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Title: Stress and Burnout in Forensic Community Mental Health Nurses: an investigation of its causes and effects

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Abstract

The increasing development of forensic services has seen the numbers of Forensic Community Mental Health Nurses (FCMHNs) mushroom. Community mental health nursing (CMHNs) has been found to be a stressful occupation. FCMHNs have largely been ignored in research into occupational stress. The current study identified and surveyed all FCMHNs (n=104) in England and Wales who were attached to NHS Medium Secure Units using measures of occupational stress. A response rate of 76.9% was achieved. Findings from this study showed that a substantial portion (44.3%) of FCMHNs were experiencing high burnout in relation to emotional exhaustion. 31.2% of FCMHNs reached or exceeded the threshold for psychiatric caseness on one measure. Concerns of FCMHNs included “not having facilities in the community to refer patients on to” and “interruptions in the office”. Dealing with violent patients did not feature in the top ten stressors although dealing with suicidal patients did. As a group FCMHNs appear to feel supported by their managers and colleagues.

Keywords: Forensic, community, stress, burnout, emotional exhaustion, suicide, violence
Stress and Burnout in Forensic Community Mental Health Nurses: an investigation of its causes and effects

Introduction

There is increasing attention now being given to the issue of occupational stress and burnout among nurses. This has led to research focusing upon the various branches of the profession and latterly upon mental health nursing. Within mental health nursing community work has been found to be particularly stressful (Fagin et al 1995). Recent changes in government policy (Department of Health and the Home Office 1992) have led to a growth in the numbers of Forensic Community Mental Health Nurses (FCMHNs) (Brooker and White 1997). These nurses work in a variety of settings including the patients home, providing treatments and intervention to people with mental health problems who have usually committed criminal offences. Levels of stress and burnout among this group have not as yet been described. Given the developing nature of this speciality together with the challenging behaviour of the client group it would seem that their work would be inherently stressful. This study examines stress and burnout levels among this group using standardised psychometric schedules to enable description of the experiences of these nurses in relation to the established literature.

Throughout this paper the term Forensic Community Mental Health Nurse (FCMHN) is preferred to Forensic Community Psychiatric Nurse (FCPN) as suggested by the Mental Health Nursing Review (Department of Health 1994). The term CPN continues to be commonly used among nurses in mental health and appears regularly in the literature as well as being contained within the title of one of the measures used. It is for these reasons that the term will be used interchangeably when describing the results.
Literature review

Dewe (1987) suggests that definitions of stress should reflect its relationship to adaptive factors. The individual’s ability to cope with external pressures is dependent upon a cognitive appraisal of the stressor and the coping strategies the person has available to them. Stress therefore is perceived in relation to the person’s previous experience, success or failures in dealing with similar situations and their familiarity with the situation (Lazarus and Folkman 1984). This formulation of stress is termed a transactional view and reflects current understanding of the concept. Inherent within these definitions is the notion that stress is not always a negative element and it is certainly true that without some stress in our lives we would lose much of the motivation to succeed at what we do.

The term ‘burnout’ has commonly been used to describe an array of symptoms experienced by a stressed individual. These include reduced energy, lowered self-esteem and a sense of negativism towards the job and oneself. Maslach and Jackson (1986 p.1) define burnout as “a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that occur among individuals who do “people work” of some kind”. Emotional exhaustion is a result of emotional resources becoming depleted and workers feeling unable to give of themselves. The development of negative and cynical attitudes about one's clients is termed depersonalisation and can lead to staff feeling that their clients are somehow deserving of their problems. Reduced personal accomplishment is the tendency to view oneself negatively in regard to one's work with clients (Maslach and Jackson 1986).

Within the area of the caring professions there is a widely accepted assumption that people centred occupations are endemically stressful.
In the area of mental health increased stress can lead to nurses losing the ability to empathise with their patients. Empathic understanding is seen as crucial in therapeutic relationships and is a fundamental component of the humanistic ethos of mental health nursing (Rogers 1951). Carson et al (1991) conducted one of the first studies on stress and burnout in community mental health nurses. A sample of 61 CPNs in four district departments were surveyed. The 28-item General Health Questionnaire (GHQ-28) (Goldberg and Hillier 1979), the Maslach Human Services Survey (MBI) (Maslach and Jackson 1986) and the CPN Stress Questionnaire (CPNSQ) were used to measure stress. Lack of community facilities to refer patients on to was seen as the most stressful element of CPNs work as rated by the CPNSQ. The second most stressful item was working with clients with a history of violence while office interruptions was rated third. Carson et al (1991) also found 23% of their sample had GHQ-28 scores suggesting psychiatric caseness and 24% were experiencing emotional exhaustion. The majority (81%) of CPNs in this sample had low depersonalisation scores suggesting few had developed negative attitudes towards their patients. In terms of personal accomplishment, 39% of CPNs had high scores suggestive of viewing themselves and their work negatively. Carson et al (1991) conclude that low job satisfaction is a worrying feature and suggested that managers take account of the concerns expressed by CPNs for personal safety.

