

The impact of inpatient violence on mental health staff

Michael Daffern

Centre for Forensic Behavioural Science













- Mental health in forensic mental health units work can be stressful.
- Various causes - exposure to patient-perpetrated aggression is an important issue and is causally related to stress.
 - A UK National Audit of Violence found that a third of mental health consumers had been threatened or made to feel unsafe during their hospital stay (Royal College of Psychiatrists, 2007).
 - Verbal abuse and threats reported by 80-90% of mainstream and forensic unit-based mental health nurses (Nijman *et al.* 2005; Bilgin & Buzlu 2006).
 - In its most extreme form violence has dramatic consequences.
 - Significant consequences – personal, professional - role, service – recruitment/retention/sick leave

FEATURE ARTICLE

Towards a model for understanding the development of post-traumatic stress and general distress in mental health nurses

Joyce Lee,^{1,2} Michael Daffern,^{1,3} James R. P. Ogloff^{1,3} and Trish Martin^{1,3}

¹Centre for Forensic Behavioural Science, Swinburne University, ²Monash Health, and ³Victorian Institute of Forensic Mental Health, Melbourne, Victoria, Australia

ABSTRACT: *In their daily work, mental health nurses (MHN) are often exposed to stressful events, including patient-perpetrated aggression and violence. Personal safety and health concerns, as well as concern for the physical and psychological well-being of patients, dominate; these concerns have a profound impact on nurses. This cross-sectional study explored and compared the psychological well-being of 196 hospital-based MHN (97 forensic and 99 mainstream registered psychiatric nurses or psychiatric state enrolled nurses). The aim was to examine exposure to inpatient aggression and work stress, and identify factors contributing to the development of post-traumatic stress reactions and general distress. Multiple regression analyses indicated that working in a mainstream setting is associated with increased work stress; however, mainstream and forensic nurses experienced similar psychological well-being. As a group, 14–17% of mainstream and forensic nurses met the diagnostic criteria for post-traumatic stress disorder, and 36% scored above the threshold for psychiatric caseness. A tentative model of post-traumatic stress and general distress in nurses was developed, illustrating the impact of aggression and stress on well-being. The present study affirms that mental health nursing is a challenging and stressful occupation. Implications for organizations, managers, and individual nurses are discussed.*

KEY WORDS: *aggression, forensic, mental health nursing, stress, trauma.*

- Cross-sectional study explored and compared the psychological wellbeing of 196 hospital-based mental health nurses (97 forensic and 99 mainstream nurses).

