinate theme of ‘no sense of community’ and the sub-themes of ‘problematic relationships with colleagues’ and ‘a fractured team’. Indeed, staff identified a number of issues in their relationships with their colleagues, including the other ward-based staff, MDT members and the organisation management. Problems with ward-based colleagues typically centred around issues such as

bitching, disagreements and personality clashes. Relationships with colleagues sometimes became so intense that 'cliques' formed, which subsequently impacted on the team dynamics. Staff also identified a 'divide' between the ward-based staff and the management of the organisation, typically presenting themselves as very patient-focused and the organisation hierarchy as having a more commercially-driven agenda. The ward-based staff also had differing opinions on patient care when compared to members of the MDT, with poor communication and a lack of understanding of patients being cited as the reasons for this.

The fairness aspect of the AW model refers to extent to which decisions at work are perceived as being fair and people are treated with respect. Fairness communicates respect and confirms people's self-worth. Unfairness can occur when there is inequity of workload or pay, when there is cheating or when promotions are handled inappropriately. Fairness is also central to equity theory (Walster et al., 1973), which is based on the balance between a person's inputs and outputs. This core notion of inequity is also reflected in the ERI model (Siegrist, 2002). Research based on these theoretical frameworks has found that a lack of reciprocity, or an imbalanced social exchange processes, can predict burnout (Bakker et al., 2000; Schaufeli et al., 1996). In the current research, while fairness was not identified as a theme in its own right, feelings of inequality and unfairness were evident throughout the interviews. A number of staff expressed that favouritism was common in the organisation, with certain staff having access to more opportunities for progression than others, depending upon whether your 'face fits' or not. It was also apparent that certain staff would be given a 'nicer' day, with a lower workload, whereas other staff would be allocated more duties and would typically be much busier. Additionally, some staff also expressed concerns that their breaks were shorter than others.

The values aspect of the AW model encompasses the ideals and motivations that originally attracted them to the job, going beyond the exchange of time for money or advancement. Rather, contributing to a meaningful personal goal is a powerful incentive for individuals (Leiter & Maslach, 2003). However, when there is a values conflict on the job, it can undermine people's engagement with work. In some cases, people may feel constrained by the job to do things that are not in accord with their own values. Alternatively, there may be a conflict between their personal aspirations for their career and the values of the organisation. In the current research, while values was not identified as a theme in its own right, issues regarding a mismatch in values were present throughout the interviews. Staff depicted an organisation which was divided into different groups based on hierarchy, with contradictory ideas about the nature of the work being undertaken. Staff described the agenda of their managers as different from their own, seeing managers as commercially-driven and themselves as patient-focused. This split in ideologies was difficult for staff to comprehend, as they saw their role as, first and foremost, caring for the patients. The values of staff are represented in more detail in the sub-theme of 'why I still do it'. Throughout this theme, the staff conveyed a strong duty of care towards the patients. They also expressed a great deal of empathy and compassion towards the patients and, due to their traumatic histories, the staff typically felt a sense of protectiveness over them. Moreover, seeing the patients progress and feeling that they had 'made a difference' were typically cited as being the most powerful incentives of the job.

Finally, equity theory (Adams, 1963) outlines that subtle and variable factors can affect an employee's assessment and perception of their relationship with their job. Equity theory is built on the belief that employees become de-motivated, both in relation to their job and their employer, if they feel as though their inputs are greater than the outputs. In return for their investments at work, an employee may expect a reasonable workload, financial rewards,

appreciation, career progression and sufficient support (Smets et al., 2004). However, it is clear that participants in the current study did not receive any of the above, as they regularly referred to such issues throughout the interviews. In fact, the majority of the interviews with staff centred around the overarching themes of unfairness and inequality, with participants typically expressing that they were putting a great deal of effort into their jobs on a daily basis and receiving very little in return. Indeed, they were sacrificing aspects of their own personal lives and were working so hard that they were making themselves physically and mentally unwell. However, they were still concerned that they were not providing the best standard of patient care that they could, due to the lack of resources, support and training opportunities that they received from the organisation. Moreover, participants also felt unappreciated, as they were never recognised for all their hard work.

Throughout the interviews, it became apparent that participants were discussing numerous aspects of their jobs which were inequitable. Indeed, they were required to support patients every day, but were not provided with adequate support themselves. They were required to provide a good standard of patient care, but had not received the appropriate training to do so. They were required to arrive at work on time, but were always late to leave. They were given a substantial work load every day, but were not provided with enough staff to get all the necessary tasks completed. Finally, they were criticised if they did something wrong, but they were never recognised for going above and beyond. Therefore, it is likely that this experience of persistent inequity at work may eventually lead to some of these participants experiencing emotional discomfort, a negative attitude towards the organisation and, ultimately, burnout (Adams, 1963, 1965; Smets et al., 2004; Walster et al., 1978). That is, if they are not already.

Equity theory also claims that people pursue reciprocity in their relationships and that what they invest and gain from a relationship should be balanced (Adams, 1963; Walster et al., 1978). With this in mind, it has previously been hypothesised that forensic hospital staff may perceive intrapersonal inequity in their relationships with patients. However, what is apparent from the results of this study is that the participants accepted the nature of their relationships with the patients and understood that such relationships would be inequitable. Participants understood that they would need to put a great deal of effort in to building their therapeutic relationships, in order to gain the trust of patients. Participants were aware that managing challenging behaviours was integral to the job role and they were aware that they would be required to support distressed individuals on a daily basis. However, they could accept this, as they knew that patients were unwell and they understood that such behaviours had developed as a result of their traumatic histories. Moreover, while participants did not receive rewards from the organisation, they did receive rewards from their patients, in terms of being able to feel that they had made a difference in their lives and being able to witness their progression.

Other models relevant to the results: The job-demands-resources (JDR) model (Demerouti et al., 2001) suggests that burnout is a response to imbalance between demands on the individual and the resources that he or she has to deal with those demands. In the current research, participants typically expressed that the demands of the job (such as the workload, patient contact and time pressures) considerably outweighed the resources provided (such as support, feedback and the number of staff on shift). The general feeling from the majority of participants was that caring for the patients was the most important part of their job, but they did not have the resources to provide the high standard of care that they wanted to.

The job-demands-control (JDC) model (Karasek, 1979) is established on the balance of job requirements and autonomy. The JDC model proposes that those who experience high job demands, with little control over their working environment, are more likely to feel stressed. Since the initial development of the JDC, the model has been expanded (Johnson & Hall, 1988) to include social support (JDCA), as this may act as a buffer in high demand situations (Cooper et al., 2001; Karasek & Theorell, 1990; Lim, 1996). In the current study, participants typically described high job demands, low job control and low levels of support at work.

The effort-reward imbalance (ERI) model (Siegrist, 1996) is based on reciprocity, where effort at work should be compensated by suitable rewards, and a mismatch between these will lead to stressful experiences (Peter & Siegrist, 1999). Rewards can include money, esteem, career opportunities and job security. In the current research, participants typically described putting a considerable amount of effort into their work and receiving a distinct lack of rewards and recognition for their hard work, often going unnoticed and unappreciated. A number of other research studies have also found that insufficient rewards and perceived unfairness can lead to feelings of stress and burnout (Hayes et al. 2006; Shields & Ward, 2001; Maslach, 2003).

The person-environment fit (PEF) model (French, 1973) suggests that the match between a person and their work environment is key in influencing their health. For good well-being, it is necessary that employees' attitudes, skills, abilities and resources match the demands of their job. In the current study, participants often spoke of their desire to improve their knowledge and skills and attend extra training sessions, while some participants spoke of feeling 'out of their depth'. It is understandable that working in a forensic setting will not 'suit' everyone, due to the nature of the job role. However, effort should be made by organisations to ensure that employees are given all the opportunities they need to succeed in such an environment.

In summary, the themes apparent in the current research are concurrent with the occupational stressors identified by the existing psychological models of stress and burnout, as discussed above. The themes apparent in the current research also resonate with the risk factors for burnout in forensic mental health staff, as previously identified by a number of quantitative studies, which are discussed in greater depth in Chapter 3. However, the current study offers additional insight into the experiences of forensic hospital workers, by providing context to the occupational stressors that such staff experience and by focusing more specifically on the perspective of the individual and the meaning that certain events have for them personally.

Limitations: The current study was explorative and findings cannot be reliably generalised to other organisations. Indeed, it is likely that each forensic hospital employs slightly different practices and philosophies with regard to service provision and this may create difficulties in comparing findings across organisations. Moreover, as ward-based staff were the largest group in the sample, and it should be considered that the themes may say more about their experiences than the experiences of other staff, such as MDT members. Therefore, future research may benefit from exploring the similarities and differences between different professional groups. However, it is worth noting that the researcher interviewed staff who worked across a range of different wards and this was done deliberately, in an attempt to give the most balanced view possible across the organisation as a whole. Interestingly, despite the participants working on a range of different wards, considerable homogeneity was observed across the interviews.

It is important to note that there was potential bias in the method of sampling, as the sample was selected by convenience, fitting in with which staff members were available and willing to participate in an interview. Additionally, as discussed previously in relation to the primary research study, it is important to consider the reasons why staff may or may not have decided

to take part in the interview, as the motives of staff to participate may have impacted on their responses to the interview questions and the subsequent research findings. There may also have been some bias which occurred as a result of the researcher having previously worked at the organisation in a support worker role. However, it is also likely that this facilitated open communication, as there was a level of familiarity and trust.

It is possible that other dimensions of the participants' experiences may have been missed due to limitations of the interview schedule. Moreover, the reliance upon participants' self-report can also be problematic, in terms of achieving an objective picture. However, given the study aims, it would be impossible for such a piece of research to be truly objective, as the discussion of human experiences will always be subjective to that person. Using observations would have been an interesting additional component and may have added more depth. Additionally, in the future, it may be helpful to include the patients in the research. In the current research, this was not pursued for a number of clinical and ethical reasons. However, future research could incorporate the views of patients and this would add an interesting dimension to the findings.

It is also necessary to discuss the limitations of thematic analysis as an analytic method. The flexibility of the thematic analysis allows for a wide variety of analytic options, however, this also means that the possible range of things that can be said about data is broad. This can be difficult for a researcher who is trying to determine which aspects of their data to focus on. Another issue is that thematic analysis can have a limited interpretative power beyond mere description, as it does not allow the researcher to make claims about language use. There is also a great deal of subjectivity on behalf of the researcher when deciding what constitutes a theme and it is possible that some researchers may be more sensitive to some information than

others. Furthermore, in the current study, the data analysis and subsequent validity of findings may have been limited due to the researchers' inexperience using thematic analysis.

Clinical implications: Unfortunately, participants expressed that the job had been affecting them in negative ways and was impacting upon both their physical health and mental health, with some participants noticing symptoms of burnout in themselves and their colleagues. When the physical and mental health of staff began to deteriorate, it subsequently began to impact upon the standard of patient care that was being delivered on the ward. Additionally, it was recognised that the impact of the job could ultimately lead to staff leaving the organisation, with a high staff turnover typically being seen by the participants as a common feature of working in a forensic hospital and something which they witnessed regularly. Indeed, a number of the participants expressed their desire to leave the organisation and either join alternative mental health organisations or pursue an alternative career entirely. These findings surely have clinical implications for the management of the organisation involved in this research.

It seems that if staff are not adequately supported, the demands placed on them are too high or their needs are not recognised, then this presents a considerable problem. The effects of this problem can subsequently impact upon the standard of care that patients receive. The service developments in this area are still at an early stage and there is little previous research to determine how exactly to support staff who work in this challenging and complex setting. Some staff indicated that they do not have regular opportunities to reflect on incidents at work and process their own feelings, which has potential implications for their well-being in the long term. With this in mind, issues such as staff sickness and burnout may be inevitable outcomes if adequate resources for staff are not made available. In turn, the turnover of the organisation

will increase, which will subsequently lead to cost implications for the organisation, as a result of having to either recruit and train new staff or use bank and agency staff to cover deficits.

Despite these challenges, staff came across as extremely dedicated to doing their best for the patients within their care. They evidently put a great deal of effort into engaging the patients and achieved job satisfaction through their clinical work. This is concurrent with the findings of previous research, which outline that healthcare staff typically experience a combination of both job satisfaction and occupational stress at the same time (Carson et al., 1995; Commission for Health Improvement, 2004; Onyett et al., 1997). This finding emphasises the importance of organisations recognising and rewarding their staff, as individuals may be more likely to stay in a job where they feel appreciated. Unfortunately, some participants made reference to a lack of rewards and not feeling recognised. With this in mind, receiving positive feedback seems crucial to the well-being and job satisfaction of forensic mental health staff, as this feedback may be able to moderate the effects of working in a highly demanding environment with a complex client group. Therefore, organisations should make greater effort to recognise and reward their staff for their hard work. Suggestions as to how organisations can do this include line management appraisals, wage increases for experienced staff, employee of the month schemes, annual awards ceremonies or just a simple 'thank you' at the end of each shift.

Adequate support and resources tailored specifically to the environment and client group would be useful. In particular, opportunities for group and individual supervision would be beneficial, alongside reflective practice groups, formulation meetings and debriefs after distressing events. Supervision should aim to create a safe space, in which staff can reflect on their clinical work, their relationships with colleagues and the organisational environment as a whole. Supervision should also aim to help staff develop a reflective approach to clinical practice. A number of

issues with supervision were raised throughout the interviews, including the fact that it rarely happens, due to time pressures, or there is a lack of trust in supervisors. With this in mind, it is proposed that supervision could be provided by an external consultant, who is not involved in internal dynamics and can take an impartial view. Group supervision for each ward team would also help staff to communicate openly with each other and develop shared goals. In turn, when provided with effective support and given the opportunity to reflect on their feelings, staff may be more able to maintain a healthy work-life balance. The provision of both group and individual supervision may be costly. However, the cost of such resources would surely offset against the cost of paying the wages of all the staff who are absent from work due to stress.

Additionally, relevant training in the complexities of working with this particular client group would also be useful. Such training could include more practical on-the-job training for new staff, as well as more in-depth training opportunities for long-standing staff who work with a particular client group or who are interested in learning a particular skill. Again, the provision of more extensive training would likely be costly. However, the cost of such resources would surely be worthwhile, if it meant that staff were better-equipped to provide a good standard of care to patients. In turn, this may impact positively upon treatment outcomes.

Conclusion: The current research explored the experiences of forensic hospital employees, giving particular focus to the occupational stressors they encounter. According to the current literature, this study is one of very few studies to utilise a qualitative methodology to explore staff burnout in forensic hospitals. Due to the exploratory nature of this study and the scarcity of previous research in this area, further research to supplement the findings of this study would be beneficial. Participants in the current study indicated that their work with the patients was a contradiction in itself, as it was both very rewarding and highly challenging at the same time.

The overriding impression was that participants were incredibly passionate about the job that they did. However, they felt frustrated due to the lack of resources, support and recognition they received, especially as they were putting in a great deal of effort and sacrificing aspects of their own personal lives. Moreover, due to the lack of resources provided by the organisation, participants felt that they were simply ‘getting by’, rather than providing a high standard of patient care. This general feeling is summarised by the title of this research study. Clearly, this is a challenging area of work and there are implications for services if staff are not adequately supported to meet the range of demands placed upon them and not recognised for their efforts. Further research in this area is required, in order to establish whether the themes in the current study may be generalised to other similar settings. This could be achieved by a combination of qualitative and quantitative research methods to enhance both flexibility and generalisability.

Chapter 6 - General discussion

This research thesis aimed to provide a broad investigation into the issue of staff burnout in forensic hospitals, including the prevalence of burnout, the risk factors for burnout and the lived experiences of individuals who are employed in such settings. Ironically, over the years, the mental health field has given little consideration to the health and well-being of its own workers. However, there is little doubt about the importance of this area of study, as research into this topic is likely to provide information that is beneficial to staff, organisations and the patients who they provide care for. Identifying what factors may lead to the development of burnout and which staff are most at risk of developing burnout, as well as implementing practices to prevent or reduce burnout, can all contribute towards reducing staff absenteeism. Subsequently, this would reduce the financial implications to the organisation. Furthermore, the implementation of practices that serve to reduce feelings of burnout amongst staff can also, in turn, improve the quality of patient care, a goal that is particularly important in the current climate. With this in mind, it appears crucial to study the unique challenges of working in a forensic hospital, so employees working in such an environment can be adequately supported.

This thesis has worked toward contributing to this growing body of research in several ways. It has reviewed and evaluated the current evidence regarding the risk factors for burnout in forensic hospital workers, examined the prevalence of burnout in a sample of forensic hospital staff and explored the associated risk factors, explored the lived experiences of a sample of forensic hospital staff and provided a critical evaluation of the most popular and most widely used measure of burnout. The results of these investigations supplement the growing body of literature into burnout in forensic mental health workers. In particular, this study adds weight to the notion that the unique challenges of working in forensic hospitals can be linked to a high

degree of burnout. However, the evidence base still remains small, with a number of different hypotheses being generated by different researchers. Therefore, perhaps the most important aspect of this thesis is the implications it has for the direction of future research and practice.

Summary of findings and implications:

An investigation into the risk factors for burnout in forensic hospital workers began with a critique of the MBI-HSS (Maslach et al., 1996), the most widely used measure in burnout research, which is presented in Chapter 2. This chapter gave an overview of the MBI, a psychometric measure identified as one of the most widely used measures of burnout within the field. Primarily, Chapter 2 focused on the development, validity and reliability of this tool. The aim of the critique was to examine the scientific properties of this measure, its applicability within organisational settings and its research uses. The MBI is a self-report measure designed to ascertain the level of experienced burnout through assessing the three core components of burnout: EE, DP and PA. As discussed in Chapter 1, Maslach et al. (1986) proposed that EE is a measure of feeling emotionally overwhelmed by one's work, whereas DP is a measure of cynical and impersonal responses towards clients. Finally, a reduced sense of PA relates to feelings of incompetence and a negative self-evaluation of one's work. While other measures assessing burnout exist, the MBI features sizable normative data across a range of professional groups, increasing its reliability and utility for a number of professions.

