Profiling referrals to a trauma support service: needs and outcomes for staff working in a secure adult developmental disorder pathway

Elanor Lucy Webb, Annette Greenwood, Abbey Hamer and Vicky Sibley

Abstract
Purpose – Forensic health-care workers are frequently exposed to behaviours that challenge and traumatic material, with notably high levels in developmental disorder (DD) services. The provision of support is key in alleviating distress and improving work functioning. This paper aims to incite clarity on whether staff in DD services are more likely to access trauma support. The prevailing needs and outcomes for this population are also explored.

Design/methodology/approach – Data was extracted retrospectively from a database held by an internal trauma support service (TSS) for staff working in a secure psychiatric hospital. Overall, 278 permanent clinical staff accessed the TSS between 2018 and 2020, 102 (36.7%) of whom worked in an adult DD forensic inpatient service.

Findings – Staff working in DD services were over-represented in referrals to the TSS with a greater number of referrals per bed in DD services than in non-DD services (0.94 vs 0.33). DD staff were comparatively more likely to access support for non-physical, psychologically traumatic experiences. Psychological needs and outcomes following support were comparable between staff across services.

Practical implications – The findings highlight the more frequent need for trauma support of staff in forensic inpatient DD settings. Embedding a culture of safety and openness, and establishing appropriate and responsive models of staff support reflect key priorities for inpatient DD health-care providers, for the universal benefit of the organisation, workforce and service users.

Originality/value – This study offers novel insight into levels of access to support for staff working with people with DDs.

Keywords Forensic services, Autism spectrum disorder (ASD), Developmental disorder (DD), Intellectual disability (ID), Staff trauma, Trauma support

Paper type Research paper

Interpersonal aggression and violence are significant challenges for health-care professionals working in mental health services. Incidents of aggression against staff are rising, increasing by 8.7% between 2012 and 2014 (NHS Protect, 2014) and 9.7% between 2015 and 2017 (HSJ and Unison, 2017). In 2019 alone, 14.5% of NHS staff reported experiencing physical violence at work, increasing to 20.2% for staff working in mental health and intellectual disability (ID) trusts (NHS England, 2019). A number of service user and staff characteristics have been identified as factors which increase risk for exposure to violence and aggression, including service user gender (Broderick et al., 2015) and staffs'
level of experience (Lepping et al., 2013). Yet, beyond dispositional factors, service type presents as a major influence driving exposure to such incidents.

The prevalence of aggressive and violent behaviours towards health-care staff varies greatly across settings, and differences in methodologies and definitions of aggression prohibit clear synthesis of findings (Cooper et al., 2008). A recent review of the literature on physical assault on staff in U.S inpatient psychiatric hospitals documented prevalence rates between 25% and 85% (Odes et al., 2020). Nevertheless, one finding of consistency is the significantly elevated exposure to aggression for staff working in forensic settings (Bowers et al., 2011).

Staff working in forensic services provide care for people with complex mental health needs in the context of behaviours that challenge. Such settings provide a secure environment for people who pose a risk, often in the form of violence (Novaco and Taylor, 2015), and the restrictive nature of forensic services themselves may also incite a tendency for aggression (Greenwood and Braham, 2018). Verbal conflict is experienced almost universally by staff in such settings (Kelly et al., 2015), and rates of actual or attempted violence exceed 40%, cross-culturally (Bowers et al., 2011; Dickens et al., 2012), with an average of 4.1 incidents per admission, compared to 0.5 and 0.4 incidents per admission in non-forensic acute and psychiatric hospitals, respectively (Bowers et al., 2011). Such figures are also likely to be an underestimate, with staff often failing to report incidents (Arnetz et al., 2015), largely due to fear of the repercussions, and the normalisation of violence as “part of the job” (Brophy et al., 2017; Kvas and Seljak, 2014). Alongside aggression, staff working in forensic settings are also frequently exposed to traumatic material by virtue of the experiences of the people in their care (Newman et al., 2019). They report greater direct exposure to a range of traumatic incidents and have twice the risk for post-traumatic stress disorder, compared to non-forensic staff (Rodrigues et al., 2020). As such, they represent a population at significant risk for both physical and psychological trauma.