Schafer (1992) studied the effects on community psychiatric nurses (CPN’s) (n=16), of organisational change in relation to levels of stress and burnout. This study replicated Carson et al’s (1991) study which had taken place in the same area 2 years previously. The questionnaires consisted of the 28-item GHQ-28, the MBI and the CPNSQ (Carson et al 1991). The results of this study showed an increase of stress using the GHQ-28 post organisational change with results
from the MBI showing an increase in scores on the emotional exhaustion scale and on the depersonalisation scale. However personal accomplishment scores improved post change.

While the above studies focused on community staff, ward based psychiatric nurses have also attracted research attention. In a study of 78 qualified psychiatric nurses working in 8 acute admission wards Sullivan (1993) found that violence, potential suicide and observation were the most frequent stressors in relation to patient care.

Fagin et al (1995) conducted a large study on stress and burnout in community and ward based psychiatric nurses. The study compared occupational stress in CPNs and ward based nurses. The sample consisted of 250 CPN's and 323 ward based psychiatric nurses (WBPN) who were asked to complete the GHQ and the MBI as well as questionnaires on self attitude, job satisfaction and coping skills. The CPN's were also asked to complete the revised 48-item version of the CPN Stress Questionnaire (CPNSQ). Within the CPN group 41% were found to have a degree of psychological distress which constituted "caseness" in terms of a clinical condition when measured on the GHQ. Among WBPN this figure was almost 28% when measured on the GHQ. Some nurses had high scores on the GHQ which would have been expected of the “individuals they nurse rather than the nurses themselves”(Fagin et al 1995 p.353). Findings from this study also showed that more WBPNs had lost their ability to empathise with their patients compared with CPN’s. The WBPNs had lower personal accomplishment than the CPN group. Both groups scored highly on the emotional exhaustion subscale of the MBI. When CPNs were compared with WBPNs they tended to score higher on the GHQ and the emotional exhaustion subscale of the MBI. The authors conclude that those experiencing the most stress were more likely to have more sick leave, lower self esteem and feel unfulfilled in their work.
In a naturalistic study Prosser et al (1996) examined the hypothesis that burnout is higher and job satisfaction lower among community mental health staff than hospital-based staff. Their sample consisted of 160 multidisciplinary staff working in one of 3 settings, community-based, inpatient staff and out-patient staff. Instruments used included the GHQ-12 and the MBI. Results showed high scores for stress using the GHQ-12, with community based staff having higher scores than their counterparts in other parts of the service. The MBI scores showed significant differences between staff in the community and other settings on items in the emotional exhaustion subscale. The mean scores for depersonalisation and personal accomplishment were moderate and similar across work settings. The higher levels of stress among community based staff is consistent with Fagin et al’s (1995) study of CPNs.

Fagin and colleagues later extended their research to include 2 further studies of ward based psychiatric nurses (Fagin et al 1996). Giving a combined sample size of 648 ward based psychiatric nurses. The sample was drawn from two district general hospital psychiatric units and five mental hospitals. The sample included staff nurses (55.5%), unqualified nurses (20.2%) and charge nurses or above (23.2%). Demographic information was sought from the sample and the GHQ-28 and MBI both used as well as a new stress scale and a scale for measuring coping. The overall caseness rate on the GHQ-28 for the sample was 31%, that is those scoring 5 or more on the scale. Staff in study three however had a caseness rate of 38%. The mean overall score for the sample on the GHQ-28 was 3.77. The most stressful items for ward based nurses were “inadequate staffing cover in potentially dangerous situations” and “dealing with changes in the health service and hospital closures”. The finding in regard to service changes is unsurprising given that two of the hospitals in the study were scheduled for closure.
More recently Carson et al (1997) surveyed a random sample of 2000 mental health nurse members of the public sector union UNISON. The sample consisted of 189 community nurses and 281 hospital based nurses providing a 24% response rate. In contrast to previous studies there were no significant differences between community nurses and their hospital colleagues in terms of stress levels. The study suggested that ‘D’ grade nurses experienced the highest levels of stressors and ‘I’ grade nurses the lowest. Nurses reported a number of stressors which related to organisational issues suggesting that remedial action by management may help reduce these sources of stress.

Stress and threats of violence

Many staff working in the area of mental health experience both verbal and physical aggression from the patients they care for (Whittington 1994). Staff working in forensic services not unlike their colleagues in acute settings may be subjected to aggression or the threat of aggression on a frequent basis (Coldwell and Naismith 1989). This can range from an assault every 10 hours (Larkin et al 1988) to less than one per fortnight (Dooley 1986) in some forensic services. Medium secure forensic services themselves are defined by the dangerousness or difficulty of the patient population “units…which care for patients who are too difficult or dangerous for local hospitals but who do not require the higher security available at Special Hospitals” (Department of Health and Home Office 1992 p.117).