However, the MBI been criticised for its atheoretical nature and the difficulty in assessing its content validity due to the synonymous nature of the measure with the definition of burnout (Schaufeli, 2003). The MBI is founded on a three-dimensional conceptualisation of burnout and it incorporates 22 items into three separate subscales (EE, DP and PA). While the three-factor structure of the MBI has been shown to be consistent across occupations and national

contexts (Belcastro et al., 1983; Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998), it remains debated. Indeed, some researchers argue that burnout is only a two-dimensional construct (Demerouti & Nachreiner, 1996; Demerouti et al, 2003) or even a one-dimensional construct (Pines et al., 1981). The MBI has also been criticised for its self-report nature, as issues with using a self-report method can include introspective ability, socially desirable responding and response bias. Furthermore, there are also a number of limitations of using a Likert scale to measure participant attitudes, such as the possibility that participants may avoid choosing the most extreme options on a scale and the difficulty in measuring a psychological construct on a continuum. These limitations are discussed at length in Chapter 2. However, while limitations of the MBI do exist, there is also significant research exploring the use of the MBI in a range of samples, cross-culturally and across different professions, which has regularly demonstrated excellent levels of reliability and validity. Therefore, Chapter 2 is able to conclude that the MBI is an effective tool for measuring burnout in a range of occupational settings.

Following the critique of the MBI-HSS, a systematic review of the literature is presented in Chapter 3. The systematic review aimed to bring together all the existing research regarding the risk factors for burnout in forensic hospital workers and concluded that there is a growing evidence base linking the unique challenges of working in forensic hospitals to a high degree of burnout. Overall, the systematic review aimed to identify all relevant published and unpublished research, select studies for inclusion, assess the quality of each study, synthesise the findings from studies in an unbiased fashion and present an interpretation of the findings in a balanced and impartial summary, taking into consideration any flaws in the methodological rigour of the included studies.

The extent to which the identified research was able to demonstrate consistent results across the studies was also considered. Unfortunately, it was not possible to provide a comprehensive conclusion regarding the specific risk factors for the development of burnout in forensic hospital staff. This is because each study identified a number of different risk factors for burnout, which is possibly attributable to individual differences in organisations and individual differences in people. Therefore, the extent to which each factor contributes to the development of burnout remains unclear. However, some commonalities were identified and a number of risk factors for burnout were consistently identified across studies. This meant that the risk factors identified across studies could be categorised into four separate sub-categories: organisational/occupational factors, clinical factors, personal/individual factors and feeling detached from the outside world. The findings were considered in relation to study quality and methodological limitations and future research recommendations were also discussed.

None of the studies included in the systematic review were considered to have strong methodologies, mainly due to their cross-sectional designs and their small sample sizes. Some studies were at risk of potential selection bias, as they did not provide sample size justifications, did not discuss power calculations and did not discuss the overall target population. Therefore, it was not possible to ascertain the response rate and it was unclear whether the participants who did respond were representative of the target population or not. Other limitations of the studies included drawing conclusions without discussing issues with generalisability, using measurements that had not been validated (and had been created by the researchers themselves) and not acknowledging confounding factors. Moreover, a key issue identified with a number of the studies included was that the researchers did not acknowledge the limitations of their own studies and they did not discuss any potential sources of bias.

On the basis of what was highlighted in Chapter 3, a number of recommendations were made for researchers in this field to consider going forward. It was suggested that more emphasis should be placed on comparison studies in the future, as they are an effective way of knowing whether exposure to a particular factor has made a difference or not, which can help attribute an impact to that particular exposure. Additionally, future researchers may also benefit from conducting longitudinal research to explore the long-term effects of burnout and how this can impact on both the individual and the organisation. As burnout is changeable over time and is dependent upon the context in which it occurs, longitudinal research could aim to monitor a group of staff over a certain period of time to explore both the risk factors and the maintenance factors for burnout. Moreover, it was also recommended that future research should consider a greater exploration of the factors that may protect against burnout, as protective factors may work against risk factors to combat burnout in individuals who may have otherwise been susceptible. Protective factors were not included in the current systematic review, as making observations about them was beyond the scope of the research. However, future research could explore protective factors such as resilience, self-esteem, self-efficacy and coping skills.

Following the systematic review, Chapter 4 presented a quantitative research study that aimed to explore the relationship between the development of burnout in forensic hospital workers and a number of risk factors. Despite the lack of prior research in this area and the limitations of the current evidence base highlighted in Chapter 3, synthesising the small body of available research provided some support for the relationship between a number of risk factors and the development of burnout in forensic hospital workers. Synthesising the available literature also allowed the researcher to clarify where the gaps in the literature were. The primary research study aimed to identify the prevalence of burnout in a sample of forensic hospital employees and explore the relationship between the level of burnout and a number of risk factors. The

study found that over half of the sample experienced high levels of EE, almost a third experienced high levels of DP and nearly a quarter experienced low levels of PA. When these results were compared to the normative data for mental health workers, it became apparent that participants in the current study were reporting higher than average levels of EE and DP. The findings of the current study should also be considered in relation to the findings of previous studies into the same population. The current study found an average EE rating of 27.13, an average DP rating of 9.40 and an average PA rating of 32.23. The results of other studies into burnout in forensic hospital workers are displayed in the table below:

Table 14. Average levels of burnout found in previous research

	Average EE	Average DP	Average PA
Burdock (2016)	27	7	37
Dennis & Leech (2007)	13	11	33
Elliot & Daley (2013)	16	6	34
Hellin (1999)	19	9	33
Johnson et al. (2012)	23	6	35
Oddie & Ousley (2007)	23	7	35
Current study	27.13	9.40	32.23

Overall, it appears reasonable to conclude that participants in the current research study were experiencing greater levels of burnout when compared to the normative data (both the human services sample and the mental health sample) and when compared to the findings of previous studies into the same population. Moreover, the quantitative outcome measures yielded some

statistically significant results, which are discussed at length in Chapter 4. Both the clinical implications and the research implications of the study results were subsequently discussed.

An important finding is the higher than average levels of burnout found in the current sample, when compared to the normative samples. These results would suggest that forensic hospital managers need to increase their awareness of staff well-being and consider the fact that their staff may be particularly susceptible to burnout, due to the forensic environment that they are working in. A number of risk factors were also significantly linked to burnout, which means that the staff who are potentially at the highest risk of developing burnout can be identified and strategies can be developed to target these high risk individuals. It was recommended that the appropriate support mechanisms should be in place for all employees and should be actively encouraged by hospital managers, including of clinical supervision and line management. It was also recommended that hospital managers could consider implementing psychologically informed environments (PIE), which may be beneficial and therapeutic for both the staff and patients on a ward. Educational interventions for employees may also be useful, in terms of teaching the employees new ways of coping and strengthening their resilience.

The quantitative research study presented in Chapter 4 contributes to the evidence base in this highly specialised care area and is valuable to the forensic hospital in which it was conducted. Overall, the results appear to support the commonly held assertion that working in a forensic hospital is an inherently stressful experience, which can lead to staff experiencing marked levels of burnout. However, there is a strong need to continue to explore the phenomenon of burnout among staff who work in forensic hospitals, as further research into this topic may provide further information that is beneficial to staff, patients and organisations. Other areas of interest for future research may include a greater exploration of the factors that may protect

against burnout, as protective factors may work against risk factors to combat burnout in individuals who may have otherwise been susceptible. Going forward, it is hoped that the recommendations made will be put into practice and that ongoing staff training and supervision will endeavour to protect individual employees from developing burnout. In turn, it is hoped that this will improve both the experiences of both the staff and the patients.

Chapter 4 concludes by suggesting that the use of qualitative methods to study burnout would be worthwhile in the future, as this approach would provide greater insight into the daily experiences of forensic hospital workers. With this in mind, Chapter 5 presented a qualitative research study that aimed to further explore the experiences of stress and burnout in forensic hospital workers. Using a qualitative methodology, this study aimed to develop a greater insight into the day-to-day experiences of forensic hospital workers, by giving a voice to the employees themselves. More specifically, this study aimed to explore how forensic hospital workers may come to develop feelings of burnout and which occupational stressors influence how they feel about their jobs. The interview data was analysed through the process of thematic analysis, which aimed to identify any important or interesting patterns within the data and then use these themes to make a statement (Braun & Clarke, 2006).

Participants described a range of experiences within their work, both positive and negative. The data analysis yielded three main themes and ten sub-themes. These themes included: ward-level issues (problematic relationships with colleagues, the nature of working with forensic patients and difficulty running the ward), organisational-level issues (training needs, difficulty accessing support, lack of recognition and a fractured team) and individual perspectives (the impact on my personal life, why I still do it and how the job affects me). Participants felt passionate about the clinical aspects of the job and valued their work with the patients, which

they found both rewarding and challenging at the same time. On the other hand, greater stress appeared to come from organisational aspects of the job, including negotiating complex relationships with colleagues and the organisation hierarchy. Participants typically saw the management as detached from the front-line staff, with a more commercially-driven agenda. The overriding impression was that participants were incredibly passionate about the job that they did. However, they felt frustrated due to the lack of resources, support and recognition they received, especially as they were putting in a great deal of effort and sacrificing aspects of their own personal lives. Moreover, due to the lack of resources provided by the organisation, participants felt that they were simply 'getting by', rather than providing a high standard of patient care. This general feeling is summarised by a quote by Participant 12, who stated that 'it's just a case of getting from one day to the next without anyone dying'.

Chapter 5 illustrates the value in analysing the experiential accounts of forensic hospital workers. From the accounts of the twelve participants interviewed, it is clear that forensic hospital workers experience a range of challenges within their work and they require the appropriate support and resources to manage the demands of such. If staff are not adequately supported to meet the range of demands placed upon them, then there are surely implications for both organisations and patients. According to the current literature, this study is one of very few studies to utilise a qualitative methodology to explore staff burnout in forensic hospitals. Therefore, due to the exploratory nature of this study and the scarcity of previous research in this area, further research to supplement the findings of this study would be beneficial.

Each chapter of this thesis is affected by its own limitations, which have been discussed at length. These limitations impact on the ability to draw definitive conclusions within this field, as well as the ability to make recommendations for the future. One further limitation of this

thesis relates to the quantitative study in Chapter 4 which, upon reflection, would have benefitted from the inclusion of the elements of a number of occupational stress models as predictor variables. Indeed, the quantitative study could have included predictor variables derived from various occupational stress models, for example, the JDR model, the JDC model, the ERI model, the PEF model or the AW model (Leiter & Maslach, 1999). Subsequently, incorporating a number of relevant predictor variables (i.e. demands, resources, control and reward) into the quantitative study could have allowed associations to be drawn between aspects of the occupational stress models and the level of burnout experienced by employees. In turn, this could have facilitated an understanding of the relationship between work-related psychosocial factors and psychological health. With this limitation in mind, future research is recommended to explore the predictor variables associated with the occupational stress models discussed, to determine their linkages with psychological health in this field. Future research could also further explore the themes identified in Chapter 5 and how these relate to the occupational stress models discussed, as some of the themes identified may be particularly useful in understanding the challenges of working in forensic environments. Nevertheless, despite this limitation of the current thesis, there are several implications that can be drawn from this research, along with subsequent recommendations for the future.

Theoretical framework:

As stated in the introduction, the theoretical framework of this thesis has been grounded in the foundations of equity theory, which assumes that people pursue a balance between what they invest in a particular relationship (e.g. time, skills, effort) and the benefits they gain from it (e.g. status, appreciation and pay). Disturbance of this balance is expected to result in negative outcomes (Adams, 1965; Buunk & Schaufeli, 1999). Previous research has generally supported this prediction, for example, inequity in work relationships has been shown to be associated

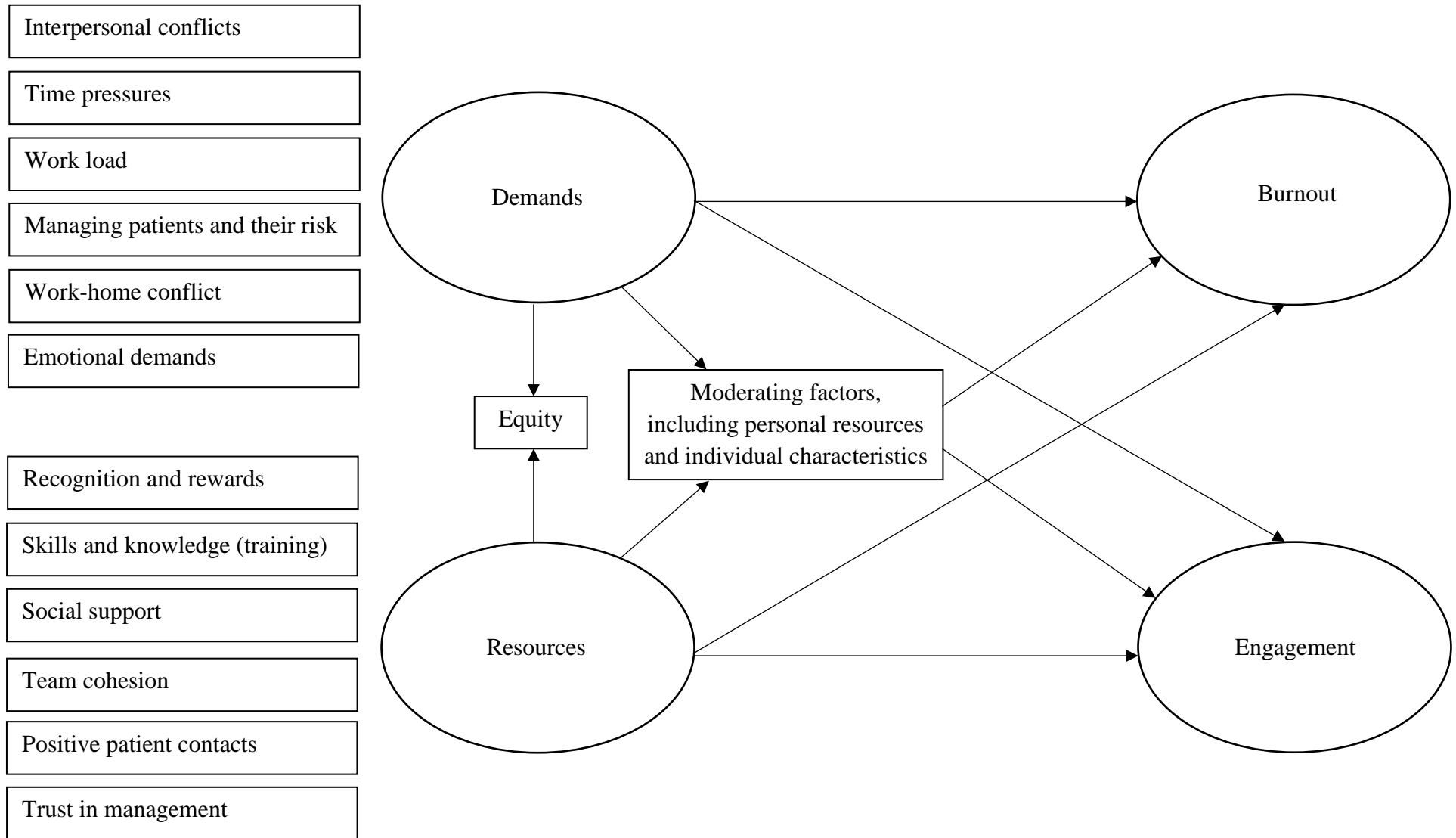
with lack of organisational commitment (Schaufeli et al., 1996), absenteeism and turnover (Cropanzano & Greenberg, 1997; Geurts et al., 1999) and burnout (Van Horn et al., 2001).

This thesis also gives consideration to a number of other conceptual models, especially the JDR model, which will be discussed in greater depth. As with equity theory, the JDR model assumes that employee health and well-being result from a balance between positive and negative. With regards to the JDR, the balance is between the demands of a job (negative) and the resources available to ensure that the job can be done (positive). For example, the emotional demands of working in a forensic hospital setting could be balanced by support from supervisors. Unlike other models, such as the JDC and the ERI, the JDR model does not restrict itself to specific job demands or job resources. It assumes that any demand and any resource may affect employee health and well-being. Therefore, the scope of the JDR model is much broader than that of the other models. The JDR model is also more flexible and can be tailored to a wide variety of work settings. The revised version of the JDR model also makes a distinction between workplace resources and personal resources, with personal resources being defined as psychological characteristics or aspects of the self, which can include resiliency, self-efficacy and intrinsic motivation (Schaufeli & Taris, 2014).

The JDR model appears to be an appropriate theoretical model to use to explain the findings of the current thesis, as this thesis has highlighted a number of job demands (including work load, the emotional demands of working with forensic patients, interpersonal conflicts and work-home conflicts) which disturb the balance needed for employee health and well-being. This thesis has also highlighted a number of job resources (including appreciation, financial rewards, social support and trust in the management) which disturb the balance needed for employee health and well-being, if they do not exist. Additionally, this thesis has also outlined

a number of personal/individual factors which can either increase or decrease the risk of burnout, which can be integrated into the 'personal resources' aspect of the JDR model. The findings of this thesis, therefore, appear to validate the appropriateness of the JDR model in explaining the development of burnout in forensic hospital staff. An adapted version of the JDR model (Bakker & Demerouti, 2007; Demerouti et al., 2001; Shaufeli & Bakker, 2004), which takes into consideration the findings of this thesis, is presented on the following page. This model outlines the importance of equity at work and the delicate balance between job demands and resources. The model also acknowledges the moderating effect that personal resources and individual characteristics can have upon the development of burnout.

Figure 5. An adapted version of the JDR model to show the development of burnout in forensic hospital settings



Suggestions for future research:

Considering the thesis as a whole, it appears that there is a growing evidence base linking the unique challenges of working in forensic hospitals to high degree of burnout. However, relatively few well-designed, empirical studies have investigated burnout in forensic hospitals. Moreover, many of the existing studies are plagued by significant methodological weaknesses, including a lack of experimental designs, samples of convenience, small sample sizes, limited demographic data, high attrition rates, cross-sectional designs and limited follow-up periods. Furthermore, the conclusions of many of the existing studies are limited in their scope for generalisation, as they involve the analysis of a small area of practice only. Despite these frequent methodological limitations, it is clear that burnout is a significant problem in the mental health field, both in its prevalence and its association with a wide range of other problems for the individual staff, the organisations that employ them and the patients who are entrusted into their care. Therefore, it is evident that further research in this area is necessary.

