



One of the mental health nurses interviewed in this article, recovering from her injuries – “it took a year out of my life”.

Assaults leave nurses fearful

Reported assaults on mental health nurses are rising. Behind the statistics are the human faces of nurses coping with the fallout of violence.

By Bernie Burns

Assaults on New Zealand mental health nurses at work is a concerning and increasing problem. Statistics obtained under the Official Information Act (OIA) show violence in mental health services is rising. The total number of reported assaults by patients on mental health staff for 2010-2012 was 4821, more than doubling between 2010 and 2012. The total number of reported assaults by patients on fellow patients and visitors for 2010-2012 was 1950, increasing by more than 50 per cent between 2010 and 2012.¹

Waikato, Capital and Coast, Hutt Valley, Hawkes Bay, Tairāwhiti, Waitemata, Nelson Marlborough and Southern District Health Boards (DHBs) all show a steady increase in assaults on staff between 2010 and 2012. Canterbury DHB identified the total number of reported assaults on staff, other patients and visitors had risen from 806 in 2010 to 1411 in 2012.¹ Because the Ministry of Health does not keep national data on reported incidents of workplace violence in mental health, such data has to be gathered separately from each of the 20 DHBs.

Research shows mental health nurses are the most frequent victims of assault among health

professionals,² yet violence against nurses in New Zealand is formally under-reported by nurses themselves. Nurses put forward a number of reasons for this – because some of them have become desensitised to violence, because they don't have time to do the additional paperwork and because there is a lack of active feedback to reporting. A belief that “nothing will change” is another reason for not reporting; and casual nurses can fear they won't get more work if they report violence.

Also, in my long career as a mental health nurse, I have experienced managerial cultures that discourage reporting (either explicitly or implicitly), or which endorse the attitude that being assaulted is part of a nurse's job. A culture of blaming the nurse for the actual assault,³ can be another barrier to reporting.

What's more, formally reporting an assault doesn't always guarantee the information reaches its designated destination in its original form. In 2011, *The Herald on Sunday* newspaper uncovered a flawed reporting system at Auckland's Te Whetu Tawera mental health unit, where senior managers were unaware of the extent and seriousness of assaults at the unit. At least 50 assaults were filed as only seven incidents, and some “serious” assaults were downgraded to “minor” by managers. Minor classification was used

to describe assaults including strangulation, punching, kicking and biting. A “minimal” severity rating was given to an incident when a nurse was knocked to the floor by the force of a kick to the stomach.⁴

The International Labour Organization defines workplace violence as any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed or injured.⁵ Different types of assaults include physical, sexual, psychological and verbal.

The level of violence in mental health can be explained firstly by the nature of some mental illnesses and secondly by accentuating factors. Illnesses which feature psychotic symptoms, such as persecutory/paranoid beliefs and instructive auditory hallucinations, can be a terrifying world for the sufferer and incline them towards violence. Organic disorders, personality disorders of the borderline, narcissistic and anti-social types, and the communication difficulties and low frustration tolerance associated with intellectual disability can be other predisposing factors.

Accentuating factors include access to drugs and alcohol, badly designed units, overcrowding, high patient-to-nurse ratios and inadequate staff gender and skill mix.

In my research for this article, many mental health nurses shared their experience of violence with me. What does the face of violence against these nurses look like in New Zealand? It is the male nurse, knocked to the floor, punched and kneed in the face with sufficient force to break his nose and cheekbone. The result was “six weeks off work, two surgical operations to fix my nose and permanent damage to my sinuses and sense of smell”. It is the female nurse, battered so severely around the head that she required a year of rehabilitation before being able to return to work – “it took a year out of my life”. It is the team of nurses who were frequently subjected to

assaults with faeces; and those who likened themselves to “human canon fodder” because of the number of physical assaults perpetrated by one patient.

It is the female nurse who went to the aid of her colleague who was being sexually assaulted, and ended up being assaulted herself. It is the nurse who got taken in a headlock by a male patient, who then threatened to kill her by breaking her neck, in a potential hostage-taking situation. Her nursing colleagues had to make the instantaneous decision “to either restrain and risk her neck getting broken or not intervene and let her be taken hostage”.

It is the many nurses who fear coming to work – “the feeling of dread starts as soon as I wake up in the morning” – and who, despite their fear, are required to nurse those whom they fear. It is the many nurses who are verbally assaulted on a daily basis and those who are threatened with menace: “He blocked my exit as he continued to verbally abuse me and said if I pressed my alarm, he would bash me before help came.” It is the nurse whose family is threatened; the nurses who do not register their cars to their home addresses and who remove their names from the electoral roll to keep their home address private; and those nurses who have left mental health permanently because of concerns for their own safety.