It has been found that aggression is inherently stressful for staff (Sullivan 1993). Mackay (1994) reports a study for the Health and Safety Executive which demonstrated 17% of NHS staff reporting that they had been verbally abused or threatened at work in the previous 12 months. The rates among psychiatric staff were even higher at 30% with nurses being the occupational group most likely to experience such abuse. Cassidy (1994) found that 25% of community staff
had encountered verbal aggression in the preceding year with higher rates among community mental health nurses. While there appear to be no comparative studies looking at this area there are some studies which have explored the effects of verbal and physical aggression as well as threats of violence upon staff. Adams and Whittington (1995) surveyed 68 registered mental nurses in two settings, ward based and community based, over a 10 week period. During the period of the study 50 episodes of verbal aggression were reported by 20 nurses. A significant association with workplace was found with inpatient staff reporting more incidents than community staff. Most verbal threats or abuse derived from male patients and the majority of incidents did not involve physical assault. Community nurses reported higher levels of anxiety during the episode than ward-based nurses. The authors hypothesise that community nurses higher levels of anxiety reflect their relative isolation. That is, they often visit patients in their homes alone and do not have easy access to assistance should they be assaulted. It is also suggested that hospital staff may have become habituated to verbal abuse (Adams and Whittington 1995). The authors found that traumatic stress can be generated in some staff who had experienced verbal aggression unaccompanied by physical assault.

Psychiatric nurses within forensic settings work with patients who have often demonstrated dangerous behaviour in association with their mental illness. Many of these patients may have seriously injured or killed others in the past. It could be assumed therefore that working with these patients on a daily basis would be perceived by nurses to be inherently dangerous and therefore stressful. Jones et al (1987) surveyed nursing staff (n=349) in one Special hospital and demonstrated a higher mean score on the GHQ-12 item questionnaire than other reported employed samples but lower scores than unemployed samples. No differences existed between senior and junior staff in levels of stress experienced. An association between levels of demand
and experienced stress was also demonstrated. Demands which are high, such as patient supervision were not related to health and well-being while aversive demands such as ‘working with patients I am afraid of’ which were rated as occurring less frequently were strongly related to stress. It appears therefore that it is the perception of potential threat which influences the experience of stress in this context. Female nurses reported greater job satisfaction than their male counterparts although the reasons for this finding are not examined (Jones et al 1987).

It is acknowledged that forensic services are concerned with multi-disciplinary risk assessment and management (Doyle 1999). Although it remains to be demonstrated these processes may have ameliorating effects upon perceived occupational stress experienced by nursing staff.

In terms of the effects on patient management by psychiatric nurses as a consequence of stress there is little reported in the literature. It is commonly postulated but rarely demonstrated that staff experiencing high levels of stress will have negative outcomes for the patients they treat. Whittington and Mason (1995) for example offer the perspective that seclusion is used by ward based psychiatric nurses as an attempt to cope with perceived threats from patients. That is, psychiatric nurses become anxious and stressed as a result of appraisal of threat from a patient and then use seclusion as method of coping ostensibly for the patients benefit. This hypothesis is based on the theoretical model of stress and coping suggested by Lazarus and Folkman (1984). Whittington and Mason (1995) did not seek to demonstrate their hypothesis. Cronin-Stubbs and Brophy (1984) however found a relationship between stress and nurses behaviour. In their study nurses with higher levels of burnout spent less time with patients and used prescribed medication to calm patients down. These findings suggests that when nurses are experiencing
high levels of stress they are unable to emotionally support their patients and use medication as a way of attaining the control they are unable to secure for themselves.

The studies presented here while offering contrasting styles and methodologies have all managed to identify high levels of occupational stress in those working within the area of mental health. The literature is therefore extensive and points to a number of interesting questions which should be posed when investigating stress and burnout among forensic community mental health nurses. The results presented here form part of a study which aimed to measure and describe occupational stress and burnout among FCMHNs. This included qualitative-type data and detailed demographic as well as comparative inferential on high and low stress score subgroups. This paper is concerned with reporting findings from the standardised measures and will consider the following research questions

Research Questions

1. What are the levels of stress and burnout among Forensic Community Psychiatric Nurses working in National Health Service medium secure units in England and Wales?

2. What are the main stressors experienced by Forensic Community Psychiatric Nurses?

Method

The measures chosen (MBI and GHQ-28) are those which appear in most studies of occupational stress. The CPNSQ-r is used, as it is the only measure, which directly seeks to measure stress in community mental health nurses. The initial sample consisted of all FCMHNs (n=104) attached to National Health Service (NHS) Medium Secure Units in England and Wales. A further 4 FCMHNs from the authors service were excluded from the study. Medium Secure Units were identified through the Directory of Forensic Services (Rampton Hospital Authority 1997).
FCMHNs were sent individually by post an introductory letter with measures attached. The letter explained the purpose of the study assuring them of confidentiality and offered a copy of a summary of the results. A demographic data sheet for background information and instructions for completing the measures was also enclosed. The results presented here are from standardised measures used in the study.