Further research into this topic may provide further information that is beneficial to staff, patients and organisations. Identifying what factors may lead to the development of burnout and which staff are most at risk of developing burnout, as well as implementing practices to reduce burnout, can all contribute towards reducing staff absenteeism. Subsequently, this would reduce the financial implications to the organisation. Furthermore, the implementation of practices that serve to reduce feelings of burnout amongst staff can also, in turn, improve the quality of patient care, a goal that is particularly important in the current climate. In the future, further emphasis could be put on comparison studies, which are rated highly because they are an effective way of knowing whether exposure to a particular factor has made a difference or not, which can help attribute an impact to that particular exposure. Additionally future researchers may benefit from conducting longitudinal research, as burnout is a social

and psychological construct that reflects an individual's experiences at that moment in time. Therefore, as burnout is changeable over time and is dependent upon the context in which it occurs, longitudinal research could aim to monitor a group of staff over a certain period of time to explore both the risk factors and the maintenance factors for burnout.

Finally, future researchers may consider using qualitative methods to study the phenomenon of burnout, to learn more about the daily lives of forensic hospital employees and the meaning that certain events have for them. Qualitative methods can also be used to bridge the gap between the existing literature, which consists of a small amount of quantitative results, and the real life experiences of forensic hospital staff. Moreover, a combination of qualitative and quantitative methods may be used to enhance both the flexibility and the generalisability of research. Additionally, going forward, it may be valuable to include the patients in the research, as this would surely add an interesting dimension to the findings of any future research.

Implications for organisations:

If staff are not adequately supported, the demands placed on them are too high or their needs are not recognised, this presents a considerable problem. The effects of this problem can subsequently impact upon the standard of care that patients receive. The service developments in this area are still at an early stage and there is little previous research to determine how exactly to support staff who work in this challenging and complex setting. Nevertheless, issues such as staff sickness and burnout may be inevitable outcomes if adequate support and resources for staff are not made available. In turn, the turnover of the organisation will increase, which will subsequently lead to cost implications for the organisation, as a result of having to either recruit and train new staff or use bank and agency staff to cover deficits.

The higher than average levels of burnout found in the current sample, when compared to the normative samples, may suggest that forensic hospital workers are particularly susceptible to burnout. A number of risk factors were also significantly linked to burnout, which means that the staff who are potentially at the highest risk of developing burnout can be identified and strategies can be developed to target these high risk individuals. It was recommended that appropriate support mechanisms should be in place for all employees in the organisation and should be actively encouraged by hospital managers. This would include effective clinical supervision, which aims to allow staff to reflect on their experiences and work through their emotions within a safe environment, as well as line management, reflective practice groups, formulation meetings and debriefs after distressing events. Placing greater emphasis on these methods of support in forensic hospital settings can help to manage staff absenteeism and staff turnover, which, in turn, can minimise spending costs for the organisation.

It was also recommended that hospital managers could consider adopting a psychologically informed environment (PIE), which may be beneficial and therapeutic for both the staff and patients on a ward. Additionally, relevant training in the complexities of working with forensic mental health patients would also be useful. Such training could include more practical on-the-job training for new staff, as well as more in-depth training opportunities for long-standing staff who work with a particular client group or who are interested in learning a particular skill. Other suggestions include staff rotation and reducing staff exposure to stressful situations by offering staff off-ward duties or the opportunity to become involved in other departments.

The thesis also emphasises the importance of organisations recognising and rewarding their staff, as individuals may be more likely to stay in a job where they feel appreciated. It appears that receiving positive feedback seems crucial to the well-being and job satisfaction of forensic

hospital staff, as this feedback may be able to moderate the effects of working in a highly demanding environment with a complex client group. Therefore, organisations should make greater effort to recognise and reward their staff. Suggestions as to how organisations can do this include line management appraisals, wage increases for experienced staff, employee of the month schemes, annual awards ceremonies or just a simple ‘thank you’ at the end of each shift.

It has been suggested that the most effective mode of intervention is to combine changes in organisational practice with individual-level interventions (Maslach et al., 2001). Therefore, future individual-level interventions aimed at promoting the well-being of staff working in forensic services are recommended. This could include the use of educational interventions to enhance the capacity of employees to cope with the demands of their job. At the root of this approach would be teaching staff new ways of coping and strengthening their resilience.

When considering implications of this thesis and making subsequent recommendations, an important note to make is that mental health services receive considerably less funding, relative to demand compared with physical health services (The King’s Fund, 2018). A new report by the King’s Fund documents that the budgets of mental health trusts in England rose by less than 2.5% in 2016-17, while the budgets of acute trusts and hospitals providing specialist rose by 6%. The report outlines that it is now the fifth year in a row that NHS bosses have given physical health services a larger cash increase, even though ministers have repeatedly stressed the need to give mental health services more money. The result of underfunding is that mental health services are stretched beyond their resources, placing greater demands on the staff and creating a stressful and pressurized environment. Underfunding also creates problems such as high vacancy rates, high staff turnover, a reliance on bank and agency staff, insufficient numbers of staff on the ward and an inappropriate skill mix of staff. In turn, these problems

can impact on the continuity of care provided to patients, can cause delays in treatment, can result in escorted leaves and therapeutic activities to be cancelled and can increase the risk of suicide, self-harm and violent behaviour on wards.

The NHS Five Year Forward View (2014) outlines that one in four people will experience mental health problems in their life, but only 13% of the NHS budget is actually spent on treating people with mental health problems. Moreover, despite mental illness being the single largest cause of disability in the UK, mental health services have consistently been the ‘poor relation’ compared to acute hospital services for physical conditions. The NHS Five Year Forward View (2014) outlines that, over the next five years, the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. A start has already been made, through the Improving Access to Psychological Therapies Programme. However, it is necessary that improvements continue to be made to mental health services, access to a range of treatments continues to be expanded, waiting times to access psychological therapies continues to decline and funding for mental health services continues to be made available by the government. Therefore, it remains to be seen whether a genuine parity of esteem between physical and mental health services will be achieved by 2020.

A summary of this thesis has been shared with the host organisation and there are a number of ways in which the findings of the investigations included in this thesis have informed practice. External supervision is now being offered to all staff working in patient-facing roles, which gives staff the opportunity to talk to someone who is suitably qualified but is not employed by the organisation. An employee of the month scheme has also been set up, as well as an annual awards ceremony, which recognises all members of staff and not just those in management positions. A greater importance is now being placed on reflective practice and formulation

meetings, which are happening weekly and are contributing to the creation of a psychologically informed environment. Ward clerk roles have been introduced on each ward, to allow for support workers and nurses to be able to spend more time with their patients and less time completing paperwork. Additionally, more specialised training sessions have been running and further training opportunities are planned for the future, including autism awareness training and personality disorder awareness training. Training in Dialectic Behavioural Therapy skills has also been offered to all staff working on the female services and it is planned to be offered to all staff across the hospital shortly. Moreover, staff rotation is allowing the most ‘at risk’ staff members to have time off their own wards and spend some time on different wards for a number of weeks. Therefore, while it is clear that the organisation still has some way to go in terms of implementing interventions to improve staff well-being and specifically target burnout, it is evident that they have been committed to making some changes for the better.

Conclusion:

It is evident that a broad spectrum of information has been provided and that this has been helpful in answering current questions regarding employee burnout in the specific context of forensic hospitals. However, for those questions which this thesis has helped to answer, it has also identified a number of areas which continue to warrant further investigation. There is a considerable body of research literature available regarding burnout in a variety of occupational settings, which perhaps leads one to inaccurately presume that a considerable amount is known about the complex phenomenon and the variety of different risk factors which may contribute to its development. On the contrary, this thesis has demonstrated that there is much work still to be done both in terms of understanding burnout in forensic hospitals and how it can be prevented or treated. As with most things which are not truly understood, further exploration is likely to be the best way forward. In forensic hospitals especially, more research simply

needs to be done, in order to investigate the true impact that working with a highly complex client group in an emotionally demanding environment can have on an individual employee's health and well-being. In conclusion, it is clear that forensic hospital workers experience a range of challenges within their work. With this in mind, forensic hospital managers should ensure that all their employees are suitably equipped with effective support, adequate resources and appropriate training, in order to successfully manage the daily the demands of their jobs.

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Appendix

Appendix A - Systematic review protocol

This systematic review protocol was written in accordance with the guidelines outlined in the PRISMA-P (Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols) checklist (Shamseer, Moher, Clarke, Gherzi, Liberati, Petticrew, Shekelle & Stewart, 2015).

Introducing burnout:

The concept of burnout has been defined in various different ways throughout the existing literature (Burke & Richardsen, 1993; Chemiss, 1980; Pines & Aronson, 1988; Stalker & Harvey, 2002). However, many researchers prefer the definition developed by Maslach et al. (1996), which incorporates three distinct dimensions and asserts that burnout can be defined as 'a psychological state that is characterised by the following symptoms: emotional exhaustion, de-personalisation and a decreased perception of personal accomplishment'. The element of emotional exhaustion refers to feelings of being emotionally depleted, overextended and fatigued. The element of de-personalisation is characterised by unsympathetic and impersonal responses towards clients, as well as negative and cynical attitudes toward consumers or work in general. Finally, a decreased perception of personal accomplishment is distinguished by negative self-evaluation of one's work with consumers or overall job effectiveness (Stalker & Harvey, 2002).

Since burnout was first described in the early 1970s, an abundance of conceptual papers and empirical studies have concentrated on this complex phenomenon. From the onset, it was accepted by some of the most prominent researchers in the domain that the emotional demands that are associated with working with challenging individuals are what cause burnout to materialise (Chemiss, 1980; Freudenberger, 1974; Mashlach, 1982). Therefore, traditionally, the concept of burnout has been closely linked to the human services, where professionals work directly with people (Mashlach & Schaufeli, 1993). However, there now appears to be little theoretical rationale for limiting burnout exclusively to human service professions (Maslach & Leiter, 1997; Schaufeli & Enzmann, 1998) and sufficient empirical evidence now indicates that burnout can occur in a variety of other work settings as well (Buunk, De Jonge, Ybema & De Wolff, 1998; Kahn & Byosiere, 1992).

Burnout in mental health settings:

For the purpose of this review, a mental health setting can be defined as any setting in which an employee works with a patient who has been diagnosed with a disorder defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This can include depressive disorders, schizophrenia spectrum disorders, bipolar disorders, personality disorders, eating disorders, trauma or stressor related disorders, anxiety disorders and neurodevelopmental disorders (such as learning disabilities, autistic spectrum disorders and attention deficit hyperactivity disorder). It has now become clear that burnout transpires cross culturally and is predominant across a variety of occupations and fields (Leiter & Schaufeli, 1996; Stalker & Harvey, 2002). Not unexpectedly, burnout is thought to be a recurrent problem among people who work in mental health settings and much literature has now focused on the

link between the mental health field and burnout (Awa et al., 2010; Dickinson & Wright, 2008; Edwards & Burnard, 2003; Morse et al., 2012; Paris & Hoge, 2010). Research has also demonstrated that staff in secure settings can experience even higher rates of burnout (Cacciacarne et al., 1986; Coldwell & Naismith, 1989; Dickinson & Wright 2008; Ewers et al., 2002; Mason, 2002).

A secure hospital can be defined as a hospital whereby the individuals who reside there are detained and are not free to leave. These hospitals are for individuals who have been diagnosed with a disorder defined in the DSM-5 and are considered to pose a risk of harm to themselves or others. In some cases, these services are an alternative to prison for people who have committed a crime. However, in other cases, some people in secure hospitals have never been involved in the criminal justice system and are admitted to a secure hospital when they are detained under the Mental Health Act (1983) as an involuntary patient.

Secure wards are demanding places to work for staff, as they care for a wide array of challenging individuals, whose needs are complex and cannot be met by community services. A growing body of literature now demonstrates that staff working in secure settings tend to experience higher levels of occupational stress and burnout than other professionals (Aiken et al., 2002; Jones et al., 1987; Medland et al., 2004). However, while the body of research in this area is certainly growing, it is thought that there is not currently enough research into this area to support an effective systematic review. Therefore, it has been decided that the current systematic review will focus on all hospital-based (as opposed to community-based) mental health workers, as mental health hospitals frequently occupy forensic patients too.

Regarding the proportion of mental health workers who suffer from burnout, the current literature gives varying statistics. Indeed, Morse et al. (2012) review several studies to determine the extent to which burnout is a problem in the mental health field and conclude that the percentage of mental health workers who experience high levels of burnout is anywhere between 21% and 67%. Oddie et al. (2007) examined 71 forensic mental health workers in the United Kingdom and 54% reported high rates of emotional exhaustion. Prior United Kingdom studies reviewed by Oddie et al. (2007) also reported a range of 21% to 48% of mental health workers as having high emotional exhaustion. Furthermore, the turnover of staff in the mental health field also appears to be particularly high. Mor Barak et al. (2001) reported that rates of turnover in mental health workers ranged from 30% to 60%. Additionally, Ben-Dror (1994) found that the turnover rate of employees in the mental health field hovered around 50% each year, rising to 72% when involuntary turnover was included.

While risk factors may be apparent in many different professions, a somewhat unique characteristic to working in the caring profession, particularly in mental health services, is the role of staff to engage with patients and listen to their experiences, which can be distressing at times (Figley, 1995). Mental health patients are often complex people, who have sometimes suffered traumatic histories and can demonstrate a wide range of challenging behaviours as a result of this. Their traumatic histories can

manifest in ways that can be traumatising for staff to witness, for example, in the form of self-harming behaviours or suicide attempts. The exposure to these potentially traumatising experiences can place mental health professionals within a 'critical occupation' (Paton & Violanti, 1996) and can have a substantial impact on their psychological well-being (Paton & Violanti, 1996; Sabin-Farrell & Turpin, 2003). Furthermore, as qualified nurses and nursing assistants/support workers are the staff who have the most regular direct contact with patients, especially when patients are in a time of crisis, they are subsequently considered to be the most at risk of having their psychological well-being compromised. Indeed, research has revealed that the highest rates of burnout are being reported by lower-ranking staff, who typically have more direct contact with patients. Indeed, Maslach et al. (2001) and Lasalvia et al. (2009) both discussed the notion that staff who had close face-to-face interaction with patients were more likely to develop burnout.

Research exploring staff morale and burnout has been carried out in various mental health settings, both inside and outside of the United Kingdom, which yields some critical evidence regarding the factors that may influence staff morale and burnout levels. It is a generally accepted notion that burnout occurs as a result of a complex interaction between individual characteristics and organisational factors (Green et al., 2014). Poor supervision and management (Sainsbury Centre, 2000; Harper & Minghella, 2001), too much administrative work (Prosser et al., 1997; Onyett et al., 1997; Billings et al., 2003; Priebe et al., 2005), role ambiguity (Onyett et al., 1997; Carpenter et al., 2003; Sainsbury Centre, 2000), large caseloads (Coffey & Coleman, 2001) and the threat of violence (Coldwell & Naismith, 1989; Reid et al., 1999, Sainsbury Centre, 2000) have all been identified as sources of stress in U.K. studies of mental health staff. Other organisational-environmental variables linked to burnout also include time pressures, role conflict, an absence of supervision and co-worker social support, limited job feedback, insufficient rewards (including social recognition), limited participation in decision-making matters, a lack of autonomy and unfairness and inequality (Maslach, et al., 2001; Paris & Hoge, 2010; van Dierendonck, Schaufeli, & Buunk, 2001).

However, many of these studies also have methodological limitations. Various methods have been used, with some studies using simple self-report questionnaires and others using a wide range of measures of various psychological and organisational concepts. Moreover, most studies are confined to a limited range of potential risk factors for burnout. Therefore, while a number of investigations have provided pointers to potential determinants of low staff morale and causes of stress, there is still a relative lack of large and systematic investigations that highlight the main risk factors for staff burnout.

As well as organisational-environmental factors, individual factors may also influence staff morale and burnout levels. Several individual factors, including external locus of control, poor self-esteem and maladaptive coping styles, have been linked to burnout (Maslach et al., 2001). The association of demographic risk factors with burnout has also garnered some support. Purvanova and Muros (2010) completed a meta-analysis examining gender differences in burnout and found that women reported significantly higher levels of emotional exhaustion and men reported significantly higher levels of de-

personalisation. Meta-analytic results have also indicated a negative relationship between age and emotional exhaustion (Brewer & Shapard, 2004). However, such findings should be interpreted cautiously, due to the possibility of a 'survival bias', whereby employees experiencing the highest levels of burnout may have higher levels of job turnover at younger ages (Brewer & Shapard, 2004; Maslach et al., 2001). Subsequently, individuals with lower levels of burnout symptoms may be over-represented among older employees who remain in a particular line of work.

Furthermore, with regards to patient characteristics, Nathan et al. (2007) adopted a case-control approach to compare a group of nurses on a medium secure male ward to a group of nurses on a medium secure female ward. Nurses on each ward were assessed for burnout before the ward opened and a subgroup was re-assessed 18 months later. It was concluded that nurses working on the female ward experienced a significantly greater increase in the emotional exhaustion component of burnout.

Bowers's (2009) acute inpatient ward study places a particular emphasis on the relationship between staff morale and the structural and organisational features of acute wards. Working in a deprived area, experiencing higher levels of verbal abuse and lower levels of routine and organisation on wards were among the aspects of staff's experience found to be associated with higher levels of burnout. Furthermore, Johnson et al.'s (2011) national investigation into mental health staff morale considers explaining the risk factors for burnout in mental health staff using the context of the 'demand-support-control'. Factors associated with high staff morale included: job control, high levels of support from colleagues and managers, role clarity, fairness and good communication within the team. Factors associated with low staff morale included: role conflict, experiencing bullying or discrimination, experiencing threatening behaviour and experiencing violence. It is clear that Johnson et al. (2011) discussed a variety of potentially important links, but the causal status of these links is often unclear.

The link between mental health and criminal behavior:

Research has found that people in the criminal justice system have significantly higher rates of mental illness and mental disorders than people in the general community. People with a mental illness are also more likely to be detained in custody, sentenced to imprisonment, or to become a victim of crime (Short et al., 2012; MacPhail & Verdun-Jones, 2013; Kim et al., 2015). Furthermore, the HCR-20 V3 (Douglas et al., 2013) is a structured professional guideline to assessing an individual's risk of violence and was developed from a thorough consideration of the empirical literature concerning risk factors that relate to violence. Indeed, according to the HCR-20 V3, a person's risk rating would be increased if they had a diagnosis of a major mental illness, a diagnosis of personality disorder, if they lacked insight into their mental illness or if they had active symptoms of major mental illness.