Within forensic settings, further discrepancy is seen in risk for exposure to violence and aggression between staff, dependent on service user population. One such population who are frequently exposed to behaviours that challenge are those working with people with developmental disorders (DDs). Developmental disorders, by definition, represent a group of psychiatric disorders characterised by delays in neurodevelopmental, behavioural, emotional and physical functioning, and include Autism Spectrum Disorder and intellectual disabilities. Such impairments can be a source of frustration to the individual, and behaviours that challenge, including aggression and violence, may serve the function of communicating an unmet need (National Institute for Health and Care Excellence, 2015). As such, it is perhaps unsurprising that challenging behaviours, including aggression, are common within this population (Bowring et al., 2019), often contributing to the preliminary need for inpatient care (Tenneij et al., 2009).

Whilst sparse, evidence demonstrates notably high levels of aggression and behaviours that challenge in inpatient DD services (Baeza et al., 2013; Dickens et al., 2012; Romani et al., 2020), and in parallel, high levels of trauma symptomatology in staff (Baker, 2017; Baker et al., 2019), who are the most frequent target of such behaviour (van den Bogaard et al., 2019). The rates of externally directed aggression reported in forensic DD settings exceed those reported in non-DD forensic mental health services (Dickens et al., 2012). In the UK alone, levels of exposure to physical violence by staff in DD services are as high as 81%, and staff often experience multiple incidents of aggression (Kiely & Pankhurst, 1998). Verbal displays of aggression towards staff are also notably prevalent in adult DD services. A review of aggressive behaviours within a secure forensic adult ID service highlighted verbal aggression as the most common form of aggressive behaviour, followed by physical aggression to others (Batten et al., 2016), and this finding has been echoed (van den Bogaard et al., 2019; Crocker et al., 2006). As such, the prevalence of staff-directed
aggression is likely to be further elevated when adopting a broader definition of aggressive behaviour to encompass both physical and non-physical incidents.

Besides, incidents of aggression, staff working with people with a DD are also at risk for indirect exposure to trauma as a by-product of the narratives of the people in their care. The challenging behaviours often demonstrated by people with DDs have been linked to trauma (Rittmannsberger et al., 2020), and extensive trauma histories are common in this population (Wigham and Emerson, 2015; Morris et al., 2020). As such, staff working in DD services contend with greater risk for trauma, both directly, through exposure to high levels of aggression and behaviours that challenge, and indirectly, as an artefact of the significant trauma histories of the service users they care for. Trauma-informed approaches to care are increasingly being implemented in DD services, in which adverse experiences and their impacts are actively considered and embedded at all levels of a service users’ care. Nevertheless, the recognition and addressing of trauma symptoms and their pervasive impacts on wellbeing in staff working with this population is less established.

The particular vulnerability for trauma in staff working within forensic DD services represents a major clinical concern. For staff, research has documented adverse impacts on work functioning and burnout (Oates et al., 2020), levels of anxiety and depression (d’Ettore and Pellicani, 2017), perceptions of safety (Pelto-Piri et al., 2020) and physical health (Kelly et al., 2016). Such adversities may also translate into consequences for service users, resulting in poorer quality of care (Armetz and Armetz, 2001) and a longer length of stay in services (Broderick et al., 2015).

Given the consequences of aggression and violence within inpatient health-care settings, responding to the trauma experiences and needs of staff working in such an environment is pivotal. Inadequate support can compound the distress experienced (Brophy et al., 2017), and is associated with burnout and trauma symptomatology amongst staff in DD services (Baker et al., 2019; Ryan et al., 2019). There is substantial evidence demonstrating the benefits of work-based counselling, for both the individual affected and the organisation within which they work (Greenwood, 2006), preventing the worsening of psychopathological symptoms and improving work functioning (Klaver et al., 2020). Yet, whilst the need for personal and emotional support for staff working in such settings is recognised in clinical guidance (National Institute for Health and Care Excellence, 2015), the actual provision of post-incident support within forensic and health-care settings is less documented (Pelto-Piri et al., 2020), and self-care behaviours to combat work-related stress are not frequently practiced by staff (Keesler and Troxel, 2020). Therefore, insight into the levels of access to trauma support for staff working in DD settings and the associated outcomes for this particularly at-risk group is key.