TABLE 1: *GHQ-28 caseness and PTSD diagnoses by setting*

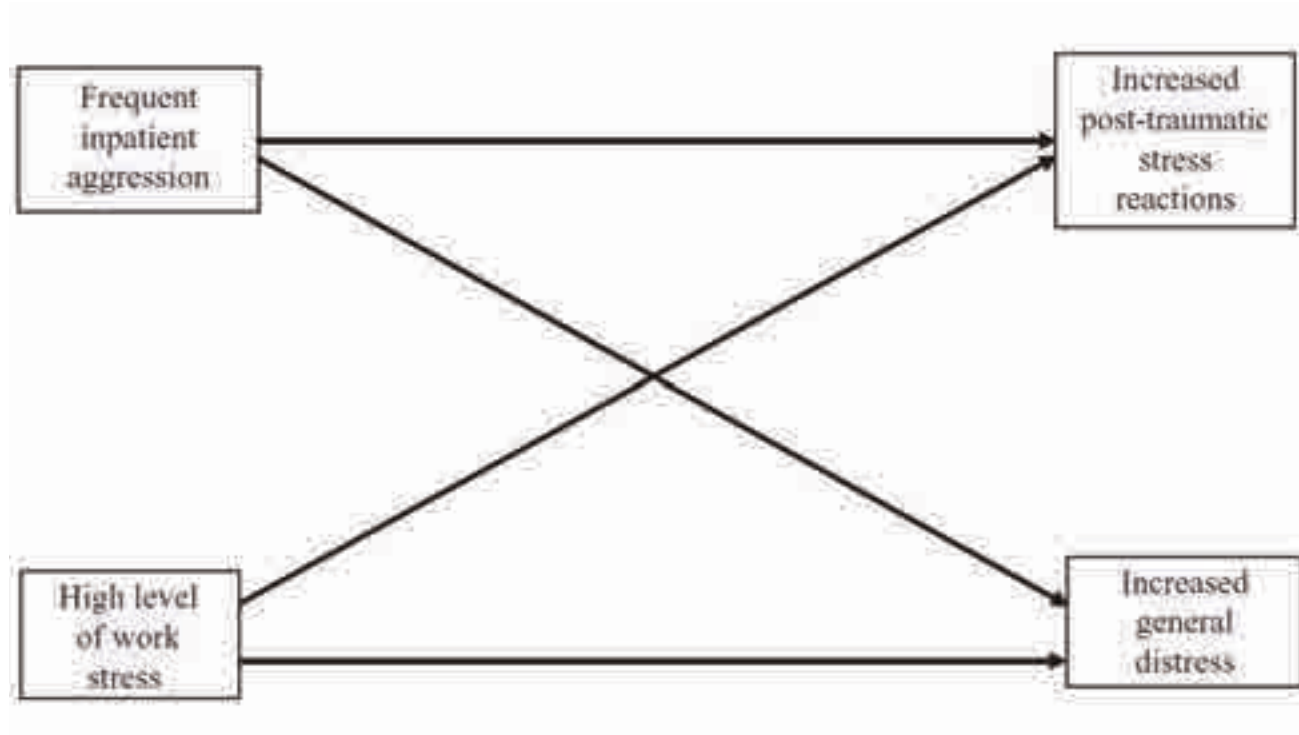
Variable	Setting		Total
	Mainstream	Forensic	
GHQ-28 caseness, % (n)			
Case	43 ^a (43)	29 ^a (28)	36 (71)
Non-case	57 (56)	71 (69)	64 (125)
PTSD diagnosis (severity scoring method), % (n) [†]			
PTSD	18 (17)	17 (16)	17 (33)
No PTSD	83 (80)	83 (79)	83 (159)
PTSD diagnosis (symptom endorsement scoring method) % (n)			
PTSD	16 (15)	12 (11)	14 (26)
No PTSD	85 (82)	88 (84)	87 (166)

- 36% of nurses constituted a 'case' (i.e., distressed- if they presented in general practice, they would be likely to receive further attention)
- 17% met diagnostic criteria for PTSD as determined by the severity scoring method (PTSD Checklist) and 14% met diagnostic criteria for PTSD as determined by the symptom endorsement scoring method.
- No significant differences in percentages of individuals meeting a diagnosis of PTSD between mainstream and forensic nurses.

What predicted psychological ill health?

Organizational stress
(low morale, lack of
collaboration with
peers and
management, and
general lack of
feedback)

Staffing stress/staff
conflict.



What helped?

- More hours of aggression management training over the course of one's career is associated with decreased post traumatic stress symptoms and decreased general distress.

Implications

- Since higher levels of stress concerning job redundancy and hospital restructures are associated with increased distress, support regarding this issue may be useful.
- Regular consultation and provision of feedback from management about any pending changes in the hospital system.

Implications

- Incorporating multiple aggression management training courses and update sessions as part of on-site professional development.
- Repeatedly attending courses staggered over one's entire career is necessary to rehearse skills.
- Attempt to prevent and reduce the severity of aggression.

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH, 14: 93-100, 2015
Copyright © International Association of Forensic Mental Health Services
ISSN: 1499-9013 print / 1932-9903 online
DOI: 10.1080/14999013.2015.1045632



The Impact of Inpatient Homicide on Forensic Mental Health Nurses' Distress and Posttraumatic Stress

Joyce Lee

*Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne,
Australia; Monash Health, Melbourne, Australia*

James R. P. Ogloff, Michael Daffern, and Trish Martin

*Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne,
Australia; Victorian Institute of Forensic Mental Health, Melbourne, Australia*

- November 2009, a patient stabbed two co-patients to death on a low secure rehabilitation unit.
- Coincidentally, between two and five months prior to the homicide, forensic mental health nurses (n=97) had been recruited for a study examining how inpatient aggression and work stress impact distress and posttraumatic stress.
- Five months following the homicide, the original measures were re-administered (n=107).