Existing reviews:

A scoping exercise was undertaken to explore previous reviews aiming to answer a similar review question. The scoping exercise took place on the 18th of June 2016 using Cochrane Library, D.A.R.E,

Embase, MEDLINE, PsycINFO and Web of Science. The findings from the scoping exercise are discussed below.

There are currently no large scale international surveys that can clearly identify common stressors in mental health nursing. Moreover, there are currently no systematic reviews into the risk factors for burnout in mental health workers. Indeed, the majority of such reviews focus on the risk factors for burnout in general healthcare professionals, these include: general nurses (Duquette et al., 1994; Khamisa et al., 2013), critical care nurses (Epp, 2012) oncology nurses (Gómez-Urquiza et al., 2016), emergency medicine physicians (Arora, 2013), general practitioners (Dagrada et al, 2011) palliative care workers (Pereira et al., 2011), doctors and nurses (Walkiewicz, 2014), physiotherapists (Mikolajewska, 2014) and dentists (Singh et al., 2015). Indeed, numerous risk factors have now been examined with regards to burnout in general nursing. However, the relative significance of such risk factors remains somewhat unclear within the area of mental health nursing.

Literature reviews:

Reviews into the risk factors for burnout in mental health staff primarily exist in the form of narrative reviews. Morse et al. (2012) considered the extent to which burnout is a problem for mental health services in terms of two critical issues: its prevalence and its association with a range of undesirable outcomes for staff, organisations and recipients.

Dickinson and Wright (2008) reviewed the literature specifically on stress and burnout in forensic mental health nursing to identify the stressors and to highlight recommendations. From the review, the main stressors placed on forensic nurses were identified as inter-professional conflicts, workload, and lack of involvement in decision-making. Recommendations to reduce stress and burnout for nurses were also highlighted.

Karanikola and Kleanthous (2011) investigated the differing levels of burnout among general mental health nurses and the factors associated with burnout. A review of the literature published from 2000 to 2010 was undertaken and 14 relevant studies were found. A significant percentage of mental health nurses reported intense professional burnout symptoms. Factors that contributed to burnout symptoms were related to the individual characteristics of the nurses, working parameters and the characteristics of the patients. It was concluded that burnout among psychiatric nurses is a multi-dimensional phenomenon and that work factors appear to have a greater impact than the individual characteristics of the nurses.

Leiter and Harvie (1996) summarised findings regarding established norms, demographic variables, possible antecedents of burnout, possible consequences of burnout and burnout models tested with mental health workers and proposed directions for future research.

Finally, Edward and Hercelinskyj (2007) considered a number of hypotheses for managing and reducing the impact of burnout amongst nursing staff. They reported that role conflict, role ambiguity and time constraints contribute to the development of burnout, along with employment insecurity, organisational structures, inadequate resources, safety issues relating to risk of violence from patients, and fewer fundamental rewards. The authors conclude that those who experience the circumstances outlined above, yet transcend burnout, possess certain resiliencies, which they characterise as intrapersonal and environmental factors. These factors include optimism, humour, intelligence, and aspirations towards future goals.

Systematic reviews:

Upon scoping the literature for systematic reviews, three were found that were considered to be relevant. Freestone et al. (2015) provided an overview of the impact on staff of working with personality disordered offenders (PDOs) in a forensic personality disorder service. 27 papers were included in the review, but the authors stated that the overall quality of the evidence identified by the search was 'very low', according to the hierarchy proposed by Greenhalg (1997). The studies identified negative impacts upon staff, including: negative attitudes, burnout, stress and negative counter-transferential experiences. Two studies found positive impacts of job excitement and satisfaction, and the evidence related to perceived risk of violence from the PDOs was equivocal. Studies demonstrated considerable heterogeneity and meta-analysis was not possible. The overall level of identified evidence was low: 23 studies (85%) were descriptive only, and only one adequately powered cohort study was found. The review identified a significant amount of descriptive literature, but only one cohort study and no trials or previous systematic reviews of literatures. The authors of the study concluded that clinicians and managers working with PDOs should be aware of the potential impacts identified, but there remains an urgent need for further research.

Edwards et al. (2000) conducted a systematic review to synthesise the evidence base on stress and burnout for community mental health nursing staff. 17 papers were identified, seven of which explored stress and burnout for all community mental health workers and ten which focused solely on community mental health nurses. The review indicated that the risk factors for stress and burnout included: increasing workloads, increasing administration and lack of resources. For community mental health nurses, specific stressors were identified. These included increases in workload and administration, time management, inappropriate referrals, safety issues, role conflict, role ambiguity, lack of supervision, not having enough time for personal study, NHS reforms, general working conditions and lack of funding and resources.

The third relevant systematic review found was Melchior et al. (1997), who conducted a meta-analysis into the relative strengths of a number of variables on burnout among psychiatric nurses. A meta-analysis of correlations revealed that burnout was negatively associated with job satisfaction, staff support and involvement with the organisation and positively associated with role conflict. The results of the meta-analysis were in line with results of other studies in which different populations were

investigated. Therefore, the findings as such are not specific to psychiatric nurses. Three typical risk factors of burnout among psychiatric nurses were found: the patient group worked with (such as patients who are aggressive and suicidal), the inequity in the exchange process between nurses and patients, and the unrealistic expectations of nurses of the patients' potential for rehabilitation.

As part of Melchior et al.'s (1997) review, 33 articles were found. Of these articles, nine articles met the criteria for inclusion. However, in only three of these studies did the sample consist completely of psychiatric nurses and only two of these studies gave a total burnout score. Moreover, three of the studies gave information regarding significant correlations only. Furthermore, Melchior et al. (1997) draw conclusions about risk factors which have only been identified in individual studies alone, which questions the generalisability of these findings.

With regards to Freestone et al.'s (2015) review, the researchers concentrated solely on personality disordered offenders in a forensic hospital, whereas the current review will not specify the diagnosis of patients and will consider the whole patient population. With regards to Edwards et al.'s (2000) review, the authors focused specifically on community mental health nursing staff. Therefore, it would not be possible to generalise these findings to inpatient mental health nursing staff, as the patients worked with are likely to present with very different characteristics and often more challenging behaviours, meaning that the risk factors for burnout could also be very different. Furthermore, Melchior et al.'s (1997) review was conducted nearly 20 years ago, in 1997. It is likely that an array of contemporary research papers will now exist, which will be considered to be more relevant, recent and up-to-date. Furthermore, there are a number of issues with Melchior et al.'s (1997) review and conclusions that were drawn, which are discussed above. Therefore, from scoping the literature, it appears that there is no current systematic review which specifically considers the risk factors related to the materialisation of burnout in mental health nursing staff.

Rationale:

The current systematic review was justified on the basis that, while an array of previous studies have considered the possible risk factors for burnout in mental health staff (including both organisational factors and individual factors), no systematic review has collaborated the findings of this body of literature since the review by Melchior et al. (1997). However, there are a number of critiques regarding this study, which are outlined above. Furthermore, as Melchior et al.'s (1997) review was conducted nearly 20 years ago, it is likely that a greater number of contemporary research papers will now exist.

Objectives:

The aim of this systematic review is to determine whether the materialisation of burnout in mental health workers can be predicted by presence of certain risk factors and, if so, what these risk factors are. While the review will include any studies that involve forensic mental health populations, the review will not concentrate on forensic mental health populations exclusively, as after scoping the literature, it is

believed that there would not be enough research available in this area alone to conduct an effective systematic review.

This review will focus specifically on staff who work in mental health settings, as opposed to general health settings and other branches of the nursing profession, as research has highlighted that specific factors of mental health nursing can have an impact on the development of burnout. The staff members the review will consider are staff members who have regular direct contact with the patients. Therefore, this will include qualified nurses and nursing assistants/support workers. As highlighted previously, the unique characteristics of working closely with mental health patients can include exposure to potentially traumatic experiences, placing these nurses and nursing assistants/support workers in a 'critical occupation' (Paton & Violanti, 1996). Accordingly, the objective of this systematic review will be to synthesise the existing empirical literature in order to investigate which risk factors are associated with the materialisation of burnout.

The review question:

A systematic review on the risk factors for burnout in mental health staff.

Inclusion and exclusion criteria:

To develop and confirm the inclusion criteria, preliminary scoping searches were completed in Cochrane Library, D.A.R.E, Embase, MEDLINE, PsycINFO and Web of Science. The inclusion criterion consisted of the following:

Population: Mental health nursing staff who have regular and direct contact with patients, namely qualified nurses and unqualified nursing assistants/support workers only.

Exposure: Risk factors.

Outcome: Burnout.

Context: Mental health hospital environment, e.g. secure hospitals, psychiatric hospitals and forensic hospitals. It will not include a general health environment and will not include mental health work in a community setting.

Study design: Cohort studies, case control studies, cross-sectional studies and qualitative studies will all be included. Review papers, opinion papers, editorials, newspaper articles and popular media will not be considered.

Language: No restriction.

Sources of literature and search strategy:

The following databases will be searched as they are deemed most relevant to this question.

- CINAHL
- Embase
- MEDLINE
- PsycInfo
- Web of Science

Grey literature will also be searched and may include theses, dissertations, clinical trials, official publications, discussion papers or government reports. Moreover, manual searching will also be utilised, whereby the references of selected studies will be scanned and authors of key studies and experts in the area will also be contacted, if necessary.

All of the above databases will be searched using the same search strategy and keywords:

"mental health hospital" or "mental health ward" or "mental health unit" or "secure hospital" or "secure ward" or "secure unit" or "forensic hospital" or "forensic ward" or "forensic unit" or "psychiatric hospital" or "psychiatric ward" or "psychiatric unit"

AND

"risk factor" or "risk*" or "factor*" or "cause*" or "link*" or "associate*" or "high risk*" or "attribute*" or "occupation* factor*" or "contribute*" or "cause*" or "high risk*" or "stressor*" or "variable*" or "correlate*" or "reason" or "chance" or "likelihood" or "danger" or "exposure" or "possibility" or "increase* risk" or "predictor*" or "antecedent*" or "personal* characteristic*" or "organisation* characteristic" or "organisation* factor" or "demograph*" or "personal* factor" or "personality" or "socio-demograph*"*

AND

"burnout" or "stress" or "job satisfaction" or "job dissatisfaction" or "well being" or "wellbeing" or "well-being" or "work relate* stress" or "job relate* stress" or "occupation* stress" or "exhaust*" or "low morale" or "morale" or "occupation* stress" or "profession* stress" or "job stress" or "work stress" or "depersonal*" or "emotion* exhaust*" or "person* accomplish*" or "impact" or "outcome" or "effect" or "strain" or "frustration" or "sick day" or "turnover" or "performance" or "overload"*

AND

"staff" or "ward staff" or "mental health nurs" or "forensic nurs*" or "psychiatric nurs*" or "psychiatric hospital staff" or "psychiatric unit staff" or "mental health staff" or "mental health hospital staff" or "mental*

health unit staff" or "registered nurs" or "RGN" or "RMN" or "qualified nurse" or "nurs* assist*" or "car* assist*" or "health car* assist*" or "support* assist*" or "support* work*" or "help* staff" or "help* work*" or "car* staff" or "car* work*" or "mental health work*" or "mental health support* work*" or "forensic hospital staff" or "forensic unit staff" or "secure hospital staff" or "secure hospital staff" or "staff nurs*" or "mental health profession**"*

Study selection:

- An initial screening will ensure that any duplicate papers are removed.
- Any reviews or opinion papers will also be removed.
- The titles of the remaining references will be examined against the inclusion and exclusion criteria to exclude anything clearly irrelevant to the topic.
- The title and abstracts of all the relevant references will be examined to exclude anything that clearly do not meet the inclusion and exclusion criteria
- The full references of those considered as meeting criteria or needing further clarification will be read and compared against the inclusion/exclusion criteria, using the pre-determined form.
- A flowchart to illustrate this whole selection process will be presented in the report.
- To minimise bias and errors, a second assessor will work independently to review 10% of the references. Decisions between the two assessors will be compared to minimise errors. Any disagreements will be resolved by discussion between the two reviewers.
- In case of missing information, study authors will be contacted.
- All studies considered and decisions made on them will be recorded.
- Studies excluded at the last stage and the reasons for their exclusion will be discussed.

Quality assessment:

Those references that meet the inclusion criteria will be assessed for quality. Those without clear definitions of the population, the exposure and the outcome measures will be screened out. Authors whose papers do not provide enough information will be contacted for clarification. The methodological quality of each paper will be assessed using a specifically designed quality assessment form, which has been based on both the Critical Appraisal Skills Programme Checklist (CASP, 2004) and the Effective Public Health Practice Project (EPHPP) quality assessment tool for quantitative studies.

It is predicted that the systematic review will generate a methodologically diverse group of studies, including both quantitative and qualitative studies. Therefore, different quality assessment forms will be used, dependent upon the design of the study.

The CASP and EPHPP checklists cover a variety of different factors. The quality assessment form designed for this systematic review will assess each study with regards to the population selected, the study design, the data collection procedures and the findings, as well as the applicability of the findings and any confounding variables or bias within the studies, which might be able to explain the findings. In particular, studies of a quantitative nature will be assessed for: construct validity of outcome

measures or concepts used, validity of statistical conclusions, internal validity, external validity and descriptive validity.

The risk of any potential bias in the individual studies selected, such as sampling bias and measurement bias, will be identified and accounted for. It will then be discussed how such bias was managed. If publication bias becomes apparent (for example, if there is a high proportion of positive findings in published studies compared to a low proportion of significant findings in unpublished studies), then the researcher will discuss how this was accounted for and what implications it could lead to when synthesising and interpreting the results. Locating unpublished studies and unpublished outcomes of published studies may help to reduce the level of publication bias, providing a better estimate of effectiveness or association. This will be done by grey literature searching and manual searching, which may involve contacting authors of key studies and experts in the area, if necessary.

Each of the studies will be recorded as follows:

- Y = Fully meets the criteria.
- P = Partially meets the criteria.
- N = Does not meet the criteria.
- U = Unclear.

Research has shown that quality numbering scores are arbitrary, unreliable and hard to interpret (Juni, 1999). It is also against the Cochrane guidelines to assign numerical values when assessing research design and conduct. Each paper will be assessed by the first author. A second assessor will independently assess 20% of the included studies. An interrater reliability analysis will be performed using the Kappa statistic and the degree of agreement between the two ratings will be identified and discussed. Disagreements in ratings will be resolved by discussion between the two reviewers.

Data extraction:

Data extraction forms will be used during this process. It will include information on study characteristics, which will consist of the study aims, design, recruitment process, participant demographics, sample size, outcome measures, variables considered, the use of standardised measures, statistical analysis, results, attrition bias, the findings and applicability and implications of the findings.

Appendix B - Table of excluded studies (172 excluded)

Author and date	Reasons for exclusion
Acker (2003)	Population
Acker (2008)	Population
Adali et al. (2003)	Population
Aiken et al. (2002)	Population
Ashtari et al. (2009)	Population
Bai & Suh (1989)	Population
Baver et al. (1993)	Population
Benjamin & Spector (1990)	Population
Bennett et al. (2010)	Population
Berglund & Pemelia (1979)	Population
Bougea et al. (2015)	Population
Bowden et al. (2015)	Population
Bowers (2002)	Study design
Bowers (2011)	Study design
Bowers et al. (2009)	Population
Bowers et al. (2010)	Population
Bradford (1983)	Outcome
Cacciacarne et al. (1986)	Population
Capri & Buckle (2015)	Population
Carlson & Fagin (1996)	Study design
Catanesi et al. (2016)	Study design
Chakraborty et al. (2012)	Population
Coffey & Coleman (2001)	Population
Coffey (2000)	Population
Coleman (2001)	Population
Constable & Russell (1986)	Population
Corrigan et al. (1994)	Population
Corrigan et al. (1995)	Outcome
Currid (2008)	Population
Currid (2009)	Population
Dawkins et al. (1985)	Population
Decaive et al. (2006)	Outcome

Deverex et al. (2009)	Study design
Donat et al. (1991)	Population
Dreison et al. (2016)	Study design
Dunn (2000)	Population
Eggert et al. (2014)	Outcome
Erasmus et al. (1998)	Population
Eren (2014)	Outcome
Esposito et al. (2016)	Population
Ewers et al. (2002)	Exposure
Finley (2000)	Population
Firth et al. (1987)	Population
Flanagan & Flanagan (2002)	Population
Franza et al. (2015)	Population
Freddi & Corradi (2003)	Population
Freestone et al. (2015)	Study design
Fukuzaki & Tanihara (2014)	Population
Fukuzaki (2014)	Population
Garland & McCarty (2009)	Population
Gillespie & Numerof (1991)	Population
Gustaffson et al. (2009)	Population
Halayem-Dhouib et al. (2010)	Population
Hamaideh (2011)	Population
Hamaideh (2014)	Population
Hamdan-Mansour et al. (2011)	Population
Handelsman (2013)	Population
Hanrahan et al. (2010)	Population
Happell (2008)	Study design
Happell et al. (2003)	Population
Hiscott & Connop (1990)	Population
Ito et al. (2001)	Outcome
Ito et al. (2014)	Population
Itzhaki et al. (2015)	Population
Jahrami (2013)	Outcome
Jamal & Baba (1997)	Population
Jassen (1989)	Population

Jeanneau & Armelius (2000)	Population
Jecna et al. (2009)	Population
Jenkins (2004)	Population
Johnson et al. (2012).	Population
Johnson et al. (2016)	Outcome
Jusler et al. (2015)	Population
Kelloway & Barling (1991)	Exposure
Kelly (2013)	Outcome
Kirkcaldy & Siefen (1991)	Population
Kirkcaldy & Siefen (1998)	Outcome
Kurtz (2005)	Study design
Laker et al. (2012)	Population
Lamb & Cogan (2016)	Population
Lasalvia et al. (2011)	Population
Laubach et al. (1999)	Outcome
Ledi & Edmund (2015)	Population
Lee et al. (2015)	Exposure
Leiter & Harvie (1996)	Study design
Leiter (1988)	Population
Leiter (1991)	Exposure
Leka (2012)	Population
Leung et al. (2007)	Population
Livingston & Livingston (1984)	Population
Martin (2015)	Population
Maslach & Leiter (2016)	Study design
Maslach et al. (2001)	Study design
McCarthy (1985)	Population
McGrath et al. (1989)	Population
McTiernan et al. (2015)	Population
Melchior et al. (1997)	Study design
Menon et al. (2015)	Population
Mesenzehl et al. (2006)	Population
Mesenzehl et al. (2007)	Population
Miller et al. (1988)	Population
Moore & Cooper (1996)	Study design