In summary, staff working in forensic DD services are at a particular risk for exposure to aggression and trauma, and the profound impacts for both staff and service users’ render access to trauma support a priority. As such, the current study aims to explore the trauma-related needs of staff working in DD services in a secure psychiatric inpatient setting. Specifically, we sought to understand:

- the use of the TSS;
- the trauma experiences and psychological needs; and
- the outcomes following support, for staff working in DD services.

Method

Design, setting and service

Data was extracted retrospectively from the records of all referrals to a TSS between 2018 and 2020. The TSS is an internal trauma service for staff working within a secure mental...
health organisation. The organisation provides specialist mental health care for people with complex clinical and forensic needs across a range of medium secure, low secure and specialist inpatient rehabilitation services, including intellectual disability (ID) and Autism Spectrum Disorder (ASD) pathways. The number of beds within each service are reported in Table 2.

Staff are able to self-refer to the TSS, or their line manager may recommend a referral. The support offered is dependent on the needs of the individual, but may include 1:1 and group support sessions. The TSS is led by a consultant psychologist, with over 20 years’ experience of working with health-care professionals with psychological trauma needs. Whilst the service provides support for staff working in the organisation over its three various UK sites, the current paper reports on referrals from those working at the main site only, at which the TSS is based.

**Participants**

Overall, 278 permanent clinical staff working at the hospital site across 22 professions accessed the TSS between 2018 and 2020, 102 (36.7%) of whom were working in adult DD pathways. Of these staff working in DD pathways, 63 (62%) were working in the ASD service, and 39 (38%) were working in the ID service.

Table 1 illustrates the demographic characteristics of staff working in DD and non-DD services. There was no significant difference in age between staff who worked in DD and non-DD services (p = 0.22). Similarly, there was no significant association between service type and gender (p = 0.19).

The large number of staff who did not indicate their ethnicity or access to an external support network (i.e. friends, family) inhibited statistical comparison of groups on these

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Sample characteristics (N = 278)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff working in DD services (n = 102)</td>
</tr>
<tr>
<td>Variable</td>
<td>n (%)</td>
</tr>
<tr>
<td>Age</td>
<td>39.00 (11.82)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>69 (67.6)</td>
</tr>
<tr>
<td>Male</td>
<td>33 (32.4)</td>
</tr>
<tr>
<td>External social support</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42 (41.2)</td>
</tr>
<tr>
<td>No</td>
<td>35 (34.3)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>25 (24.5)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>7 (6.9)</td>
</tr>
<tr>
<td>Black</td>
<td>12 (11.8)</td>
</tr>
<tr>
<td>White</td>
<td>41 (40.2)</td>
</tr>
<tr>
<td>Other a</td>
<td>1 (1.0)</td>
</tr>
<tr>
<td>Did not disclose</td>
<td>41 (40.2)</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
</tr>
<tr>
<td>Health-care Assistant</td>
<td>51 (50.0)</td>
</tr>
<tr>
<td>Nursing</td>
<td>35 (34.3)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>6 (5.9)</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Psychology</td>
<td>4 (3.9)</td>
</tr>
<tr>
<td>Other a</td>
<td>6 (5.9)</td>
</tr>
</tbody>
</table>

**Notes:** DD = Developmental disorder; a groups with only one participant were subsumed under ‘other’ to preserve anonymity.
variables. Additionally, due to insufficient cell counts, an association between service type and profession could not be explored. Nevertheless, for both staff working in DD services and non-DD services, the majority were working as a health-care assistant or in a nursing role.

Materials and procedure

Upon referral to the TSS, the wellbeing of staff is measured using three questions assessing levels of anxiety, depression and psychological trauma. Staff are asked to indicate the extent to which they are experiencing each of these three symptoms on a five-point Likert scale, where 1 indicates “none” and 5 indicates “extreme levels”.

Demographic and clinical information, including age, occupation, area of work, and type of trauma experienced, was extracted from an existing database held by the TSS.

Data analysis

Normality, as determined by skewness and kurtosis values, normal probability plots and the Shapiro-Wilk test, was not met and thus non-parametric analyses were utilised.