It is when unaddressed intimidating behaviours by an individual or group of patients end up running the ward. It is reflected by the nurse who said: “In some work areas, it is easier to count the number of nurses who have not been assaulted as to count the number who have.”

Nobody could hear her

In July last year, while working in the high dependency unit (HDU) of an acute admission ward at Christchurch’s Hillmorton Hospital, Annelie Gannaway was grabbed by her hair and repeatedly kicked in the face, head, legs and stomach. The reconfigured lay-out of the ward, which had put the HDU at a worrying distance from the main nursing office with two sets of doors in between, meant nobody could hear her cries for help. No surveillance camera or intercoms were available for monitoring. She was the only nurse present.

As the kicks continued, she used her arms to cover her face, so was unable to get at her wrist alarm. Eventually she managed to manoeuvre herself behind a couch, which limited the kicking, but not the severe yanking of her scalp. Now able to activate her wrist alarm,

she found it did not work. Help eventually arrived by chance when a nurse from the main unit dropped by. She had to take four weeks off work, suffering extensive bruising, intense headaches and back spasm “to the extent of not being able to sit, stand or lie in any position for more than a very brief time”.

Gannaway has been exposed to many high-risk situations during 16 years of nursing, four of them spent in the intensive care unit at Taharoto psychiatric unit at Auckland’s North Shore Hospital. “I have dealt with multiple previous volatile work situations, have been punched/assaulted before and it didn’t affect me like this. I had no time to prepare for the onslaught. Another patient saw the attack but was too traumatised to help. I felt totally isolated and vulnerable. It has impacted greatly on me, and has had a profound effect on my family, especially my 16-year-old daughter. I have always enjoyed coming to work, but not any more.”

She has now taken a year away from nursing, returning to her native Sweden where she hopes to get a job in a chocolate factory. She is greatly concerned about the frequency and nature of workplace violence faced by New Zealand mental health nurses and believes it is significantly under-reported.

She credits being physically fit for having survived the assault, and believes break-away techniques saved her life.

Research shows that among all nurses in their first year of practice in New Zealand, mental health nurses are faced with the highest likelihood of workplace violence.⁶ A young newly-graduated male nurse, in his first six weeks of DHB employment, was kicked, punched, scratched and threatened. He has, on a few occasions, needed to use breakaway skills to remove hands from around his throat and has witnessed colleagues being physically and verbally assaulted on multiple occasions.

He describes the verbal assaults as ongoing and “very personalised and derogatory. They are specifically targeted to hit your real sensitive spots. It can be a struggle to stay professional and objective with the constant verbal assaults, all day and every day. I feel mentally exhausted by the end of the day”. Nothing in his training prepared him for this.

He values what he learned from a hospital-based, five-day calming and restraint teaching programme. “The team that taught me

were fantastic . . . their guidance and skills really helped.” Despite his adverse experiences, he is committed to nursing and has now started a nurse-entry-to-practice programme.

Community nurses face particular challenges due to the isolated nature of their work. When responding to a community emergency call-out, an urban-based psychiatric emergency service (PES) nurse was confronted in the dark by a patient armed with what she thought was a rifle. “I was really scared, but managed to back away and kept walking backward. I was really conscious of being shot in the back. I crawled alongside a car and my colleague dialed 111. We then hid ourselves in the backyard of a house down the road and waited for the armed offenders squad. I was in a stunned state and don’t remember being hoisted over the hedge. I don’t remember uttering a word until safely in the police car . . .” She later learned the weapon was in fact a crossbow.

Assault by patient she knew well

A Nelson-based community mental health nurse has been left with permanent disfigurement following a prolonged assault during a visit to a patient she knew well. She did not have an alarm and although she yelled for help, the staff at the respite NGO did not hear her. She was held captive for about 30 minutes by the patient, who double-locked the door to prevent her escaping. When she did try, she was dragged across the floor by her hair and at other times by her feet. Repetitive punching to her face and head fractured her skull and caused internal bruising. She was stabbed in the face, neck and back. An arm was placed around her throat so she could barely breathe and she was told she was going to be killed. Scalding water was poured over her, causing 30 per cent burns to her face, neck, chest, arm and back. She tried to negotiate with her assailant, to no avail.

On the third attempt to undo the door locks, she escaped, and only then realised she had been stabbed. “I went into survival mode, was way beyond pain, I didn’t feel the water and I didn’t feel the stabs.” She needed a year of scar minimisation treatment, wore bandages for months and had multiple physio, dental and burns treatments. Long-term pain is a constant companion – “any breeze sets off nerve pain”.