Morse et al. (2012)	Study design
Ndetei et al. (2009)	Population
Niedhammer (2012)	Population
Nolan et al. (2011)	Population
Nuchols (1995)	Population
Ogresta et al. (2008)	Population
Olivira Santos et al. (2010)	Population
Pan & Chen (2015)	Population
Papathansiou (2007)	Population
Paris & Hoge (2010)	Study design
Parkes & Vonrabenu (1993)	Population
Peacock (1991)	Population
Pedrini et al. (2009)	Population
Penn et al. (1980)	Population
Pines & Maslach (1978)	Population
Prosser et al. (1997)	Population
Prosser et al. (1999)	Population
Qi et al. (2014)	Population
Rabin et al. (1999)	Study design
Rabin et al. (2011)	Population
Reed (1988)	Population
Richardson (1982)	Outcome
Rocha et al. (2016)	Outcome
Rossler (2012)	Study design
Rossler (2012)	Study design
Samuelsson et al. (1997)	Outcome
Sancassiani et al. (2015)	Outcome
Savicki & Cooley (1987)	Population
Scarnera (2009)	Population
Schalast (2008)	Outcome
Schulz et al. (2009)	Population
Semenova et al. (2016)	Outcome
Shen et al. (2005)	Population
Shinn et al. (1984)	Population
Shutts (1986)	Population

Siu (2001)	Population
Souza et al. (2015)	Population
Sorgaard et al. (2007)	Population
Sorgaard et al. (2010)	Population
Spaans (1991)	Population
Spear et al. (2004)	Population
Stout & Posner (1984)	Population
Sullivan (1989)	Population
Sullivan (1993)	Population
Taylor & Barling (2004)	Population
Thompson & Page (1992)	Population
Thornton (1992)	Population
Tonso et al. (2016)	Population
Totman et al. (2011)	Outcome
Tyson et al. (2002)	Outcome
Van Bogaert et al. (2013)	Population
Van Bogaert et al. (2014)	Population
Van Dierendonck et al. (2001)	Population
Van Gerven et al. (2016)	Population
Van Gorp et al. (1993)	Population
Verhaeghe et al. (2016)	Population
Verhaeghe et al. (2016)	Population
Volpe et al. (2014)	Population
Ward & Cowman (2007)	Outcome
Ward (2011)	Population
Weinberg et al. (1983)	Population
Wood et al. (2011)	Population
Wright-Herard (2014)	Population
Wykes (1991)	Population
Xanthakis (2009)	Population
Yada et al. (2014)	Population
Yang et al. (2015)	Population
Yao et al. (1995)	Population
Yiqun et al. (2007)	Population
Zautra et al. (1986)	Outcome

Appendix C - Data extraction form

Date of data extraction:	
Title of article:	
Author(s) and date:	
Source (volume, pages, country of origin):	
Quality rating:	

Eligibility of study			
P	Qualified nurses or unqualified nursing assistants/support workers.	Yes	No
E	Exposure to risk factors.	Yes	No
O	Burnout.	Yes	No
Continue to next stage?		Yes	No

Context	Mental health hospital environment, e.g. secure hospitals, psychiatric hospitals and forensic hospitals. It will not include any general health environment or any mental health work in a community setting.	Yes	No
Continue to next stage?		Yes	No

Methodology	
Research question	
Study design	
Exclusion criteria	
Recruitment process	
Participant characteristics	
Sample size	
Number of participants in each group	

Exposure	
Focus of exposure	
Setting of exposure	
Duration of exposure	
Number of conditions/content of each condition	

Outcomes	
What was measured at baseline?	
What was measured after exposure/follow up?	
What was the measurement tool?	
Was the measurement tool validated?	
Time interval between first/last measurements?	
Attrition rates overall?	
Was attrition dealt with appropriately?	

Statistical analysis	
What was measured?	
What was the measurement tool?	
Statistical techniques used?	
Were confounding variables assessed?	
Were confounding variables controlled for?	

Results	
What were the results?	
What were the conclusions?	
Limitations of the study	
Strengths of the study	
Applicability of the findings	
Any further comments?	

Appendix D - Quantitative quality assessment form

1. Population			
Is the population defined as members of staff or employees who work in a forensic mental health setting?	Yes	Not sure	No
Is this setting defined as a secure/forensic hospital environment?	Yes	Not sure	No
Do the population have regular/direct contact with patients?	Yes	Not sure	No
Do the population work with individuals diagnosed with a disorder defined in the DSM-V?	Yes	Not sure	No

2. Exposure			
Has the population been exposed to risk factors that are identified as either situational factors or individual factors?	Yes	Not sure	No

3. Comparison			
A comparison is not necessary. However, a comparison group could include staff who work in a psychiatric (non-forensic) hospital setting or staff who work in a forensic mental health community setting. Therefore, is the comparison group an appropriate comparison?	Yes	Not sure	No

4. Outcome			
Is the outcome of the exposure defined as work-related stress, burnout, physical health problems or mental health problems?	Yes	Not sure	No

5. Study type			
Is the study either a cohort study, a case control study, a cross-sectional study or a qualitative study?	Yes		No

6. Is the study to be included?			
If not, give reasons for exclusion: _____ _____ _____	Yes		No

	Yes	Partially	No	Unclear/comments
SELECTION BIAS				
Was the research question or objective clearly stated?				
Was the type of study design appropriate for the stated aim?				
Was the study population clearly defined and specified?				
Were the participants recruited in an acceptable way?				
Were inclusion and exclusion criteria pre-specified and applied uniformly to all participants?				
Were the participants selected representative of the intended population?				
Did all the population have an equal opportunity to participate in the study?				
Was a sample size justification or power description provided?				
Was the participation rate of eligible people adequate?				

Risk of selection bias	High	Moderate	Low	Unclear
-------------------------------	------	----------	-----	---------

	Yes	Partially	No	Unclear/comments
MEASUREMENT BIAS				
Would the variables measured in the study produce data that reflected the aims of the study?				
Was the exposure (risk factors) clearly defined?				
Was the exposure measured to minimise bias?				
Were the measures employed to measure the exposure shown to be reliable and valid?				

Was the outcome (stress or burnout) clearly defined?				
Was the outcome measured to minimise bias?				
Were the measures employed to measure the outcome shown to be reliable and valid?				
Were the methods described to enable them to be repeated?				

Risk of measurement bias	High	Moderate	Low	Unclear
---------------------------------	------	----------	-----	---------

	Yes	Partially	No	Unclear/comments
CONFOUNDING FACTORS				
Confounding factors that the authors accounted for:				
Confounding factors that the authors missed:				
Have the authors discussed potential confounding factors?				
Have the authors controlled for potential confounding factors?				

	Yes	Partially	No	Unclear/comments
ATTRITION BIAS (IF APPROPRIATE)				
Was the follow up of subjects complete enough?				
Was the follow up of subjects long enough?				
Was consideration given to the potentially different outcomes				

between those unavailable for follow-up and those available?				
Are those followed-up similar to those who were not?				

Risk of attrition bias	High	Moderate	Low	Unclear
-------------------------------	------	----------	-----	---------

	Yes	Partially	No	Unclear/comments
ANALYSIS				
Is it clear what statistical methods were used?				
Was the statistical test(s) employed appropriate?				
Were the size of the confidence intervals appropriate for the statistical analysis employed?				

	Yes	Partially	No	Unclear/comments
DISCUSSION				
Are the results discussed with regards to the study objectives?				
Were the author's discussions and conclusions justified by the results of the study?				
Are limitations or potential biases discussed?				
Was ethical approval and participant consent obtained?				

Overall rating of paper	Strong	Moderate	Weak	Very weak
--------------------------------	--------	----------	------	-----------

Further research is very unlikely to change our confidence in the estimate of effect.

Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Any estimate of effect is very uncertain.

Appendix E - Qualitative quality assessment form

1. Population			
Is the population defined as members of staff or employees who work in a forensic mental health setting?	Yes	Not sure	No
Is this setting defined as a secure/forensic hospital environment?	Yes	Not sure	No
Do the population have regular/direct contact with patients?	Yes	Not sure	No
Do the population work with individuals diagnosed with a disorder defined in the DSM-V?	Yes	Not sure	No

2. Exposure			
Has the population been exposed to risk factors that are identified as either situational factors or individual factors?	Yes	Not sure	No

3. Comparison			
A comparison is not necessary. However, a comparison group could include staff who work in a psychiatric (non-forensic) hospital setting or staff who work in a forensic mental health community setting. Therefore, is the comparison group an appropriate comparison?	Yes	Not sure	No

4. Outcome			
Is the outcome of the exposure defined as work-related stress, burnout, physical health problems or mental health problems?	Yes	Not sure	No

5. Study type			
Is the study either a cohort study, a case control study, a cross-sectional study or a qualitative study?	Yes		No

6. Is the study to be included?			
If not, give reasons for exclusion: _____ _____ _____			
	Yes	No	

	Yes	Partially	No	Unclear/comments
Screening questions				
Was there a clear statement of the aims of the research?				
Is a qualitative methodology appropriate for addressing the research goal (i.e. does the research seek to interpret the experiences of participants?)				

	Yes	Partially	No	Unclear/comments
Detailed questions				
Was the research design appropriate to address the aims of the research (i.e. does the researcher justify the design?)				
Was the recruitment strategy appropriate to the aims of the research?				
Has the researcher explained how and why participants were selected?				
Is it clear how data was collected (i.e. focus group or interviews)?				
Has the researcher justified the methods chosen?				
Is the form of data clear (i.e. tape recordings or notes)?				
Has the relationship between the researcher and the participants been adequately considered?				
Have ethical issues been adequately addressed?				
Is there an in-depth description of the data analysis process?				

Was the data collected in an appropriate and consistent setting for each participant?				
Is it clear how the findings discussed were derived from the data?				
Is data saturation discussed?				
Is sufficient data presented to support the findings?				
Is contradictory data either not present or fully taken into consideration?				
Did the researcher critically examine their own role, potential bias and influence?				
Is there a clear statement of findings (i.e. are the findings explicit and discussed in relation to the initial research aim?)				
Is there an adequate discussion of the evidence for and against the researcher's argument?				
Does the researcher consider the contribution the study makes to existing knowledge or understanding (i.e. do they consider the findings in relation to current practice or policy?)				
Given the conduct of the study, is the conclusion justified?				

Overall rating of paper	Strong	Moderate	Weak	Very weak
	Further research is very unlikely to change our confidence in the estimate of effect.	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.	Any estimate of effect is very uncertain.

Appendix F - Hospital manager approval letter



Emily Shaw

11/10/2016

Dear Emily

Thank you for submitting your request to carry out a research project within Cygnets Hospital Bury relating to staff burnout.

The Senior Management Team has reviewed the proposal and can confirm that we are happy for you to proceed with the project.

We would need to ensure the research is anonymised and that we can access the results, as it is an area we are also interested in.

Please link in with Colleen Fahy, Clinical Manager as your point of contact.

Good luck with your project.

Yours Sincerely

A handwritten signature in black ink that reads "cgarvey".

Charles Garvey
Clinical Quality and Compliance Manager

www.cygnethhealth.co.uk

Cygnets Hospital Bury, Butler Street (Off Bolton Rd), Lancashire, Bury, BL8 2BS

Tel: 0161 762 7200 | Fax: 0161 762 4747

Reg Office: Cygnets NW Ltd, Nespica House, London Road, Wrotham Health, Sevenoaks, TN15 7RS

Reg. in England No. 4059699

Appendix G - Permission to use MBI-HSS

For use by Emily Shaw only. Received from Mind Garden, Inc. on December 31, 2016



To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Maslach Burnout Inventory forms: Human Services Survey, Human Services Survey for Medical Personnel, Educators Survey, General Survey, or General Survey for Students.

The three sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument form may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below.

Sample Items:

MBI - Human Services Survey - MBI-HSS:

I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some recipients.

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MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):

I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

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MBI - Educators Survey - MBI-ES:

I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some students.

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Cont'd on next page

MBI - General Survey - MBI-GS:

I feel emotionally drained from my work.
In my opinion, I am good at my job.
I doubt the significance of my work.

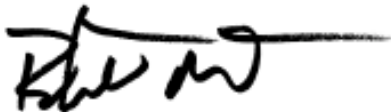
Copyright ©1996 Wilmar B. Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc.,
www.mindgarden.com

MBI - General Survey for Students - MBI-GS (S):

I feel emotionally drained by my studies.
In my opinion, I am a good student.
I doubt the significance of my studies.

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www.mindgarden.com

Sincerely,

A handwritten signature in black ink, appearing to read 'Robert Most', with a long horizontal line extending to the right.

Robert Most
Mind Garden, Inc.
www.mindgarden.com

Appendix H - Quantitative participant information sheet

Human Services Survey

0% complete

Page 1: Information sheet

Please only complete this survey if you work in a secure forensic hospital.

You are invited to be involved in this research study because you work in a secure forensic hospital. Before you decide whether you want to take part or not, it is important for you to understand why the research is being conducted and what your participation will involve. Please read the following information carefully and consider whether you wish to take part or not.

Aims: This research aims to investigate the job-related attitudes of forensic hospital employees.

Requirements: The questionnaire is 22 questions long and should take no longer than 10 minutes to complete. The questionnaire can be carried out at a time of your convenience.

Anonymity and confidentiality: All data is completely anonymous and confidential. All responses to the questionnaire will be anonymised, so that you cannot be identified from your answers. All data will be stored securely, in a password protected file. It should not be possible to identify anyone from my reports on this study.

Voluntary participation: Your participation in this study is entirely voluntary. It is up to you to decide whether to take part or not. If you decide to take part, you are still free to withdraw any time, without giving a reason. The data will only be uploaded on completion of the study by clicking the 'finish' button at the end of the final questionnaire.

Publication: Once the thesis arising from this research has been completed, a brief summary of the findings will be made available by the researcher upon application. It is also possible that the results will be presented at academic conferences and journals. The data will be kept securely for ten years from the date of publication, before being destroyed. If this study has harmed you in any way, you can contact the University of Nottingham using the details below for further advice and information.

This study has been reviewed and given a favourable opinion by the University of Nottingham, Faculty of Medicine & Health Sciences Research Ethics Committee.

Contact details: If you have any questions about this study you may email the lead researcher, Emily Shaw, at: emily.shaw@nottingham.ac.uk. If you have any concerns about this study, please contact the research supervisor, Dr Shihning Chou, at: shihning.chou@nottingham.ac.uk.

Thank you for taking the time to read this information.

Appendix I - Quantitative participant consent form

Human Services Survey

25% complete

Page 2: Consent form

This part of the survey uses a table of questions, [view as separate questions instead?](#)

1. Thank you for participating! To continue with the study, please confirm the following: * *Required*

Please don't select more than 1 answer(s) per row.

Please select at least 5 answer(s).

	Yes	No
I confirm that I have read and understood the information on the previous page	<input type="checkbox"/>	<input type="checkbox"/>
I understand that my participation is voluntary and I may withdraw from the study at any time	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I will not be identified and my results will remain anonymised and confidential	<input type="checkbox"/>	<input type="checkbox"/>
I understand that all data will be stored safely on a computer hard drive and only the researcher and the research supervisor will have access to this data	<input type="checkbox"/>	<input type="checkbox"/>
I understand that the overall anonymised data from this study may be used in the future for research and teaching purposes	<input type="checkbox"/>	<input type="checkbox"/>

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Next >

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Appendix J - Reflective journal example

Descriptive content:

This interview was with a female support worker who had worked at the organisation for approximately four years. The support worker had predominantly worked with the female clients for the past four years and was currently based on a low secure female ward. The main focus of this interview appeared to be the issues with staff relationships, a lack of support and a lack of resources. In terms of staff relationships, the participant mentioned issues with bitching and unfairness, with some staff getting longer breaks and all the opportunities, while some staff worked hard and got no recognition for their efforts. In terms of training, the participant expressed the belief that she would like more in-depth training with regards to the client group that she works with, as she would like to be able to understand them better and provide a better standard of care. It was clear that she cared about her patients greatly, but she often felt out of her depth with regards to working with patients with mental illnesses and personality disorders. It was also clear that a lack of experienced staff, with a lack of adequate training, was making the participant feel unsafe and vulnerable on the ward.

However, by far the biggest issue for this participant was the lack of support that she received at work. In fact, she described a time when she was feeling burnt out at work and the response that she received from her manager. She stated that she did not want to go into work and that she was feeling emotional all the time. She described it as 'all building up' and then 'boom'. She also described recognising the signs of burnout in some of her colleagues as well, as they 'don't want to do their job properly' because 'they can't be arsed'. Interestingly, I felt that her description of burnout reflected Maslach's three-dimensional conceptualisation of burnout very well and accurately tapped into a number of the dimensions of burnout. The participant also expressed that burnout was like a 'domino effect' and that patient stress and staff stress are inter-linked. When she was feeling burnt out, she stated that she approached her manager, stating that she was 'feeling down' and would like to move wards. However, she was ignored until she threatened to resign. Upon reflection, it felt as though this situation could have been handled much better by the management and it did not need to escalate in the way that it did. The participant highlighted that support was available from her ward-level colleagues, but not from anyone higher up in the hierarchy, as the management did not take the support worker's concerns seriously. Unfortunately, the participant stated that the support only came to her when it was too late and she had already had 'a breakdown'.

Reflective content:

Over the course of the six interviews that I have facilitated so far, I feel that I have gradually become more comfortable. At first, I felt like I was struggling with wording my questions correctly and I was often getting quite short answers from my participants. However, I now feel that I have developed a better style and am able to ask the right open ended questions, which elicit more detailed answers. I am also relying on my prompts less now as well, which means that I am able to sustain a flowing conversation without having to look at my sheet of questions. I feel more comfortable interviewing my participants now and I have been reflecting back on my first two interviews and thinking about what I could have done differently. In hindsight, I imagine that if I could go back in time and conduct my first two interviews again, then I may be able to elicit more detail from my participants. However, this has been a learning curve for me and I am glad to be able to reflect on these learning points I feel that when I go in with a

more relaxed attitude and less of an agenda about what questions I want to ask, then the conversation actually flows much easier. This is something I will take forward with me.