Measures

The measures used were as follows:

A demographic data sheet based on Brown and Leary (1995) which was adapted to include a question on shift patterns and a question to identify the area in which subjects normally worked. Maslach Burnout Inventory (MBI) was developed by Maslach and Jackson (1986) and has three subscales covering the items emotional exhaustion, depersonalisation and personal accomplishment. Respondents are asked to rate the frequency of experience of each item. Items are rated on a scale of ‘0’ = never to ‘6’= every day. The higher the score on the emotional exhaustion subscale the higher the degree of burnout. High scores on the depersonalisation subscale reflect high burnout scores. A high degree of burnout is reflected in low scores on the personal accomplishment subscale.

A low degree of burnout is demonstrated by low scores on the emotional exhaustion and depersonalisation subscales and high scores on the personal accomplishment subscale (Maslach and Jackson 1986 p.2).

The normative scores for the appropriate occupational subsample were used, that is mental health workers. The normative scores are presented in Table 1.
Table 1 here

General Health Questionnaire – 28-item version (GHQ-28) – this measure was developed by Goldberg and Hillier (1979) and is a validated inventory measuring psychological stress and the likelihood of psychiatric caseness. In non-clinical samples where scores are expected to be low the total score only be used (Goldberg and Williams 1988). Standard GHQ scoring criteria of 0-0-1-1 was employed here to allow comparison with other studies. A total score of 5 or above is the threshold for determining psychiatric caseness in terms of psychological distress as measured by this scale. The range of scores for this scale is therefore 0-28.

Community Psychiatric Nurse Stress Questionnaire – revised (CPNSQ-r) a 48-item measure tested for validity and reliability by Brown et al (1995). It consists of a 5-point Likert scale on which respondents’ score themselves as experiencing between ‘0 = no stress’ and ‘4 = extreme stress’ when presented with statements related to their work. Total scores and factor scores can then be calculated. The range of possible scores is from 0-192. Scores can be compared against the standardisation sample of 250 CPNs (Fagin et al 1995). The higher the score the more stressed the respondent is. A ranked item list of stressors can be identified in terms of responses indicating items causing most or least stress. These stressors can be examined to determine if they differ from those identified for other groups of mental health nurses. Further details of this measure can be found in Carson et al (1995).

Data Analysis

Data was analysed using the Statistical Package for Social Scientists (SPSS) for Windows (Norusis 1993) computer program. Initial analysis concerned itself with scoring of the
questionnaires and calculating frequencies. The aim being to establish detailed information about the sample for descriptive purposes as well as calculating average total scores on the standardised measures.

Total scores for the GHQ-28 and CPNSQ (revised) and MBI subscales were calculated. Subscale scores on the MBI were compared with the norms for the relevant occupational group. CPNSQ scores were compared to the standardisation sample.

**Results**

First time responses to the questionnaires totalled 63 and all non-responders were sent a second letter with the measures attached and asked to reconsider their participation. A further 17 responses were elicited giving a final total response of 80 which is 76.9% of the total identified. Not all respondents answered all the items on each measure. Where this was the case that subject was excluded from the analysis for that particular measure.

The mean age of the sample was 37.8 years, the range 28-56 years. The gender split of this sample showed there was 53.8% men and 46.2% women, 75% of the sample were married or living with a partner and 48% had children living with them at home. FCMHNs had an average of just over 15 years experience in psychiatric nursing with 25% having spent 5 years or more in their current position (mean 3.8 years). This level of experience was reflected in the grades of nurses in this sample with 56.3% at ‘G’ grade and a further 22.5% at ‘H’ grade. A small number 7.5% of nurses were graded at ‘D’ or ‘E’ grade level. The average number of sick days taken in the last year for this sample was 6.3 days with a range of 0-180 days. 70.5% of the FCMHNs in this sample felt they were ‘very happy’ or ‘happy’ in their life in general. Demographic information is discussed in detail elsewhere (Coffey 1999).
Maslach Burnout Inventory findings

The number of valid responses to this questionnaire was n=79. The mean scores for each dimension were as follows;

Emotional Exhaustion – The mean score was 19.34, standard deviation 10.13 (range 4-47). This average score was in the moderate burnout category (normative range 14-20) when compared against the normative scores for the relevant occupational group. However 44.3% of subjects scored in the high burnout category (normative range 21 or more) on the emotional exhaustion subscale.

Depersonalisation – The mean score was 5.65, standard deviation 4.31 (range 0-20). This average score was again in the moderate burnout category (normative range 5-7) and 26.58% of FCMHNs scored in the high burnout category (normative range 8 or more).

Personal accomplishment – The mean score was 33.0, standard deviation 6.22, (range 17-45). This average score was in the moderate burnout group (normative range 33-29) although 26.58% of FCMHNs scored in the high burnout category (normative range 28 or less).

These scores demonstrate that FCMHNs as a group are experiencing moderate levels of burnout in emotional exhaustion, depersonalisation and personal accomplishment. A substantial number (almost half) however have high scores on the emotional exhaustion subscale. These scores are tempered by lower scores on the depersonalisation and personal accomplishment subscales. That is FCMHNs are demonstrating emotional effects of stress but as a group appear not to be experiencing difficulty in empathising with patients or feeling that their work is futile. A substantial minority of nurses (26.5%) however report high scores on depersonalisation.
suggesting that they are having difficulties in empathising with their patients. Scores are summarised in Table 2.