To assess use of the TSS, the number of referrals from each service per bed was computed to account for differences in service size. A series of comparisons were conducted to explore differences in use of the TSS (referrals per bed, number of visits), nature of the event (place and type of trauma), psychological needs (anxiety, depression, trauma) and outcomes (onward referral, return to the workplace, re-engagement with the TSS), between services. To assess for differences on continuous variables, the Mann-Whitney U test was conducted when comparing between staff working in DD and non-DD services, at a group level. Alternatively, the Kruskal-Wallis $H$ test was applied when comparing between staff across all services, at an individual level. To assess for differences on categorical variables, the Fisher’s Exact and Chi-Square Test of Independence were utilised, depending upon the number of dimensions.

Ethical considerations

The current study reports on a service evaluation, and was approved by internal governance structures within the organisation. Upon referral to the TSS, staff are informed that data may be used for the purpose of service development. However, data was anonymized prior to analysis and staff were not identifiable.

<table>
<thead>
<tr>
<th>Service</th>
<th>No. of beds</th>
<th>No. of referrals per bed</th>
<th>Ranked proportion of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD services</td>
<td>108</td>
<td>0.94</td>
<td>–</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>54</td>
<td>1.17</td>
<td>1</td>
</tr>
<tr>
<td>Intellectual Disabilities</td>
<td>54</td>
<td>0.72</td>
<td>3</td>
</tr>
<tr>
<td>Non-DD services</td>
<td>480</td>
<td>0.33</td>
<td>–</td>
</tr>
<tr>
<td>Psychiatric Intensive Care Unit</td>
<td>20</td>
<td>0.8</td>
<td>2</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health</td>
<td>48</td>
<td>0.56</td>
<td>4</td>
</tr>
<tr>
<td>Women’s Mental Health</td>
<td>132</td>
<td>0.36</td>
<td>5</td>
</tr>
<tr>
<td>Men’s Mental Health</td>
<td>121</td>
<td>0.24</td>
<td>6</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>64</td>
<td>0.19</td>
<td>7</td>
</tr>
<tr>
<td>Dementia &amp; Huntingdon’s Disease</td>
<td>95</td>
<td>0.19</td>
<td>7</td>
</tr>
</tbody>
</table>

Notes: *A ranking of 1 indicates the greatest number of referrals, relative to service size, whilst a ranking of 7 indicates the fewest number of referrals, relative to service size; DD = Developmental disorder*
Results

Use of the TSS

Rates of referrals. Table 2 presents the number of staff referrals, per bed, within each service. Staff working in DD services were over-represented in referrals to the TSS, with a significantly higher number of average referrals per bed in DD services than in non-DD services, collectively ($U = 17328.00, p < 0.001$).

Both DD services ranked within the top three for highest proportion of referrals relative to number of beds, alongside the psychiatric intensive care unit (PICU). The number of referrals per bed from the ASD service was significantly higher in DD services than in non-DD services, collectively ($U = 17328.00, p < 0.001$), with the exception of the PICU. The number of referrals per bed from the ID service was significantly higher than the number of referrals per bed from all non-DD services ($all\ p < 0.05$), with the exception of the PICU and the child and adolescent mental health service (CAMHS). There was also a significant difference in the number of referrals per bed between the two DD services ($p < 0.001$), with a higher rate of referrals from the ASD service than the ID service.

Number of visits. The average number of visits required to the TSS was higher for staff working in non-DD services ($M = 1.68, SD = 1.56$), than in DD services ($M = 1.43, SD = 0.84$), collectively, although this difference was not significant ($U = 8486.00, p = 0.35$).

Trauma-related experiences and needs. Nature of trauma: place and type of event. Staff working in DD services accessed support for traumas occurring in both the workplace and the home, although more frequently the former. There was a significant association between the place and type of event ($p < 0.001$). Of staff who were accessing support for a personal home-based trauma ($n = 20, 19.6\%$) these were non-physical traumatic events only, such as an unexpected death within the family. Staff who accessed support for work-based trauma ($n = 82, 80.4\%$) did so for both physical (i.e. punching, strangulation) and non-physical events (i.e. verbal threats), most commonly the latter ($43.9\%$ vs $56.1\%$).

The place of the traumatic event (home vs. work) was not associated with service type. Staff who worked in DD services were not significantly more likely to experience a work- or home-based trauma, specifically, than staff working in non-DD services ($p = 0.15$). Nevertheless, the type of trauma event was significantly associated with service type ($p = 0.01$). Staff who worked in DD services were more likely to access support for a psychologically traumatic event, with almost two times greater odds than staff working in non-DD services ($OR 1.83, 95\% CI: 1.11–3.03$).