Throughout this interview, I felt that I had to be particularly aware of what I may be bringing to the interactions. As the participant herself worked on one of the female wards, I had to be mindful that my personal experiences of working as a support worker on a medium secure female ward did not influence the interview in any way. I am very aware of how passionate I am regarding working with the women and I had to be very mindful that my use of language or my enthusiasm did not influence the participant's responses in any way. I empathised with the participant throughout the interview, as I understood a lot of the issues that she was talking about, as I had encountered them too, throughout my time as a support worker. However, I made a conscious effort to remain neutral at all times, whilst also presenting myself as understanding, caring and interested in what she was saying.

After the interview, I was left with the overall feeling that the participant was drained. She stated that working in mental health affects your mental health and she wasn't sure whether she could do it anymore. With this in mind, I felt it was important to speak to her about her own mental health and remind her of the support options that were available to her, such as her clinical supervisor, her line manager or a psychologist at the organisation. I was concerned that she was feeling burnt out and I was also concerned that she felt unsupported by her managers. Therefore, this was all incorporated into the participant's debrief. The participant informed me that, as a result of her stresses at work, she had recently changed to part-time, which means that she can now pick and choose the shifts she wants to work. She stated that this is much better for her now, as she does not feel under pressure to go into work if she doesn't want to. She is also about to start studying at college, so she has new-found direction and motivation. I was pleased to hear this and I was glad that I had raised the issue with her.

Appendix K - Interview schedule

Introduction - read participant information sheet.

Can you please confirm: The type of ward you work on?
 Your job title?
 How long have you worked on that ward?
 How long you have worked at your organisation?

PROMPTS: Ask for examples and ask 'why' to expand on answers that are given.

Tell me how you currently feel about your job?

[PROBES: Why do you feel like this? Is there anything in particular that causes you to feel this way? What first comes to mind when you think about your job? What daily things do you enjoy about your job? What daily things do you dislike about your job? What aspects of your work have most influence on how you feel about your job?]

Tell me about your current stress levels at work?

[PROBES: Why do you think that is? What contributes to these low/high stress levels? If your current stress levels are high, would you say that you feel burned out? How often do you feel like this? What causes you to feel stressed or burned out? If your current stress levels are low, why do you think that is? What prevents you from feeling stressed?]

How do you find your working environment?

[PROBES: Do you find the environment calm or chaotic? Organised or unorganised? Do you feel in control? Is the communication on the ward adequate? How is the team work? Do you feel that there are enough hours in the day to get everything done? Or do you feel overloaded with work? Do you feel that your job expectations are unclear or unrealistic?]

How is the staff morale on the ward you work on?

[PROBES: Why do you think the staff morale is the way it is? Is there anything that could be done to change it? What are the most positive influences on the staff morale? What are the most negative influences on the staff morale? Do you feel that the staff morale impacts upon the patients? Do you feel that the staff morale impacts upon your stress levels?]

Tell me about the level of support you receive at work?

[PROBES: What is the level of team work on the ward? Do you feel supported by the team you work with? Do you feel supported by the more senior members of staff and your managers? Do you feel that you have people who you can turn to for guidance or reassurance? Do you have regular access to supervision and line management? In a time of crisis, do you feel like you have the adequate support needed?]

Tell me about the training that you have received in order for you to do your job?

[PROBES: Do you feel that you have the necessary skills and training to complete your job? Do you feel overqualified or underqualified to do your job? Do you feel like you have the skills you need or do you feel like there are some skills you need to develop? Do you feel comfortable or do you ever feel out of your depth? What do you think about the skill/experience mix on your ward? Do you feel like you have received the appropriate training for your job or is there more training you would like?]

Tell me about the other staff you work with, how are your relationships with them?

[PROBES: How do you think staff relationships can impact on stress or burnout? Do you have any problems with any members of staff? Have you noticed any problems with staff relationships on the ward? Have you witnessed or experienced bullying or favouritism? Do you regularly have staffing problems, such as understaffing issues or a lack of adequately skilled staff? Do you feel that all members of your team can work appropriately with the patients? Do you feel supported by your team in times of crisis?]

Tell me about the patients you work with, how are your relationships with them?

[PROBES: How do you think patient relationships can impact on stress or burnout? Do you have any problems with any patients? Do you find them challenging? Do you experience verbal aggression? Do you experience physical aggression? How does that make you feel? Do you ever feel unsafe or threatened? Do you empathise with your patients? Do you find working with the patients rewarding? Do you find it easy to build a therapeutic rapport?]

How valued do you feel at work?

[PROBES: Do you feel valued by your managers? Do you feel valued by your colleagues? Do you feel valued by your patients? Do you feel recognised and appreciated for the work you do? Do you feel like there are sufficient rewards? Do you feel like your work has meaning? Do you get positive feedback? Do you feel like you are paid adequately for the work that you do? Are there many opportunities for progression in your organisation?]

How do you feel about the shifts you work?

[PROBES: Do you feel like you have a work-life imbalance? Do you always get a break? Are your breaks adequate? Do you frequently have to start early or finish late? How often are you off sick? Do you regularly take holiday? Are you ever asked to work on your days off? Do you regularly do overtime?]

How do you feel that your job effects your personal life?

[PROBES: Do you feel an imbalance between your work life and your personal life? Do you feel that you take your work home with you? Do you think about work once you have left? Do you find it easy to switch off? Has work ever affected your personal relationships?]

How satisfied do you feel in your job?

[PROBES: What are you satisfied with? What are you not satisfied with? What are your reasons for continuing to do the job you do? What do you think it is about your job that keeps you there? Have you ever thought about leaving? What stops you from leaving?]

What does the word 'burnout' mean to you?

[PROBES: Could you tell me about your experiences of burnout on the ward? Have you ever felt burned out from your work? Please could you describe a time when you have experienced feelings of stress or burnout at work? What issues do you feel contribute to your feelings of stress or burnout at work?]

What do you think could be done to help reduce the level of stress in your job?

[PROBES: What changes do you think need to occur? Are you satisfied with the level of support? What would make your working life easier? How would you like to be supported? How do you think your colleagues would like to be supported? What more could be done to support and protect staff from feeling stress and burnout? What improvements do you think could be made that would have a positive impact on you at work?]

That's the end of my questions. But do you have any comments or questions for me? Is there anything you would like me to explain further? Is there anything else you would like to add that hasn't been covered? Do you have any further thoughts, feelings or opinions on the subject of stress and burnout?

If you feel upset or concerned over any of the topics we've discussed, then you are entitled to a full debrief, if you so wish. If you would like to talk to me further about any concerns or worries that you have, or any stress or burnout that you are currently experiencing, then you are entitled to do so. You are welcome to get in contact with me at any time. Additionally, if you feel like you need further support from your work-place with your current levels of stress and burnout, then you are advised to approach your line manager or your clinical supervisor.

Appendix L - Interview transcript example

[Interviewer]: Okay, so, first of all, I just want to ask you how you currently feel about your job?

[Participant]: Fifty-fifty, some days I love it, some days I absolutely hate it and cannot wait to leave the place, like counting down the hours on the clock and that.

[Interviewer]: So, first if all then if I ask you about, what you enjoy about your job, and the fifty percent of the time where you do like it, what are the reasons for that?

[Participant]: The team... when I have got a good team on, you are able to have a laugh and feel like you are supported and you do make strong relationships there with your colleagues because of the nature of the actual job... and also, when you do have good days and you can see the patients having some sort of improvement, that's a good feeling as well.

[Interviewer]: So, they are the things you enjoy about the job?

[Participant]: Yes.

[Interviewer]: So, tell me a bit about what you don't enjoy about your job then.

[Participant]: The low staffing, it's dangerous, the pay doesn't reflect the job that you do, you don't much support from the people high up. You do get support from the support workers and the nurses, but anything higher up than that, you are just seen as like the bottom of the barrel because you're a support worker and it doesn't matter if you get punched or spat at because it's mental health and it's what they do and all that jazz.

[Interviewer]: So, do you feel like people maybe think that them sort of things come with the job and you should just accept the fact them things happen in the job.

[Participant]: Yes.

[Interviewer]: And how does that make you feel?

[Participant]: Annoyed. I don't want to swear... a certain p word.

[Interviewer]: So, the good aspects of the job, the bad aspects of the job... but, which one of them is the overall feeling about how you feel about the job?

[Participant]: The bad aspects probably, they outnumber the good. More shifts make me not want to be there, than they do make me want to be there.

[Interviewer]: Yeah, okay, so if I asked you about your current stress levels then in terms of the factors that you have mentioned, what would you say your current stress levels are?

[Participant]: High, like, it's not just stress, it's like anxiety as well, like when you feel sick because you physically don't want to be somewhere, sometimes that's the feeling you get. I'm very stressed when I think about it.

[Interviewer]: Yeah, so, when you think about the anxiety, does that mean that you wake up on a morning and you don't want to go to work? Or you dread going into work?

[Participant]: Yeah.

[Interviewer]: And what are the reasons for that anxiety, do you think?

[Participant]: At the moment... it never used to be like this, but at the moment there is not enough staff there that are, like, experienced. So, the feeling of being the only person there that knows what they are doing, so you take all the crap then, because the patients know you are the only one there, so they will come to you more, so then you feel like you are doing the work of everyone else and not just your own job.

[Interviewer]: So, would you say then it is quite a high work load?

[Participant]: Yes.

[Interviewer]: And that's beyond your job expectations, what you should be doing, because you're taking on maybe more than your fair share and more than your responsibility?

[Participant]: Yes, in my experience especially working nights, sometimes it feels like you are doing the job role of the nurse as well, because the nurses don't know the ward. You get some nurses that do, but then you get some agency that have never worked on the ward before and they are a bit incompetent. They are more scared than anything and then you feel like you are reassuring them all the time, you are doing their jobs for them and they will just sit there reading a newspaper or falling asleep. Because they are on, like, thirty odd pound an hour and you're on, what? Nine pound an hour

[Interviewer]: So, how would you say you feel then, if you turn up to a shift and you know you have got members of staff on the ward who don't know the staff and don't know the patients. How does that make you feel?

[Participant]: Like I don't want to step foot on that ward.

[Interviewer]: Yeah, would you say that you ever feel unsafe?

[Participant]: Yes, most of the time. Because not just that, you also feel unsafe for other people because you can't be watching everyone at once, and if someone else was in a dangerous position and you're not there, you don't feel safe leaving them with certain members of staff. I won't name names.

[Interviewer]: So, obviously you mentioned, you feel your current stress levels are quite high, would you say that you feel burnt out or you have ever felt burnt out?

[Participant]: Yes, because it feels like when you get home after a shift and if something has really wound you up, you then struggle to wind down ready for bed, so you then struggle to sleep and then before you know it you are back up and getting ready for your next shift.

[Interviewer]: So, it's just a constant cycle and you are not getting any time to yourself?

[Participant]: Yes, because it's like even when you are at home sometimes you are thinking about work, thinking about who is going to be on shift, I wonder who is going to be doing this. Wondering if it is going to be settled or not, or whether you're just going to be rolling around the floor all night in restraints.

[Interviewer]: So, you mention obviously feelings of burnout, so what would you describe them as and how would you identify that you are feeling like that?

[Participant]: Just... feeling exhausted all the time, even if I do get a good night sleep, I wake up and I still feel exhausted, like your whole body just feels drained. You can't enjoy anything because you are always thinking about work and stressing about that.

[Interviewer]: Is that something you feel regularly?

[Participant]: Yes.

[Interviewer]: How often would you say you have them feelings?

[Participant]: Most of the time, like... don't know.

[Interviewer]: Quite often though?

[Participant]: Yes, it's very frequent.

[Interviewer]: And do you notice that in your colleagues as well?

[Participant]: Yes, definitely. It's not nice, especially when you see people that you care about getting upset, or sometimes even crying at work and having to leave the ward because they are that stressed out and then you're having to go and support them as well. It doesn't matter what you say because you can't change anything because you are just a support worker what can you do to make that situation better other than saying you feel the same.

[Interviewer]: So, in them situations then, what do you feel like could be done to support you more or to support your colleagues more? Is there anything that you have identified that might help?

[Participant]: Getting the recognition for it would be a start. Like when you do, do a good job. Most of the time you are only picked up on if you have done something wrong, never for when you have done anything right. There is no praise or appreciation for things even when you do go above and beyond. Erm... or even sometimes it's like say, like, an incident has happened and then it's handed over more or less like a joke and people laugh about it and you think it wasn't funny to be in that situation, people don't really take it seriously, so I think people higher

up need to take the concerns of their support workers and nurses more seriously and actively try and do things to make the job more pleasant. Pleasant isn't the right word I'm looking for, but maybe just a nicer place to be.

[Interviewer]: So, you mention feeling unrecognised for what you do, would you say you don't feel valued in the contribution that you make?

[Participant]: I feel valued by like team leaders and stuff, but I would say there is never any, like, you don't see these managers who make all these rules that you then have to enforce coming around and telling you that you're doing a good job because they don't. Like, I don't even think they realise, like, they make up these rules but I don't even think they have worked a day on the ward, especially wards like [name] and [name], where it is intense. They make up these rules and they don't know how that's going to be implemented before they make them up and then we obviously have to deal with the backlash from it and we don't even get so much as a 'so what do you think would be better' or 'how do you think it's working so far'. They don't take your opinion into account. They just want to do what they want to do, because it's cost less most of the time, like, decrease staffing or whatever.

[Interviewer]: Yeah, do you feel like maybe if support workers were given the chance to air their views on these things and... maybe better communication between the ward staff and the staff who aren't on the ward?

[Participant]: Yeah, that would be better but, the only way you can do that these days is send emails, but then a lot of them emails go unanswered so, it just carries on then. And then you get fed up of making the effort of trying to get in touch with people and then you just leave it, then obviously that's not helping anyone, is it?

[Interviewer]: Yeah, so, a lot of your concerns are just going, I suppose, unnoticed or just not listened to?

[Participant]: Yes.

[Interviewer]: So, obviously we have spoken now a bit about the stressors you are encountering on a daily basis. Now I just want to ask you about your working environment and how you find it on a daily basis on the ward. You know, whether you would describe it as, for example, calm or chaotic... organised or unorganised... how would you describe a day working on the ward?

[Participant]: Unorganised is a good word, like running around like headless chickens, especially on day shifts because, there is so much going on, but also so much is always changing. Then you have got incidents, then you have not got enough staff to do the things in the first place, never mind now you have got two staff in a quiet room or whatever because someone is self-harming or trying to attack someone or something.

[Interviewer]: So, you would use the word unorganised to describe that and the way the ward is run, I mean, who are the people that on a daily basis are in charge of that then?

[Participant]: Us.

[Interviewer]: The support workers?

[Participant]: Yes, more than anything, more often than not.

[Interviewer]: And what about the people above you? How do they help on a daily basis?

[Participant]: They tend to only help when something has already kicked off, like, you can go in the office and say to someone, a patient is brewing or what not, but nothing is ever done

[Interviewer]: So, you are saying that nobody ever intervenes before it's too late, but what do you think could be done then in terms of, how do you think these incidents could be avoided or what could be put in place beforehand?

[Participant]: Just having more staff out in communal areas rather than sitting in the office or talking somewhere and not paying attention to what's actually going on. So then even if they don't directly get involved, you have got time to sit with someone one on one and redirect their mind from whatever they are thinking of and that could potentially diffuse a situation before it gets too far. Even if it's just going in the garden or taking them to the activity room or whatever, but you can't do that because there is no staff there, because they are doing care plans, which I know are important but, at that moment in time, just taking ten or fifteen minutes, so you can show that you can be there for that patient, because otherwise they think you don't give a shit. Then they have to kick off in order to get that attention. Sorry for swearing.

[Interviewer]: It's alright, no problem. So, you say that obviously the reason that people aren't around is because they are in the office or they are doing other things? For example, care plans.

[Participant]: Yeah.

[Interviewer]: But do you have problems with staffing on a daily basis then? Is it that... how much of a concern is under staffing on the ward?

[Participant]: It's like the biggest issue that we have in that place because they are never increasing numbers, it's always decreasing numbers. And then, even when they do give you enough, somewhere else will be short staffed or they will be on response or something will happen, so then you then don't have them levels to do things. Most of the time, you feel like you are just sat around watching people because you don't actually have the resources to do anything therapeutic with them at all, it kind of just makes you think, well why am I even here?

[Interviewer]: So, how do you think that impacts on the patients then and the standard of care that you can give them?

[Participant]: I don't think it's a good enough standard of care personally, because, like I said, you can't do anything therapeutic. Like, you are supposed to be a support worker, but you don't have the time to support them. You're more like a... it feels like sometimes you're working in a prison and you are just there to kind of deal with them when they are like... kicking off, or whatever, I don't know a better word for it.

[Interviewer]: Yeah, so on a day to day basis then, what does your role of a support worker actually entail then?

[Participant]: Bouncing off observations... like seclusion, one to ones, zonals.

[Interviewer]: So, like, a you say you are just constantly observing the patients, to what, to check they are okay, to check that they are settled and not having any incidents... and is that generally how you spend twelve hours?

[Participant]: Yeah, pretty much.

[Interviewer]: And how does that make you feel about what you can offer to the patients and what you can give in your role as a support worker?

[Participant]: I feel like in a way it's quite de-skilling because, you are literally just sat there and obviously, most of the time, because you can't actually go off ward... because if you're having a one to one especially, you need someone else to go with you with some of the patients, so then they just sleep or whatever. They are bored, they have got nothing else to do to occupy their minds and stuff so, they are either going to kick off or they are going to sleep.

[Interviewer]: Would you say that's generally what the patients spend most of their days doing?

[Participant]: Yeah, and the reason that they are on these one to ones or two to ones is because they have deliberately done things to get in that position, so that they do have the staff focus, because otherwise they wouldn't get a look in

[Interviewer]: Do you think maybe the patients do that because of the short staffing on the ward? Because they feel like they need their needs met and they can't get that any other way?

[Participant]: Yes, definitely.