**Table 2 here**

General Health Questionnaire findings

The number of valid responses to this questionnaire was n=77. The average score on the GHQ-28 was 3.80, standard deviation 5.65 (range 0-24). The mean score for the sample is below the threshold for psychiatric caseness which is a score of 5 or more and 41.6% of respondents scored ‘0’ on this measure. However 31.2% of the sample had scores at or above this threshold suggesting that almost a third of the sample are experiencing high levels of psychological distress. Figure 1. summarises the findings on the GHQ-28.

**Figure 1 here**

Community Psychiatric Nurse Stress Questionnaire-revised findings

The number of valid observations for this questionnaire was n=76. The mean CPNSQ-revised score for the sample was 52.79, standard deviation 27.85 (range 0-120). These scores compare with the standardisation sample provided by Fagin et al (1995) who found in their sample of 250 CPNs a mean score of 78.0, standard deviation 29.6 (range 13-161).

Analysis by item ranking

The results from all 48-items on all completed CPNSQ (revised) questionnaires were analysed by ranking the overall average value of the likert (0-4) scores for each item. This enabled the ten most stressful and ten least stressful items as rated by FCMHNs in this sample to be listed. This
method of ranking was employed by Brown and Leary (1995) and was chosen to enable some comparison of stressors reported by FCMHNs with those of their generic counterparts. The top stressor was ‘not having facilities in the community that I can refer my clients to’ while ‘having too many interruptions when I am trying to work in the office’ was rated the second most stressful item. Patient related items featured prominently on the list of top stressors. ‘Having to work with clients that are unco-operative’, ‘having to deal with suicidal clients on my own’ rated as sources of high stress. Ranking of the ten most stressful items is presented in Table 3.

**Table 3 here**

The least stressful item rated by FCMHNs was ‘having to receive supervision that I do not find helpful’. Supervision and support from colleagues and management all featured in the least stressful items. The least ten least stressful item ranking is presented in Table 4.

**Table 4 here**

**Discussion**

Discussion of MBI findings

While FCMHNs as a group displayed moderate levels of emotional exhaustion on the subscale of the MBI a significant proportion, almost half the sample had scores in the high burnout category. This means that these nurses are showing signs of being emotionally over-extended by their work as measured on this scale. The question might be posed at this point as to whether these scores are indicative of work stress or is the MBI measuring life events outside of work which transfer stress to the work setting. While this is difficult to rule out or indeed control for what is
clear is that the MBI asks work specific questions which guides subjects to respond in relation to their experiences of work.

Nurses with high scores may have problems in giving of themselves to patients. The concern is that outcomes for patients may be affected as a result of staff being unable to form therapeutic relationships with them. Frank and Gunderson (1990) have demonstrated that patients who formed good therapeutic relationships with their clinicians had improved outcomes. It would seem probable that this emotional exhaustion may be transferred to relationships outside of work (Pearlin and Turner 1987). The mean scores for emotional exhaustion in the current sample (19.34) are lower than those found by Prosser et al (1996) among a multidisciplinary team sample (22.9), Fagin et al (1995) in generic CPNs (21.5) and ward based mental health nurses (20.4) and Schafer (1992) in generic CPNs (23.56). The scores are higher than Carson et al’s (1991) sample of generic CPNs (19.07) and Melchior et al’s (1996) sample of ward based mental health nurses.

Mean scores on the depersonalisation and personal accomplishment subscales also showed moderate levels of burnout for the group as a whole. Nurses in the current study had higher group mean depersonalisation scores than generic CPNs in Carson et al’s (1991) study (4.15), Schafer’s (1992) study (5.31) and Fagin et al (1995) study (5.4). The group mean score was however lower than those found by Sullivan (1993), Melchior et al (1996) and Prosser et al (1996). The findings on the depersonalisation subscale suggest that nurses within this study continue to hold positive attitudes towards their patients. This is a reassuring finding. Forensic patients present with complex symptomatology and behaviours. They often have an enduring and serious mental illness such as schizophrenia or long standing severe personality problems (Shepherd 1993). These patients require skilled input from professionals involved with their care.
That FCMHNs continue to hold positive attitudes towards their patients despite the complexity of their needs suggests optimism for the future outcomes of these patients. The findings on the personal accomplishment subscale suggest that FCMHNs continue to find their work rewarding. The scores on this subscale are at the low end of the range for moderate burnout and are similar to findings in the other studies. This would appear to bode well for forensic services. It would seem that if FCMHNs feel they are doing well in work and find it rewarding they might be less likely to leave and seek employment elsewhere. This finding may suggest all is well within the speciality. There are however grounds for suggesting otherwise. A substantial proportion of nurses (26.5%) within this study had high scores on the depersonalisation subscale and low scores on the personal accomplishment subscale. This suggests stress-induced negative attitudes towards the client group and low job satisfaction. This means that there are a subset of FCMHNs who are already demonstrating signs of high burnout as a result of their jobs. This finding is concerning and may have worrying implications for patient outcomes. It could be argued that negative attitudes towards the client group may be indicative of the nurse themselves being unsuitable for this area of work. The MBI as a measure has been criticised by Dolan (1987) for being over-sensitive. This may suggest that its measure of depersonalisation which indicates negative client attitudes, may capture more global negative work attitudes. Maslach and Jackson (1981) suggest however that these negative attitudes are linked to the experience of emotional exhaustion. They report that there is a moderate correlation between the two subscales which is “in accord with theoretical expectations that these are separate, but related, aspects of burnout” (Maslach and Jackson 1981 p.101). This suggests that it is work-induced stress that is responsible for negative attitudes exhibited by staff. Further validity data for the MBI is described in detail by Maslach and Jackson (1981). What is apparent however is that high levels
of chronic stress are likely to affect an individual in both work and home life (Maslach and Jackson 1979) and while its measurement is problematic the MBI appears to offer a validated and reliable measure of the phenomenon of burnout.