Of all staff who had experienced a workplace physical trauma ($n = 124, 44.6\%$), the severity of physical injury sustained was lower for staff working in DD services ($M = 2.79, SD = 1.74$) than in non-DD services ($M = 2.88, SD = 1.54$), although this difference was highly non-significant ($U = 1463.50, p = 0.99$).

Psychological needs of staff referrals. Scores for the severity of psychological needs of referred staff within each service are presented in Table 3. Across both DD and non-DD services, collectively, self-reported trauma ratings presented as the most severe need, with depression needs being of the lowest severity. When comparing between these two groups, findings showed no significant differences in severity scores for anxiety ($U = 8057.00, p = 0.59$), depression ($U = 8153.00, p = 0.66$), nor psychological trauma ($U = 7964.50, p = 0.49$). Similarly, when comparing across all eight services, individually, no significant differences were yielded for scores of anxiety ($H(7) = 9.48, p = 0.22$), depression ($H(7) = 5.39, p = 0.61$), nor psychological trauma ($H(7) = 6.77, p = 0.45$).

Staff outcomes. Need for onward referral. There was a significant association between service type and need for onward referral ($p = 0.02$), with staff from non-DD services being
more likely to require referral to bespoke psychological services. Nevertheless, the need for further referral was still low for both staff working in DD services ($n = 2, 2\%$) and non-DD services ($n = 15, 8.5\%$).

Return to the workplace. Data pertaining to staff’s transition back to work following referral to the TSS was not available for 12.95\% of the sample. Nevertheless, examination of the data showed that, even when accounting for missing data, the majority of staff working in DD and non-DD services were able to remain in work following engagement with the TSS, without further periods of absence in relation to the referring event ($65.7\%$ and $50.6\%$, respectively). The remaining staff were on short-term sick leave ($<3$ weeks), before returning to the workplace.

Re-engagement with the trauma support service. Re-engagement with the TSS was higher in staff working in DD services ($n = 20, 19.6\%$) than in non-DD services ($n = 25, 14.2\%$). Nevertheless, the association between service type and re-engagement was not significant ($p = 0.16$).

Of those who did re-engage with the TSS, this was typically for a different trauma. Of those working in DD services who re-engaged with the TSS, just one (5\%) re-engaged for support for a different trauma than that which prompted their primary visit. Of those working in non-DD services who re-engaged with the TSS, three (12 per cent) re-engaged for support for a different trauma to that which prompted their primary visit. This difference between groups was not significant ($p = 0.39$).

Discussion

The current study explored the use of the TSS by staff working in DD and non-DD services, and the associated needs and outcomes. Findings demonstrated that staff working in DD services were over-represented in referrals to the TSS, with a significantly greater number of referrals from both ASD and ID services than from non-DD, non-acute services. Further discrepancy was apparent within DD services, with higher rates of referrals from the ASD pathway than the ID pathway. Nevertheless, staff referred from DD and non-DD services presented with similar psychological needs, and outcomes following referral were also comparable.

The finding that a greater proportion of referrals were working in DD services is consistent with the literature documenting high exposure to aggression and violence for staff working in inpatient DD settings (Dickens et al., 2012; Romani et al., 2020), indicating that elevations in referrals likely parallel elevations in incidents. Nevertheless, it was beyond the scope of the current study to explore referrals in relation to the number of reported incidents of aggression and violence within the service. Thus, it cannot be concluded that the