[Interviewer]: So, you mention obviously about... you describe the ward as being unorganised, do you feel in control on the ward on a day to day basis?

[Participant]: I don't think I have ever felt in control because there is always something, like I said before, there is always something. Like, you might feel in control for about an hour of your shift thinking things are going smoothly, but then, more often than not, something happens. Then, all of a sudden, everyone is running around not knowing what to do, but it depends what team you have. Sometimes it doesn't matter what happens on a shift because you have got that team and you know that even if you are dealing with a situation,, if something else is going off you know it's going to be okay because someone else is there who knows how to manage that situation, so then you are not feeling like you have to constantly go back and forth between things, which is nice.

[Interviewer]: So, you mention obviously, you know, working in a team, so what would you say the team work is like on the ward that you work on then?

[Participant]: It depends who's in, more often than not these days, you got like one or two regular people or someone that you have even seen before. Some shifts you come on you have never even seen the person and you don't know their name, they don't know the ward, they have never worked on it and they really couldn't care less about the patients... they are just there for the easy money. It's just easy for them because they don't really need to do anything. No patients are going to approach them, because the patient doesn't know them, and they haven't built up any trust with them, so it's all on you again.

[Interviewer]: So, you're struggling for that, I suppose the consistency.

[Participant]: Yes, there is never any consistency, never, because it's got such a rapid turnover as well. You can get someone and you think, yes they are brilliant, but because they are so good, they know that they are too good to be there and then they move on to somewhere else, where they get more money or more value or whatever.

Interviewer]: Is that common occurrence where you work then, in terms of the turnover and new faces being there quite regularly?

[Participant]: Yes, definitely and if they are not going somewhere else they are going to a different ward because they can't deal with the stresses of that ward.

[Interviewer]: And how do you think that impacts on the patients then, that rapid turnover?

[Participant]: Again, it's like... that's obviously having a bad effect on them because they haven't... they spend all this time building up trust with someone and knowing if they are having a bad day they can talk to this person, which potentially diffuses the situation before it starts, then obviously if there is only one or two regular people on and they are already taken up with someone else then this person has got no one to go to, so they are obviously going to do anything to get that attention, which then results in an incident. It's then more work for the other staff because they have then got to manage that and all the paperwork that comes after it.

[Interviewer]: Do you think maybe then the lack of permanent staff is contributing to the patient's distress?

[Participant]: Yes, definitely. Patients voice it all the time, that they don't know anyone there and they feel concerned that people are just let onto this ward when they don't know what they are doing and it's unsafe, then they feel unsafe. I think they can see it in the regular staff's faces that they feel unsafe and unsure, and some of them are like actually concerned, then obviously other people just take advantage of that and know that they are going to get away with more things than they normally would. Obviously, that's dangerous.

[Interviewer]: So, tell me a bit about the staff morale on your ward at the moment then, what's that like?

[Participant]: Quite low at the moment.

[Interviewer]: What do you think is contributing to that?

[Participant]: Everything we have talked about like, just the lack of support from people, obviously with it being very intense ward there is at least one incident a day. We don't go there to... obviously we know it comes as part of the job and people are going to be unwell, but that's not what we go there for. We are not there to be fighting with people or be getting punched and kicked and getting called every name under the sun, but most of the time that's what you are there for and it's not a nice environment to be in. So, obviously you don't feel good being there and you find that, most of the time, that results in you just not wanting to be there and then obviously asking to move to a different ward and then the people that are left behind their morale drops even more, because, even when they ask to move, they are never given the opportunity to move, which is weird how some staff can and some staff can't. I don't understand that, but it does happen a lot.

[Interviewer]: Obviously the low staff morale is going to impact on the patients and that's going to end up, I suppose, in a constant cycle.

[Participant]: It is just constant though. The patients know when the staff have low morale, because they are not as engaging with them. Like, obviously they will do their job, but they are not... I think the patients prefer it when it feels more like they are not staff. Like, not their friends, I know that's not the right word but, you know you can just sit there and have a laugh with them. Then obviously it doesn't feel as such a closed environment, then it feels more natural and then that's more comfortable for everyone, not just the patients.

[Interviewer]: Maybe that's when they feel like they can build their relationships up and maybe the staff are going beyond what's expected of them, but I suppose if you're feeling burnt out you don't want to go above and beyond.

[Participant]: Yeah, like why should I bother doing it, because no one is going to recognise it.

[Interviewer]: And you're not going to get valued for it, so people think there is no point.

[Participant]: Yes.

[Interviewer]: So what support is available for you at work then, because you speak a lot about, you know, the stress levels seem quite tough for you on your ward at the moment, so what support can you rely on?

[Participant]: They do clinical supervision, which you are supposed to have once a month, but in the four years that I have been there, I think I have had it about three times.

[Interviewer]: Three times in four years?

[Participant]: Yes.

[Interviewer]: Right, okay.

[Participant]: You are supposed to have, like, an hour every month, I think that's how it's supposed to work. They allocate it to certain people that you wouldn't feel comfortable divulging certain information to because you don't know where that information is going to go.

They say it's confidential and stuff but, I think the idea of it is to go and really let off steam, but I would feel more comfortable doing it to people that know the environment, so they work on the ward, which you're not allowed apparently. You're not allowed a clinical supervisor who is on the same ward as you. Someone you can trust and can say exactly what you need to say and you know it's not going to go any further and you're not going to be bit in the arse for it, which I don't know anyone that doesn't work on another ward that I would completely trust. So, most of the time I would just, if you have got the same break as someone, you can sit in the staff room and then you would let it off there, but then obviously sometimes that isn't appropriate because of confidentiality, but sometimes you need to get it off your chest because you then don't want to go back in off your break, still feeling so wound up because then it's going to affect how you do your job.

[Interviewer]: So, would you say that you don't feel like you have got the appropriate people then that you can turn to, that you can trust and that you know what you say is going to be kept confidential.

[Participant]: I don't think so no, in my personal opinion, no. I don't know anyone that I would trust, one hundred percent trust.

[Interviewer]: So, do you not feel like you have got that outlet then?

[Participant]: No, not in the sense, like, obviously it's all very well out letting to your friends, but they are in the same position as you, they can't do anything. Whereas, if you have got a clinical supervisor that's usually higher up, they can then have the means to try and change something, but you're not allowed to have clinical supervision with someone that understands you or someone that you trust, because it's someone from a different ward that you might never have even met before.

[Interviewer]: So, obviously that's clinical supervision, but what about line management with someone on your ward then? I mean, do you get any support from that? Does that help you with implementing anything?

[Participant]: I actually forgot about line management, but now that I think of it, yes. There was one person, there was a nurse that I could trust, but then that would be difficult sometimes, in terms of getting the time to really go through your line management. But, yes, I definitely felt better after speaking to her, because she knew what I was going through at that time and she... she was a nice person anyway and, like, it wasn't like I felt like I had to tell her things, I wanted to tell her things. So, that helps getting things off your chest a bit more.

[Interviewer]: I suppose what you're saying then is, it's useful, but only if it's the right person and if it's someone you can click with and trust and, more often than not, you don't feel like you have got that safe space to air your views and your thoughts?

[Participant]: Because most of the time, with it being that busy on the ward you get like half an hour and then you have to rush off really quick and then you feel like, I don't want to take up this person's time because, she was the nurse on the ward and they was always behind and stuff and constantly having stuff thrown at them, so they ask how you feel and you say fine, even though you're not, but you don't want to be loading stuff on them because they are

stressed enough or thinking that you are taking up to much of their time when they have got other stuff to do. That was an issue. When I worked nights, there was more time to do things, but then again being on nights with that person wasn't very often, but when it was I felt better. Not just for having the line management but because they were such a good nurse. They kept everything under control and you felt like you weren't having to play the nurse for that night.

[Interviewer]: Yes, because actually someone more senior than you were, I suppose taking charge and you could do your role as a support worker, because they were there to run the shift.

[Participant]: Yes, but not in the sense of taking charge like telling you what to do, they also valued you as a support worker and thanked you at the end of a shift, which was enough for me most of the time, just for someone to say thank you for last night, thanks for your support and stuff.

[Interviewer]: Yes, do you think that makes a difference then, I mean if someone said thank you to you at the end of every shift you know that they appreciate the work you have done. Would that make a difference to you?

[Participant]: Definitely yes, which you only get with certain people.

[Interviewer]: So, you mention obviously your line management and clinical supervision, but thinking about then on the ward on a daily basis the support that you get, I mean in times of crisis if there is an incident going on what's the support like then?

[Participant]: It all depends on the shift that you are on, like, sometimes the support is really good, especially like in terms of the response staff from different wards, you get some that come on the ward and you think... oh thank god, it's going to be okay now. And then some come on and you think, you might as well not be here... sometimes they just stand and they just stare at you like... there was one situation where there was three patients kicking off at the same time and there was only three members of staff and we all had to grab one patient each, because they were all trying to fight with each other and you are literally using every single limb possible to hold them down and then someone will just come on the ward and just stare at you and it's like... feel free to grab a limb at any point! But they just stand there and you have to tell them what to do. It should be instinct really, when three women are getting battered on the floor to jump in and try and help, but most of the time the staff are just, because they're just so used to being chilled all night or all day, whatever shift you are doing, they don't understand how we must be. Like, obviously this has been brewing up all night, so all the staff are already on edge and now it's completely been blown out of proportion and now everyone is fighting everyone and then people just ... they don't want to have allegations made or they don't want to get punched and it's like, well, we don't either, but we haven't had the choice, we have had to get right in, it so why not you? You're on the same money as us, you have probably had a better night than us so far, so can you just take some of this crap off us? But they don't.

[Interviewer]: So, when you pull your alarm then, is that something you're expecting? Are you expecting for the staff who turn up on response to be inadequate and not support you? Is that a general theme or...?

[Participant]: About eight out of ten times, yes.

[Interviewer]: So, you don't feel like, when you pull your alarm, you know you're going to get the support that you need?

[Participant]: No, I don't think... it depends, because there are some staff that come from wards that, even though they don't fully understand what the wards, like they do get involved and they are not only there just to do the restraining. They will say like, they will actually engage with the patients, because sometimes it's nice for the patients to have someone different and who hasn't been involved with enforcing boundaries or whatever and they will get involved or they will say, you know, you go and have a break we will deal with this. Just little things like that just shows that they actually care about how you're feeling. That helps, to know that people actually know what you're going through and think, we will give you a break we will deal with this for now, just like take ten minutes and have a breather.

[Interviewer]: So, what would you say about... that's obviously the staff off other wards, what would you say about the staff on your ward then in terms of you know, the ward managers or maybe the people a little bit higher up, what's the support like from them?

[Participant]: They are never there, you just feel like you just do the incident forms, send it off to them and then you don't know what happens when they read that, what's going to be done about it. Most of the time nothing, it's just forgotten about and then the next day that person that, like, battered your colleague black and blue, is out on leave... because least restrictive practise or whatever. It's not supposed to be punishing them, I know that, but there does need to be implications for the behaviours that there having, like, if they don't that last night are they really safe to be going out in the community the next day and how is that staff going to feel taking them out, knowing what they have done the night before. Obviously, everything is handed over, and then even if you turned around and said I don't feel comfortable taking them out, you wouldn't be taken seriously, they would be like... oh just take them out, it's fine, it's only such a person she's like this sometimes. It's like, well, that's not okay, it's not an excuse.

[Interviewer]: Do you feel like they are quite detached from it all then?

[Participant]: Yes, because there not in the thick of it most of the time.

[Interviewer]: Do you feel comfortable going to see your ward manager with an issue or if you wanted to raise or had any ideas for things that could be changed on the ward, do you feel comfortable?

[Participant]: No, no, like we have done things in the past where a few people have made a list of things that is annoying us and things that we would like to see changed, then obviously we typed that up and emailed it to someone and you get a response like... we will look into it. But then that's it, you don't see anything else. It would be nice of them to turn round and say should we have a meeting about it and discuss it because, obviously, I'm not expecting all the needs to be met at once, but even for someone to take it seriously would be enough and to understand where you're coming from or maybe spending a full day on the ward to see what it's like. But then more often than not, it's not realistic because everyone behaves when certain people are around so, they don't have a realistic view of what's actually happening. So, then

nothing changes, because then they think... I don't know what you're moaning about, because I have had a lovely da.

[Interviewer]: Yeah, so that's obviously speaking about the support that you get on the ward and elsewhere. So, now, I just want to ask you a bit about the training you've received, so tell me a bit about the training you have been through to do your role as a support worker.

[Participant]: You get MAPA training, that's the one that's the most focused on, I think you get about three or four days, once a year training for that... and they do offer other bits of training, but more often than not, you don't find out about that training unless one of your colleagues has been put on it and then you have to ask to go on that training. But there have been times where you have been on the training and then you get taken off that training last minute, even though you're not even supposed to be on shift, because you are on annual leave or you're on nights... and then you're told you cannot go on that training because of staff shortages, so you're then not benefitting from that, because it's like specific training to like personality disorder or DBT, stuff like that, that could help you be a better support worker. You're then missing out on that, but, obviously, when it's something like MAPA, you are never taken off that, because that's something else they think you need.

[Interviewer]: So, I suppose what you're saying then, you feel like the training opportunities are there, but you actually being able to access them is a different story.

[Participant]: It's really difficult to get on things, like, don't get me wrong, I have had some training like clinical skills, British Sign Language, stuff like that, but other stuff I have either missed out or they have said... no you can't go on that because there isn't enough staff on the ward. Or you do get put on it, but then you get pulled off it or it gets cancelled and then you just miss out then on the opportunities. I find a lot of the time, I don't know what kind of training is actually out there unless, if I've had line management they will say to you, I think you will benefit from this or I will put you on this, but then, like I say, you don't really get line management as often as you're supposed to because of the ward dynamics.

[Interviewer]: So, do you feel like you have got all the skills to do your job then or do you still feel like there is some areas that you want to improve in?

[Participant]: I feel like I have got the basic skills, which are probably the only skills that they care about as a company. And that's not because they are the skills that they have given me, it's stuff that I have learnt from other people, like senior support workers and stuff, by taking their lead and... I don't know... I'm alright, I'm an alright support worker, I think.

[Interviewer]: But, do you have your own, sort of, interests that you would like to pursue but you feel like, I don't know, you can't or the opportunities aren't there?

[Participant]: I would like to have more knowledge of the therapies that they do, like the DBT and all that stuff, because then when they are engaging in it, you can... because, a lot of the time, some of them can't be bothered doing it, and I feel like as a member of staff, if you say come on, I'll come and do it with you, they would probably be more inclined to do it, because they've got that relationship with you. And obviously, that's going to benefit them more... but, half the time, you don't even know what they're talking about. And they tell you to encourage

them to use mindfulness or DBT when they're having incidents and stuff... but then you tell them to do it, and they kind of look at you as if to give more information, but, as far as you know, they know everything they need to know, but you don't anything

[Interviewer]: Yeah. So, maybe, if you could give them an example of a skill they could use?

[Participant]: Yeah.

[Interviewer]: But, you don't feel comfortable in that situation, because you've not had the appropriate training to do that?

[Participant]: Yeah, exactly. Because, then, if they expect more information from you, and you're like... I really don't know. And then you look stupid. And then they're going to be like... don't tell me to do it if you don't even know what it is. Because, how do you know if it's going to help me, if you don't even know what it does? That kind of thing.

[Interviewer]: Yeah, so maybe greater awareness, I suppose, of what the patients are offered.

[Participant]: Yeah, definitely.

[Interviewer]: So, I want to speak a bit now about staff relationships, the other staff that you work with. And I know you've touched on this a bit about sometimes, you know, you don't recognise the staff, a lack of consistency in the staffing. But, thinking about the staff that you work with on a daily basis, how are your relationships with them?

[Participant]: Good... I don't tend to have issues with other staff. I think that's just me as a person, like, even if I do have an issue with someone, I'm very unlikely to broach it, because I'm not one for arguments or confrontation. But, saying that, there are people that grid my gears because they either do nothing and sit in the office... and then you've got people there who haven't been there as long as you and they're trying to tell you how to do your job. And you're just thinking... don't tell me what to do. I mean, you can ask me to do something, I don't mind, but don't come out and start dictating what I should and shouldn't be doing or where I should be... because I'm not going to do it then and obviously that just puts everything to pot. Or you've got people that think they know everything or you've got people that take the job a little bit too far and you think sometimes they enjoy the incidents too much. So, like, they'll purposefully wind people up, because enjoy being in restraints and they enjoy being in the thick of it, because they want all of the... oh, look at me, dealing with this... kind of business. And you've got people there who can be quite intimidating as well. Like, they literally stand and watch everything you do and you feel like they're reporting everything back to someone or trying to turn it into something it's not, because, that's just the kind of people that they are, I guess.

[Interviewer]: So, how often would you say that you work with a member of staff who, not that you've got a problem with, but somebody you struggle to work with?

[Participant]: Not often, if I'm honest, because I tend to work more nights and the staff on nights are usually quite nice. I mean, obviously, you get the odd people who have never been there before and the only issue that I would have with them is that they're a bit lazy, they don't

tend to want to do anything apart from sit and read a newspaper or fall asleep on their obs or whatever. But, most of the time, you do get people that are willing to work with you really.

[Interviewer]: Yeah. So, overall, your staff relationships are decent?

[Participant]: Yeah.

[Interviewer]: And no problems with, like, bullying or favouritism or things like that?

[Participant]: You always get favouritism wherever you go, I guess. But, again, I've only ever noticed that on day shifts, when you get... you see people who get to do all the nice section 17s and they're not on as many obs as other people, when certain people do the allocation sheet. But, like, it's a different atmosphere when you work nights, because you have most of the control over that allocation sheet or you know somebody, like, one of your colleagues that you are close with has control over that allocation sheet and you know that they're fair with it and you know that you're all going to chip in. Like, I know the roles are different on nights, I know you don't have section 17, but when you've got like, I don't know, ward rounds, deep filing, even just cleaning, you all just chip in and you don't make it like a chore, like, you do it in pairs and you can talk then, and that's a good time to, like, vent or even just, have a good chat. And that makes your night go quicker and it doesn't really feel like work, in that sense.

[Participant]: So, you feel like it's shared out more... more fairly on the nights shifts then?

[Participant]: Yeah.

[Interviewer]: So, we've spoke a bit about your staff relationships, so now tell me what are your relationships like with the patients, how do you get on with them?