Discussion of GHQ findings

A large proportion of FCMHNs (41.6%) scored ‘0’ on this scale. It is unlikely that this group of FCMHNs are leading a stress-free existence. This finding therefore may reflect problems in using this scale on non-clinical samples which have been suggested by Goldberg and Williams (1988) or that the measure is not sophisticated enough to detect occupational stress. The mean scores on the GHQ-28 for the group were below the threshold for psychiatric caseness as measured by this instrument. This finding however masked the fact that almost one-third (31.2%) of the sample were above this threshold. That is many nurses in this sample were experiencing symptoms of psychological distress more akin to that expected to be found in the patients they treat. This is a concerning finding. Moore and Burrows (1996) note that there is now a considerable body of evidence to support the concept of stress having a negative effect on an individuals mental health. There is further evidence that high levels of stress can have detrimental effects on an individuals physical well-being (Tsigos and Chrousos 1996). The implications for the workforce are clear. If these nurses continue to experience high levels of stress this may eventually manifest itself as disease. In terms of the health service there is not only a problem in these individuals not being able to carry out work tasks because of their ill-health but a further cost is involved in treating them for what may have been a preventable condition. One positive note, which should be sounded for forensic mental health services, is that when compared with their generic counterparts a lower percentage of nurses in this sample are
above the threshold for psychiatric caseness. In Fagin et al’s (1995) study 41% of CPNs crossed this threshold. FCMHNs may not as a group therefore demonstrate the levels of psychological distress that their generic counterparts have demonstrated but there still remains grounds for concern.

Discussion of CPNSQ findings

FCMHNs in this study scored lower as a group on the CPNSQ-r than their generic counterparts (Fagin et al’s study 1995). This finding is consistent with findings on the other psychometric measures used in this study. That is when compared with Fagin et al’s (1995) sample the current sample has consistently lower scores on each measure. This suggests that FCMHNs are experiencing less occupational stress than generic CPNs. The reason for this difference is not clear and the data require further analysis to determine differences between samples. There are striking similarities between findings of this study and that found in generic CPNs (Fagin et al 1995) on items ranked as most and least stressful on the CPNSQ-r item analysis. The item rated as most stressful in the current study was ‘Not having facilities in the community that I can refer my clients on to’ and is similar finding to Fagin et al (1995). This is perhaps not surprising and reflects problems community nurses have in trying to prevent their caseloads becoming stagnant. It may also be evidence of a lack of resources in the community for people with mental health problems. While these results suggest that this is a universal problem nurses working with forensic patients in the community may be faced with particular difficulties. This is specifically that some organisations may be reluctant to provide services for patients with a known propensity for violence. Attempting to access community resources for their patients can be a source of enduring frustration for community mental health nurses. Surprisingly the item
‘Having to work with clients with a known history of violence’ did not figure in the most stressful items for FCMHNs but did for generic CPNs (Fagin et al 1995). This may be related to Marshall’s (1980) assertion that nurses are socialised not to admit to difficulties in relationships with patients but this would be expected of both groups. It may however be more closely related to Gray-Toft and Anderson’s (1981) suggestion that nurses who are better prepared for their task and have clear role identity experience less stress. FCMHNs therefore may experience less role ambiguity and feel better prepared for the task of working with patients with a history of violence. It is also important to note that forensic patients must pass through a number of ‘filters’ before returning to live in the community. That is they will often have spent many years of assessment and treatment in secure hospital accommodation and are seldom discharged without recourse to recall to hospital. These patients on the whole do not exhibit dangerous behaviour on return to the community (Gibbens and Robertson 1983). Problems encountered with the client group did however appear in the most stressful items. CPNs in Fagin et al’s (1995) study rated ‘Having to deal with suicidal clients on my own’ more stressful than FCMHNs in the current study. This is to be expected. Generic community mental health nurses have larger caseloads with a wider mix of risk behaviours. It could be argued that as a result they are likely to encounter more incidents of self-harming risk behaviours. The item ‘Having to visit unsafe areas’ was rated as stressful. This raises important health and safety issues for employers. Many community nurses are familiar with areas in their patches that are unsafe at certain times of the day. Nurses will often arrange visits to these areas at times when they feel safer. They may even arrange for a colleague to accompany them. This will work well in normal circumstances but if the necessity arises for an urgent visit or colleagues are unavailable then this becomes an added stress for community nurses. If the nurse is visiting outside normal working hours, at night for
instance, then this may make the situation unsafe. There is evidence that some services are concerned enough about this issue to arrange for nurses to visit in pairs (Slinger 1996). There may however be another explanation for this concern. Community nursing is by its nature a solitary profession. Many nurses will have trained and worked on busy inpatient settings and find the transfer to community work an isolating experience. Leary et al (1995) have identified isolation as stressor for CPNs. This sense of isolation may be felt most acutely when presented with a suicidal patient in the community or when visiting an unsafe area. In other words these concerns may be an articulation of this isolation.