### Table 3

Severity of psychological needs across services

<table>
<thead>
<tr>
<th>Service</th>
<th>Anxiety M (SD)</th>
<th>Depression M (SD)</th>
<th>Trauma M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD services</td>
<td>3.49 (0.85)</td>
<td>3.31 (1.01)</td>
<td>3.75 (0.86)</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>3.48 (0.85)</td>
<td>3.46 (1.13)</td>
<td>3.85 (0.78)</td>
</tr>
<tr>
<td>Intellectual Disabilities</td>
<td>3.52 (0.87)</td>
<td>3.15 (0.90)</td>
<td>3.57 (0.99)</td>
</tr>
<tr>
<td>Non-DD services</td>
<td>3.56 (0.79)</td>
<td>2.88 (1.28)</td>
<td>3.75 (0.77)</td>
</tr>
<tr>
<td>Psychiatric Intensive Care Unit</td>
<td>3.33 (0.82)</td>
<td>4.00 (0.00)</td>
<td>3.71 (0.49)</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health</td>
<td>3.52 (0.88)</td>
<td>2.59 (1.42)</td>
<td>3.80 (0.82)</td>
</tr>
<tr>
<td>Women’s Mental Health</td>
<td>3.50 (0.79)</td>
<td>2.64 (1.15)</td>
<td>3.65 (1.03)</td>
</tr>
<tr>
<td>Men’s Mental Health</td>
<td>3.68 (0.78)</td>
<td>3.10 (0.74)</td>
<td>3.77 (0.43)</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>3.78 (0.67)</td>
<td>3.25 (1.71)</td>
<td>4.00 (0.00)</td>
</tr>
<tr>
<td>Dementia &amp; Huntingdon’s Disease</td>
<td>3.60 (0.63)</td>
<td>3.60 (1.67)</td>
<td>3.71 (0.61)</td>
</tr>
</tbody>
</table>

Note: DD = Developmental disorder
over-representation of staff from DD services was a direct result of greater exposure to such incidents.

Whilst staff working in DD services were referred to the TSS more frequently than staff working in non-DD services overall, they were not significantly more likely to access support for a work-based or physical trauma, specifically. Nevertheless, this cannot be taken as evidence against their greater exposure to traumatic incidents within the workplace and need for trauma support. Indeed, previous research has highlighted particularly high levels of non-physical aggressive behaviours in inpatient DD services (Crocker et al., 2006), including an earlier review of the organisation’s own ID service (Batten et al., 2016). This is mirrored in the current study, which found that staff working in DD services were significantly more likely to access support for a non-physical, psychologically traumatic experience, than staff working in non-DD services. When such staff are exposed to physically aggressive behaviours, the likelihood for severe physical injury is low (Hensel et al., 2012), and thus the psychological impacts of such behaviours are likely greater than the physical impacts. Additionally, this staff group work with a population who often present with extensive trauma histories (Wigham and Emerson, 2015; Morris et al., 2020), and thus contend with additional risk for secondary psychological trauma. Finally, staff often fail to report and seek support for incidents of aggression (Arnetz et al., 2015), particularly in inpatient mental health setting where violence is normalised (Brophy et al., 2017). Therefore, despite the high levels of physically aggressive behaviour reported in DD settings (Kiely and Pankhurst, 1998; Dickens et al., 2012; Romani et al., 2020), DD staffs’ particular need for support for a psychologically traumatic experience is unsurprising.

Given the over-representation of DD staff in referrals, the similarity of their psychological needs to those of staff working in non-DD services is of interest. It may be that staff working in DD services are exposed to behaviours that challenge more frequently, but such incidents are of a lesser severity, requiring fewer appointments and having lesser impact on mental wellbeing. Displays of aggression and violence by people with a DD, whilst frequent, tend to be of a mild to moderate severity (van den Bogaard et al., 2019; Poppes et al., 2010) and of lesser severity to incidents occurring in non-DD forensic services (Dickens et al., 2012). Although non-significant, the severity of physical injuries sustained by staff working in DD services were lower than those sustained by staff working in non-DD services, adding further credence.

There were no significant differences in number of visits to the TSS between staff working in DD and non-DD services, and no association between service type and likelihood for re-engagement was found. It may be that staff are equipped with the skills to better manage such experiences and their impact following their referral, suggesting that a model offering responsive, brief engagement is sufficient. This is reflected in the significantly lower likelihood for onward referral for staff working in DD services.

Furthermore, the particularly high proportion of DD staff who were able to return to work is a striking outcome. Time to return to work following a non-physical trauma is often longer than that following a physically violent incident (Choi et al., 2020), and staff working in DD services accessed support for psychologically traumatic incidents at a significantly higher rate. The lack of any significant difference in the number of staff who were able to return to work between DD and non-DD services found here in the current study indicates that, whilst outcomes were positive across the sample, staff working in DD services particularly benefitted from the support.