[Participant]: Do you know, actually, I know that I've been involved in quite a few incidents, like, I've been assaulted a few times. But... I do feel like I've got a good relationship with most of them. There's probably one that I don't have any relationship with whatsoever and I just think that's because... I just think we'd clash anyway, because we're both quite... actually, I don't think we'd clash, because we're nothing like each other, but... I don't know, there's just something about her that I don't like. Like, her attitude and the way she speaks to other people rattles my cage, so then I feel like I don't want to get involved in that, because I don't like the way you speak to people and if you spoke to me like that then I'd probably get very annoyed about it. And then, obviously, I don't want to be saying stuff that's going to get me in trouble. But, most of the time, I do get on well with the patients and I am able to support them or de-escalate things because they have that relationship with me where they'll trust me to go and have a one to one or whatever.

[Interviewer]: Yeah.

[Participant]: I quite like the patients, they're not too bad.

[Interviewer]: So, would you say that you find working with the patients rewarding?

[Participant]: That's a difficult one... some of them, yeah, because you do get to see them... like, there's one patient in mind where I was there on the first ever night that she was admitted to the ward and she was such a difficult person to deal with... like, she was paranoid, she was screaming, she was trying to attack people all the time, she was really bizarre to work with because she was doing behaviours I'd never seen before, like trying to feed pillows milk and stuff and it's like, how do you deal with that situation? Do you go along with it or do you tell her that it's not a baby, it's a pillow? And she's gone from that to now, like, moving there from low secure and from low secure to being discharged home, like, she's like a completely different person. And you feel like you've been part of that, because you've been there to support her through things and you've had a good relationship, which is why you know you've had a part of that because she's trusted you at times when she hasn't trusted other people. So, that's a good feeling.

[Interviewer]: Yeah. And... would you say that you enjoy working with the patients then?

[Participant]: Yeah. Most of them. Some of them, I think, I just... I don't know what to think sometimes. I think, why are you behaving like this? Like, you've got so much to get out of here for, like, if you've got your own children at home and stuff and I think, why are you behaving like this? Like, sometimes, they choose to behave like that, because they'll have a full team on of people that are regular to that ward and they'll choose not to approach one of us to talk about their issues. They'll choose, straight away, just to start assaulting people or assaulting other patients. Or, you know, turning straight to self-harm, which always blows up into something else because you have to stop them from doing that. And you're just thinking why... why have you choose to go straight to that rather than talking through your issues with someone. Even if it's just like, I don't know, watching a film or playing scrabble, going on the computers. You've just chosen to go straight to that because... I can't even tell you why, because I don't know what goes through their heads half the time.

[Interviewer]: Yeah. So, you mentioned before that you've been involved in a few incidents then? So, I mean... tell me a bit about them, in terms of... is it challenging, verbal aggression, physical aggression, what are the sort of things that you've experienced?

[Participant]: Most of the time... obviously, we all get verbal aggression, even if it's just a split second and then they turn around and apologise for it, because it's just been heat of the moment. But there's also physical aggression, I can't even count how many times, it ranges from accidentally being kicked because someone is in restraints and they're lashing out... to being targeted by someone and, like, actually punched in the face by someone who you've had quite a strong relationship with previous to that. And it's obviously not nice then to go home with, like, a big swollen face and have to explain to your family that that's been done to you while you were at work.

[Interviewer]: Yeah, so how does that make you feel? You know, you've been punched in the face, how do you feel?

[Participant]: I was angry because of the build up to it. Like, me and another member of... like, she'd already assaulted another member of staff by this point and that member of staff had gone home. And then this patient had just continued to push and push and push, to the point where it's like... she almost wanted to make that situation happen. She was sat, like, at the

bottom of a corridor, picking at things and we were just thinking... we're not getting involved because she's the kind of patient that, as soon as you put hands on, she's too strong for you to manage. And then, obviously, she did something deliberately, knowing that we would then have to put hands on and then she took that opportunity to punch out and hit someone. And it just makes you think, like, why have I spent half my night trying to reassure you and trying to support you, for you to make that situation happen? Like, you've done that deliberately because you actually wanted to punch me in the face. But, why, what have I done to deserve you punching me in the face?

[Interviewer]: Yeah. So, you know, the next day you come on shift after an incident like that has occurred... how do you feel walking onto that ward? I mean, do you feel unsafe? Do you feel threatened?

[Participant]: Hmm. I don't feel unsafe. More often than not, I feel uncomfortable, because it's like everybody knows. Because word just spreads like wildfire and then everyone is looking at you, trying to see what's actually happened to you or asking you questions. And it does make you feel uncomfortable. But I don't think I feel unsafe, in that sense, because I just think... I've been punched in the face, so, that's out the way now.

[Interviewer]: Yeah. Do you feel like it's something that you've become sort of... used to?

[Participant]: I think desensitised is a good word to use. Like, when I first started, I was terrified of everything and everyone used to make a joke of how scared I was of things and then it got to the point where I wasn't scared of anything anymore, because I'd seen so many things happen to people. And, obviously, things happened to me that, in some situations, I'd almost, like, stand in front of people and take the hit, rather than them get the hit... and that's not normal human behaviour, is it? To stand in front of someone throwing fists around. But, it's like, what's the worst that could happen? I get punched. When the reality is, you don't know what's going to happen in that situation, like, they could have a weapon, you don't know that. Because obviously that has happened to people, but you don't think about that at the time.

[Interviewer]: Mmm, yeah.

[Participant]: I think as well, when you do build up a relationship with someone, you think... no, they wouldn't punch me... if I stand here, they'll calm down. Because they've never punched me before, we've got a relationship, why would they want to hit out at me? Which I think is a stupid way to think because you don't really know these people... they're in there for a reason, because they are unstable. And if they're having a psychotic episode, it's not like they can choose how they're behaving, they can just swing out at anyone and not know what they're doing. But, obviously, that's not what goes through your head at the time.

[Interviewer]: Yeah.

[Participant]: You do get desensitised, definitely, because you see so much. And it's like, when people ask you about it, like... oh, I don't know how you could work there... and you think, well, why? Why not? The longer you work there, I think it's like you almost become numb to it. It's just like... oh, it happens. When you shouldn't really have that mindset because it shouldn't just happen.

[Interviewer]: Yeah. So, how much do you think then that your relationships with the patients and experiencing these incidents, you know, violence and aggression... how much do you think that contributes to your stress levels?

[Participant]: A lot. Especially when it's someone, like I said, when you have got a good relationship with them, you think... if they can do that, what else can they do? It's like, have I just wasted months and months of supporting this person and building this relationship, does it actually not mean anything to them? And that does get... it does make you stressed, obviously, because it's like... what is the actual point in my time and effort going into that, it's like wasted energy.

[Interviewer]: Yeah, you feel like your work loses a bit of meaning?

[Participant]: Yeah. Yeah it does, obviously, because your role is to support people and you kind of doubt whether you've actually ever supported them, for them... if they want to hurt you, is there a reason? Like, have you done something wrong? You do begin to question yourself and doubt your skills as a support worker. Because you think, if you really did have a good relationship with them, would they call you that name, would they spit at you, would they punch you, would they not listen to you and carry on hurting other people? Why've you not got the ability to calm them down, when you have done in the past? It's very inconsistent.

[Interviewer]: Hmm, yeah. So, I know we've spoke about how valued you feel at work and not feeling recognised for the work that you put in. I know you mentioned briefly before about the pay that you get for your job. But I just wanted to ask you a bit more about that.

[Participant]: Okay.

[Interviewer]: In terms of, how you feel about the wages that you're paid and whether you feel like they're adequate? How that reflects the work that you do? What do you think about that?

[Participant]: People in McDonalds, right, get paid danger pay for working nights... and I think, danger pay, what is the worst they're going to get? Like, a McMuffin thrown at their face? It's ridiculous. Like, and then, you're dealing, sometimes... on some of the wards, people are dealing with people that have committed awful crimes and wouldn't think twice about stabbing you in the eye or whatever. I do not think the pay reflects the job at all, it is extremely underpaid, not even just a little bit. And then, when you think about how much like... when you go on the bank you even get paid more, but then you have less responsibly as a bank member of staff. And the same even more for agency, because they don't even just work in that hospital, it's different hospitals. So, they're not expected to know things... they get quite an easy shift for triple the pay or whatever.

[Interviewer]: Yeah.

[Participant]: That's annoying, most of the time, because you're just thinking... if you're, like, the only permanent member of staff on that shift and you're looking around at all these people not doing anything and you're running around like a headless chicken... with the patients, with the paperwork, everything like that. And you have people moaning at you because you've not given them the break that they want, and you just think... you're on, like, three times as much

as what I'm getting paid right now, so please do not moan about having a break one hour later than you would want.

[Interviewer]: Yeah. So, a lot of responsibility and a big workload for not very adequate wages?

[Participant]: Pittance.

[Interviewer]: Yeah. So what about the shifts that you work then? How do you feel about them, I mean do you like them? Do you dislike them?

[Participant]: I do like the shift patterns, I do, because obviously I like having week days off, I don't like having every weekend off, I don't mind working weekends, because sometimes it's nice to have a day off during the week and I like that it goes in a pattern so you kind of got a different day off every week. You are able to plan things as well, like oh I have got that Thursday off next month, so we can do this. Whereas, I know in the NHS and stuff like that it's never a set pattern is it, so you don't really know when you are going to have a day off, so you might have to book a day off when you didn't really need to book a day off because you would have had it off anyway, but you don't know that.

[Interviewer]: So, what about your work life balance then? I mean does that work alright around the shifts?

[Participant]: It works ok for me yeah, I would say so.

[Interviewer]: So personally you have no issues with twelve-hour shifts?

[Participant]: No, I actually prefer doing twelve-hour shifts, because then like on one of your weeks you are only doing three days so then you have got four days off to do your business and whatever you need to do.

[Interviewer]: And what about, in terms of what time you finish, what time you start... getting your breaks and stuff, so does that all work alright?

[Participant]: Start time obviously is fine, because that's down to you when you roll up, but half the time, when you have got an incident happening you kind of understand that you might be staying an extra hour and then obviously you are told to just put a time sheet in for it, but half the time you feel a bit stupid putting a time sheet in for an hour, which you shouldn't, because you have been there, it's your time. Then there is sometimes where nothing has happened all night, it has been really peaceful, we're supposed to clock off at quarter past seven, should only take five minutes for the handover because nothing has happened, but then your still there at quarter to eight and you are still waiting for people to come and take over you and your just thinking, I just want to go home and like I have got stuff to do, my whole life does not revolve round this place. Breaks... day shifts I find sometimes you don't get your full break or you don't get a break at all and it's expected. It's kind of well what do you expect? I've not had my break so why are you moaning about not having your break, but it's like... I wouldn't even be bothered if I didn't have my full break, but half an hour to get away from it, go and have a brew or something to eat in peace would be nice, sometimes you don't even get that. On

nights more often than not you do get your break, because It's easier to facilitate even if you need to swap things round a bit you will always get it most of the time.

[Interviewer]: So, do you feel like the job has an impact on your personal life then?

[Participant]: Only in a sense of, if something is affecting me at work, like I will either not sleep well because I will have been so wound up that I can't shut down. Or like if I have got three days off the first two will be fine, then the day before I go back to work I am thinking, or I have got to go back to work tomorrow and then you automatically feel like all your energy leaves you it's almost like your soul is coming out of your body because you know it's going to get sucked out of you as soon as you walk in to that place and its like that day is wasted then because you are just worried about going to work the next day.

[Interviewer]: So, would you say then that you find quite hard to draw a line under in and switch off?

[Participant]: Yeah, definitely. That's my worst issue, like if I could be one of them people that think, right I walk out the door and all my problems are left behind, but I can't, like it follows me home.

[Interviewer]: Why do you think that is then, is it if you have had a particularly bad shift or is it ...?

[Participant]: Yeah, because obviously after a really good shift I seem to forget about all the bad shifts and I just think, I can't believe I have just been paid for that shift, because I spent the day at the cinema or whatever, or you have had a really good day and everyone has been really nice, or you have seen a patient be discharged and it's nice to see or whatever, but then more often than not like I say, it is a bad shift so you go home thinking I hope it's not like that tomorrow. Especially if you know someone that is on the shift after you. So, you have just finished a day shifts then one of your friends is starting the night shift, you will spend the night worrying what is going to happen to them, especially if they're not on with a really good team. Then you are just up all-night thinking oh my god they could be in A&E because they have been battered or something. I just have an over active mind I think.

[Interviewer]: So, even though you're at home and you're safe, you can't switch off because you know there is still staff on the ward dealing with them issues, and I suppose if you're in the day after you don't know what you're walking into.

[Participant]: yeah, that is exactly it in a nutshell. I wish I could put things in a nutshell.

[Interviewer]: So, just in general then to summarise, if I asked you then, how satisfied do you currently feel in your job what would you say?

[Participant]: I don't feel satisfied, that's not a word for it, like... overall no. Obviously there are days where you do feel satisfied you have done a good job, but more often than not I don't feel satisfied with the way that we're treated, the way we are paid, the way that the patients are treated sometimes I don't think is right, it's hard to feel satisfied in a nob where you're undervalued.

[Interviewer]: So, what is the reason that keeps you going back there, what is the one main thing?

[Participant]: Convenience.

[Interviewer]: What do you mean by that?

[Participant]: It's close to where I live, and I don't like applying for new jobs and I don't like interviews, I know the staff. To have to go somewhere and start over again, to get to know the people and then find out that you don't even like that place, it's like the grass is always greener on the other side. Better the devil you know.

[Interviewer]: So, would you say that you feel comfortable there and that's the reason you stay there?

[Participant]: Yes, because like, it is shit... but it's my shit.

[Interviewer]: And you know the staff and you know the patients.

[Participant]: Yeah.

[Interviewer]: And even if you are dealing with incidents, you know what incidents you are going to be dealing with.

[Participant]: Yeah and you don't feel like a spare part when you have been there for four years and you feel useful, even if it's just to one of your colleagues, to feel useful to them

[Interviewer]: So, what changes, if I said you could make some changes what changes would you make to help reduce the level of stress in your job?

[Participant]: More staff is literally it. That's the biggest problem that that place has is that they are so concerned with trying to cut staffing down, but all the issues I have mentioned come down to that, because there is not enough people there to support the patients. There is not enough people there to support you, so you feel over worked.

[Interviewer]: Do you feel that's a change that would be made?

[Participant]: It could be made but it won't be because they don't want to spend the money, even though they end up spending more money because they have to get staff in for seclusion because people have kicked off.

[Interviewer]: Yeah.

[Participant]: But that doesn't seem to go through their head, they seem to like look into the future and they have this perfect image that you know, we can run it on this less staff and then we have got more money in our pockets. That's all they care about, how much money they are making. They take all the difficult patients because they get more money for them.

Appendix M - Qualitative participant information sheet

You are invited to be involved in this research study. Before you decide whether you want to take part or not, it is important for you to understand why the research is being conducted and what your participation will involve. Please read the following information carefully and consider whether you wish to take part or not. Thank you for taking the time to read this. For more information about the research, please contact me on emily.shaw@nottingham.ac.uk.

Aims: This research study aims to investigate the daily experiences of forensic hospital workers.

Requirements: The interview will be carried out face-to-face, at a time of your convenience. The interview will be based around a semi-structured interview pattern and will take approximately one hour. The interview is intended to provide you with an opportunity to discuss your daily experiences of working in a forensic hospital and what your role entails. You will also be given the opportunity to discuss what you enjoy about your role, any issues that you have encountered in your job and your current stress levels at work. The interviews will be recorded, and later transcribed into text form.

Anonymity and confidentiality: All data is completely anonymous and confidential. As part of the presentation of results, your own words may be transcribed in text form. This will be anonymised, so that you cannot be identified from what you said. All data will be stored safely, in a secure place, in a password protected file.

Please note that:

- It is up to you to decide whether to take part or not. If you decide to take part, you are still free to withdraw any time, without giving a reason. If you withdraw from the study, all data will be withdrawn and destroyed. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.
- You can decide to stop the interview at any point and you do not need to answer any questions that you do not wish to.
- It should not be possible to identify anyone from my reports on this study.

Once the thesis arising from this research has been completed, a brief summary of the findings will be made available by the researcher upon application. It is also possible that the results will be presented at academic conferences and journals. The data will be kept securely for ten years from the date of publication, before being destroyed. If this study has harmed you in any way you can contact the University of Nottingham using the details below for further advice and information.

Contact details:

Researcher: *Emily Shaw, emily.shaw@nottingham.ac.uk*

Supervisor: *Dr. Shihning Chou, shihning.chou@nottingham.ac.uk*

Research Ethics Coordinator: *educationresearchethics@nottingham.ac.uk*

Appendix N - Qualitative participant consent form

This is a research study designed to understand more about the daily experiences of staff working in forensic hospital settings. All data is completely anonymous and confidential and will be stored safely. You do not have to take part in the study and you are free to withdraw at any time. For more information about the research, please email emily.shaw@nottingham.ac.uk.

(please tick as appropriate)

I have read the Participant Information Sheet and the nature of the research project has been explained to me. I understand and agree to take part.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand the purpose of the research project and my involvement in it.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that I may withdraw from the research project at any stage and That this will not affect my status now or in the future.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that I will be audio recorded during the interview.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that all data (transcripts of interviews and recordings of interviews) will be stored safely on a computer hard drive.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that only the researcher and supervisor will have access to the data.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand that I may contact the researcher or supervisor if I require further information about the research and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signed: (research participant)

Print name: **Date:**

Contact details:

Researcher: *Emily Shaw, emily.shaw@nottingham.ac.uk*

Supervisor: *Dr. Shihning Chou, shihning.chou@nottingham.ac.uk*

Research Ethics Coordinator: *educationresearchethics@nottingham.ac.uk*

Appendix O - Copy of MBI-HSS

For use by Emily Shaw only. Received from Mind Garden, Inc. on December 31, 2016

MBI Human Services Survey

Christina Maslach & Susan E. Jackson

The purpose of this survey is to discover how various people working in human services or the helping professions view their job and the people with whom they work closely.

Because people in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following page are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	Statement:
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1. _____ I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "How often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number "5."

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How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)

EE Total score: _____ DP Total score: _____ PA Total score: _____
EE Average score: _____ DP Average score: _____ PA Average score: _____

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