It is interesting to note that Dawkins et al (1985 p.15) found that organisational stressors were perceived as being most stressful for nurses rather than negative patient characteristics. Within the current sample organisational issues accounted for a number of the most stressful items. The second most stressful item on the CPNSQ-r was ‘Having too many interruptions when I am trying to work in the office’. Nurses appear to value the presence of their colleagues in terms of the support they derive from such proximity. This proximity can however bring with it practical problems in day to day working. This could be a reflection of poor office design and crowding. Practical experience would suggest that many planners of office space for nurses pay little attention to providing a comfortable working environment. Many nurses will have heard the oft quoted maxim of planners and management alike that their office space matters little as they are community nurses and are therefore unlikely to spend much time in the office and if so seldom at the same time. The findings of the current study suggest that there remain problems in this area.
The current study in terms of least stressful items may provide grounds for optimism. The least stressful item on the CPNSQ-r was ‘Having to receive supervision that I do not find helpful’. This suggests that nurses within this study found their supervision useful. The list of least stressful items on the CPNSQ-r consists of many items that are related to support in work and management style suggesting that FCMHNs as a group find their managers and colleagues supportive and dependable. This may be one reason FCMHNs have lower CPNSQ-r scores than their generic colleagues. Firth et al (1986) found that support from seniors was associated with burnout in the expected direction. That is, poor support was correlated with higher stress scores. It may be worthy of note however that the management communication item does not appear in the ten least stressful items in the current study. Lack of communication may suggest lack of support although this suggestion is contradicted by the current findings.

**Conclusion**

A number of conclusions are suggested from the findings of this study. Although as a group FCMHNs are not experiencing high levels of burnout when compared to generic CPNs a substantial minority are showing signs of high burnout. This is worrying in a field of community mental health which attracts significant public attention and concern. If FCMHNs are so stressed by their work that they are unable to engage with their clients on an emotional level then this may effect therapeutic outcomes.

It appears from the findings of this study that a range of factors such as organisational pressures and factors related to working with patients are important in determining stress levels. In addition, factors inherent to the individual play an important role. Domestic and social pressures also contribute to the persons experience of stress. Despite this complexity of factors the current study has illustrated some of the factors which FCMHNs find stressful in their work. Addressing
these factors may help to reduce levels of experienced stress and burnout. This does not mean that this responsibility lies solely with managers. They may not have the expertise in this developing field and may require training. Nurses themselves have been reluctant to attend stress management groups when they are offered (Kunkler and Whittick 1991). A collaborative effort in addressing occupational stress and burnout when it is identified may prove more fruitful than adopting adversarial roles. It would seem that an alliance between management and staff could provide one option for securing the provision of supportive mechanisms. Such an alliance may best articulate the need for support and could provide information to purchasers on the most useful composition of such support.

Reducing isolation of FCMHNs is also important. FCMHNs value the interaction and support that shared office space provides them but also find constant interruptions stressful. Consideration should be given to innovative solutions in providing office space that allows some privacy and encourages supportive relationships. The solution could be relatively straightforward. Involvement in decision making improves sense of ownership and may contribute towards positive work attitudes. It would seem that paying real attention to the needs of community nurses when planning and designing office space would go along way towards resolving these issues.

Further research in the field of occupational stress is indicated. The use of more sophisticated methods of investigation may yield data that will lead to improved understanding of causal direction. It would also be useful to research the effects on patients of being treated by stressed staff for example correlating stress and burnout among staff with treatment outcomes for patients. If the ethical difficulties could be overcome then research in this area may provide the most powerful evidence yet of the need to seriously address occupational stress and burnout.
Research specific to forensic psychiatry might include effects of high stress levels on attitudes of staff towards their patients. The influence of such attitudes on ongoing risk assessment of patients in the community or even decisions to discharge patients into the community may usefully be explored.

Identifying the relationship between staff retention and levels of occupational stress and burnout may also prove enlightening. Research which detailed a cost-benefit analysis including cost to the health service of treating stress-induced illnesses of its staff may provide the sort of compelling evidence which government and purchasers can readily understand.