Clinical implications

Primarily, responding to the traumatic experiences and subsequent needs of staff working with people with DDs, particularly within a forensic setting, is a key clinical priority, not least because of the consequences for both staff and service users. Current guidance for the
“management of behaviours that challenge in people with learning disabilities” (National Institute for Health and Care Excellence, 2015) documents the need for provision of personal and emotional support for staff working with this population and the findings evidenced both here and within the existing literature (Baker, 2017; Baker et al., 2019) echo this. When given the opportunity to do so, staff working in DD services will access support for a traumatic event, and do so at a higher rate than staff working in non-DD mental health services. Whilst staff primarily accessed support for traumas occurring in the workplace, a number were also referred in response to home-based incidents; as such, staff require a support service that responds to external sources of distress, as well as workplace events. A brief model of support that goes beyond psychoeducation and provides staff with the skills to manage the experience and subsequent sequel is key in evoking positive outcomes (Singh et al., 2020).

Furthermore, establishing a culture where staff feel able and encouraged to acknowledge such experiences is key. A culture of safety represents one of the guiding principles to a trauma-informed service approach (SAMHSA, 2014) and extends equally to staff, and the people in their care. The failure to report experiences’ of aggression and violence not only downplays the true prevalence of the problem faced, but also serves to be a major barrier to improving staff safety and wellbeing (Arnetz et al., 2015).

Responding to the traumatic experiences and needs of staff is also likely to translate into improvements in service users’ care. Evidence documents clear links between the welfare of health-care staff and service quality, including service user safety and experience (Boorman, 2009; Hall et al., 2016). This may occur directly, as a result of poorer work functioning in staff (Oates et al., 2020), or indirectly, through inadequate staffing levels as a result of high levels of sickness and turnover (McDermid et al., 2019). Thus, staff welfare represents a crucial mechanism contributing to the recovery experiences of the people in their care, and the two should not be approached in disconnect.

Limitations and future directions

The current study holds a number of important caveats. Firstly, data was not available for number nor severity of incidents against staff; thus, it cannot be concluded that the over-representation of DD staff in referrals to the TSS was a direct result of more frequent and/or more severe exposure to trauma. Any future investigations into levels of access to support by health-care staff should analyse and interpret their findings in the context of the frequency and severity of traumas experienced.

Furthermore, the current study did not control for a number of potential confounding variables. For example, the organisation in which the current study was conducted provides care through medium secure, low secure, and specialist inpatient rehabilitation pathways; level of security is likely to be an important factor associated with levels of aggression (Dickens et al., 2012), as an artefact of greater severity of patients’ needs and higher levels of restriction. Future research should control for such factors to better demarcate the role of psychiatric diagnosis in determining staff risk.

Finally, whilst the current study did not seek to explore the causes of referrals, this represents an important gap. Whether the differences in rates of referrals between DD and non-DD services is an artefact of exposure to violence and aggression, or perhaps accounted by other factors, such as service culture and staff training, remains an important question. Indeed, the lack of significant differences in the severity of psychological needs, despite higher rates of referrals from staff working with DD populations, might be explained by a more supportive and responsive culture within the such a service. Understanding the role of culture and perceptions of safety by staff remains a priority.
Conclusions

Staff working in forensic DD services are over-represented in referrals for trauma support and are more likely to access support for psychological traumas. Despite this, this staff group have good outcomes following referral, mirroring those of staff working in non-DD services. The study offers novel insight into how the high levels of behaviours that challenge and trauma faced by this staff population translates into levels of access to support. This study also demonstrates the benefit of providing trauma support in mitigating against the adverse impacts on staff wellbeing and functioning. Such findings are of valuable clinical significance, highlighting the need for organisational provision of adequate support for staff working in vulnerable settings. Going forward, future research should simultaneously explore rates of incidents and referrals for support within a singular study. Identification of discrepancy between incidents and access to support enables exploration of the differences between staff who do and do not seek help, as well as barriers preventing staff from reaching out. Additionally, further consideration of factors related to service culture and staff investment is warranted.

References


Batten, R., Morris, D.J. and Gray, N. (2016). “Gender symmetry in reported inpatient aggression in a secure forensic ID service”, Poster presented at the 15th International Conference on the Care and Treatment of Offenders with a Learning and/or Developmental Disability, Manchester, April.


Further reading

Disability: Definition, Classification, and Systems of Supports*, 11th ed., American Association on
Intellectual and Developmental Disabilities, Washington, DC.

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