GHQ-28 Caseness and PTSD Diagnosis by Time: Nurses Across the Entire Hospital

Variable	Time		Total
	Time 1	Time 2	
GHQ-28 caseness % (n)			
Case	29 (28)	33 (35)	31 (63)
Non-case	71 (69)	67 (72)	69 (141)
PTSD diagnosis (severity scoring method) % (n)^a			
PTSD	17 (16)	18 (19)	18 (35)
No PTSD	83 (79)	82 (86)	83 (165)
PTSD diagnosis (symptom endorsement scoring method) % (n)			
PTSD	12 (11)	11 (12)	12 (23)
No PTSD	88 (84)	89 (93)	89 (177)

Note. Using chi-square tests of independence, no significant differences were found between Time 1 and Time 2 nurses on any of these variables.

^aIn the absence of a designated cut-off score for PTSD diagnoses in mental health nurses, the cut-off score of 44 (as found for motor vehicle accident and sexual assault survivors) was used.¹⁵

A small non-significant increase from Time 1 to Time 2 in the proportion of nurses meeting GHQ-28 caseness criteria (from 29% to 33%).

No significant differences in the percentage of nurses meeting a diagnosis of PTSD

- Perhaps nurses processed the occurrence of homicide as an infrequent event that didn't significantly disrupt their subjective wellbeing for a prolonged period of time.
- Or, those nurses seriously psychologically harmed by the incident did not return to work or did not participate in the research after the homicide.

GHQ-28 Caseness and PTSD Diagnosis by Time: Jardine Nurses Only

Variable	Jardine	
	Time 1	Time 2
GHQ-28 caseness % (<i>n</i>)		
Case	9 (1)	36 (5)
Non-case	91 (10)	64 (9)
PTSD diagnosis (severity scoring method) % (<i>n</i>) ^a		
PTSD	0 (0)	29 (4)
No PTSD	100 (10)	71 (10)
PTSD diagnosis (symptom endorsement scoring method) % (<i>n</i>)		
PTSD	0 (0)	21 (3)
No PTSD	100 (10)	79 (11)

Note. Using chi-square tests of independence, no significant differences were found between Time 1 and Time 2 Jardine nurses on any of these variables.

^aIn the absence of a designated cut-off score for PTSD diagnoses in mental health nurses, the cut-off score of 44 (as found for motor vehicle accident and sexual assault survivors) was used.¹⁵

GHQ-28 Caseness and PTSD Diagnosis by Time: Jardine Nurses Only

Variable	Jardine	
	Time 1	Time 2
GHQ-28 caseness % (n)		
Case	9 (1)	36 (5)
Non-case	91 (10)	64 (9)
PTSD diagnosis (severity scoring method) % (n) ^a		
PTSD	0 (0)	29 (4)
No PTSD	100 (10)	71 (10)
PTSD diagnosis (symptom endorsement scoring method) % (n)		
PTSD	0 (0)	21 (3)
No PTSD	100 (10)	79 (11)

Note. Using chi-square tests of independence, no significant differences were found between Time 1 and Time 2 Jardine nurses on any of these variables.

^aIn the absence of a designated cut-off score for PTSD diagnoses in mental health nurses, the cut-off score of 44 (as found for motor vehicle accident and sexual assault survivors) was used.¹⁵

- Nurses confronted by multiple reminders of the homicide as part of their usual work duties, including providing ongoing care for patients who either witnessed the homicide or knew the perpetrator or victims.
- Additionally, nurses were coping with internal investigations, coronial inquests and legal proceedings into the incident, prompting sadness, guilt, or fears of being blamed or having their registration examined.

Why on earth have we discussed this?

- Increase awareness so supervisors increase opportunity for review and support; *peer mentoring* may be particularly important.
 - The focus should be to facilitate an interpersonal/solution focussed response-style.
- Consider violence preventative strategies.
- Need to counter the idea that because we are mental health professionals that we should be able to handle people perfectly; ***we can't manage everything; sometimes it is hard to cope.***
- We shouldn't be reluctant to seek support or take a break; remember, we need to be in good condition to remain present and helpful.
- We don't need to tolerate threats either (although some evidence this is protective).