In terms of the current research further more detailed statistical analysis of the data is required. Repeating the research on an annual basis may provide the longitudinal data required to interpret the data more usefully. Associated with this is the need to extend the research to the inpatient colleagues of FCMHNs. The expansion in the number of Medium Secure Units and our lack of knowledge of nurses experience within them suggests that this is an area for further exploration.

To extend the research presented here may be useful and interesting. It may however be more useful to nurses in clinical practice if research now focussed on identifying clearly the strategies which help reduce occupational stress and burnout. Putting these strategies in place will not eradicate occupational stress and burnout. It may however make the job of caring for challenging people more attractive in an era when the occupation of nursing itself appears to be losing its appeal.
<table>
<thead>
<tr>
<th>subscales</th>
<th>normative low</th>
<th>normative medium</th>
<th>normative high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>&lt;13</td>
<td>14-20</td>
<td>&gt;21</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>&lt;4</td>
<td>5-7</td>
<td>&gt;8</td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>&gt;34</td>
<td>33-29</td>
<td>&lt;28</td>
</tr>
</tbody>
</table>

Table 1. Normative scores for mental health workers (n=730) on the subscales of the MBI
Table 2. Summary of percentage of respondents in high, moderate and low burnout categories of subscales of MBI

<table>
<thead>
<tr>
<th></th>
<th>High scores</th>
<th>Moderate scores</th>
<th>Low scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>n=35 (44.3%)</td>
<td>n=15 (18.9%)</td>
<td>n=29 (36.7%)</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>n=21 (26.58%)</td>
<td>n=22 (27.5%)</td>
<td>n=36 (45.5%)</td>
</tr>
<tr>
<td>Personal accomplishment</td>
<td>n=21 (26.58%)</td>
<td>n=17 (21.5%)</td>
<td>n=41 (51.89%)</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Rank</th>
<th>Ten items rated most stressful</th>
<th>Mean stress score</th>
<th>Mean stress score range 0-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not having facilities in the community that I can refer my clients on to</td>
<td>1.844</td>
<td>1.844</td>
</tr>
<tr>
<td>2</td>
<td>Having too many interruptions when I am trying to work in the office</td>
<td>1.688</td>
<td>1.688</td>
</tr>
<tr>
<td>3</td>
<td>Giving talks or lectures to other groups of staff</td>
<td>1.526</td>
<td>1.526</td>
</tr>
<tr>
<td>4</td>
<td>Having to work with clients that are unco-operative</td>
<td>1.455</td>
<td>1.455</td>
</tr>
<tr>
<td>5</td>
<td>Feeling that there is not sufficient hospital back-up</td>
<td>1.442</td>
<td>1.442</td>
</tr>
<tr>
<td>6</td>
<td>Knowing that there are likely to be long waiting lists before my clients can get access to</td>
<td>1.442</td>
<td>1.442</td>
</tr>
<tr>
<td></td>
<td>services, e.g. to see a psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Managing my workload efficiently</td>
<td>1.434</td>
<td>1.434</td>
</tr>
<tr>
<td>8</td>
<td>Having to visit unsafe areas</td>
<td>1.429</td>
<td>1.429</td>
</tr>
<tr>
<td>9</td>
<td>Not getting the proper amount of co-operation from other health care workers</td>
<td>1.408</td>
<td>1.408</td>
</tr>
<tr>
<td>10</td>
<td>Having to deal with suicidal clients on my own</td>
<td>1.408</td>
<td>1.408</td>
</tr>
</tbody>
</table>

Table 3. CPNSQ-r item rankings – showing the ten items rated by FCMHNs as most stressful
<table>
<thead>
<tr>
<th>Rank</th>
<th>Ten items rated least stressful</th>
<th>Mean stress score range 0-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Having to receive supervision that I do not find helpful</td>
<td>0.403</td>
</tr>
<tr>
<td>2</td>
<td>Feeling that there is a communication problem with my CPN colleagues</td>
<td>0.449</td>
</tr>
<tr>
<td>3</td>
<td>Not having enough internal supervision within the department</td>
<td>0.519</td>
</tr>
<tr>
<td>4</td>
<td>Not feeling that I can rely on the support of my CPN colleagues</td>
<td>0.545</td>
</tr>
<tr>
<td>5</td>
<td>Feeling that the management style within our department is inflexible</td>
<td>0.662</td>
</tr>
<tr>
<td>6</td>
<td>Not feeling that I have sufficient support from my line manager</td>
<td>0.740</td>
</tr>
<tr>
<td>7</td>
<td>Having to put up with interruptions when seeing clients at home</td>
<td>0.803</td>
</tr>
<tr>
<td>8</td>
<td>Having to carry drugs around.</td>
<td>0.803</td>
</tr>
<tr>
<td>9</td>
<td>Having difficulty in finding interview rooms to see clients in</td>
<td>0.805</td>
</tr>
<tr>
<td>10</td>
<td>Having to obtain a suitable caseload/experience for students</td>
<td>0.829</td>
</tr>
</tbody>
</table>

Table 4. CPNSQ-r item rankings – showing the ten items rated by FCMHNs as least stressful
Figure 1. Graph showing percentage of FCMHNs in GHQ ranges.
References


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