She credits being physically fit for having survived the assault, and believes breakaway techniques saved her life. “When I couldn’t breathe because of his arm around my neck, I just knew to turn my head.” Emotional numbness, loss of confidence, insomnia, sadness

and guilt were some of the psychological effects. "People would burst into tears when they saw my face – I felt guilty causing them so much distress." To protect those she loved, she minimised her own distress, just wanting things to return to normal. She felt a great sense of loss about "who I was, what I looked like, what I could do. I went from being a respected senior nurse to someone who now others were being careful around, I was being treated very differently".

She had to part pay for her multiple treatments and use her sick leave to make up the 20 per cent pay deficit in ACC payments.

Disbelief, anger and horror were some of her family's reactions. "They were horrified this could happen at work and that I had no alarm or way of raising the alarm – both my sons are now fearful for my safety. My family's trauma was further compounded by the court outcome, which in their view was not reflective of justice."

Christchurch nurse Noel Walker, who has more than two decades of acute nursing experience, was physically assaulted four times in a six-month period and believes this had a big impact on his family. The first assault (a closed fist to the mouth, resulting in a split lip and extensive bruising) had little effect on his wife – "she was reassured by what I said and we both coped with humour".

The second assault (a forceful kick to the groin) had more impact. "She could see I was in pain, that I couldn't cross my legs without vomiting for over a week. She became more reserved, worried more and humour didn't help. I got by on bravado this time. When the third assault happened, she could see how it psychologically affected me, how it badly affected my confidence. She suggested I should work somewhere else.

"At this stage, my sons [aged 12 and 14] began to pick up on it . . . I was meant to be their security. I worried they would think: if I can't protect myself, how can I protect them?" After the fourth assault, his wife was adamant he needed to change jobs. "She was frightened every time I went to work and the boys picked up on that. I felt bad about the impact on the children, they saw me beaten up, saw the physical evidence, I could see the shock on their faces." His wife was greatly reassured when he moved to a different ward.

Christchurch-based staff nurse Graham Kerstens believes the impact of verbal assaults is underestimated and its formal reporting is barely the tip of the iceberg. He has 32 years of experience across the mental health specialties of acute, rehabilitation, alcohol/drugs and forensic nursing. He gained



Mental health nurses Noel Walker, who was assaulted four times in six months, Graham Kerstens, who discusses the reasons why nurses suffer more assaults, and Annelie Gannaway, who found her wrist alarm didn't work when she was attacked.

further perspective working as an out-of-hours hospital supervisor and clinical nurse manager on three different units. Personalised assaults that focus on the nurse's appearance, weight, gender, race, or sexuality can, in his opinion, be extremely disabling. "They may appear minor in isolation, but these assaults are often constant and cumulative in their effect. Intervention following verbal assaults rarely happens and they often remain unaddressed and unresolved."

Expected to move on

He says formal reporting, if completed, rarely reflects the damage done, and there often is an implicit expectation "to just move on" and accept the abuse. The psychological effects from threats to harm, maim or kill a particular nurse or their family, are also, in his opinion, rarely acknowledged – "the more specific the threat, the greater the worry. A verbal description of an action can be more anxiety-inducing than the action itself . . . there is a sense of helplessness not knowing if the threat will be fulfilled or not. It stays with you."

Kerstens says mental health nurses' front-line role delivering prescribed treatment (eg medications), setting limits and delivering unwanted news, eg about leave etc, are all key factors in why they are assaulted most often. Nurses sometimes have to keep patients in an environment (hospital) they don't want to be in and deliver unwanted interventions

for an illness they may not believe they have (lack of insight). Explaining the practical implications of being under compulsory treatment and dealing with the emotions that can accompany such news (frustration, disappointment, anger, an increasing sense of confinement, helplessness) are other key roles.

He also believes the no-smoking policy is a major contributor to nurses being assaulted – "it heightens irritability, induces anger and the potential for violence becomes intensified and directed at the limit-setter – the nurse".

Because nurses are the professional group most involved with patients in the acute phase of their illness, when their behaviour is most impulsive and their judgement most impaired, this also puts them at increased risk, he says. He believes male staff, in particular, are expected to be available to attend potentially violent situations in other wards, at short notice, with patients they have no knowledge of. This requirement creates a chronic level of anxiety which can be detrimental to professional decision-making.

It can be difficult for nurses to get their concerns heard about workplace violence. In May 2011, when nurse Lauren Meraw spoke up about violence at Te Whetu Tawera Unit, she was dismissed by its medical director as "a relatively inexperienced staff member".⁴ He said assaults "can happen on occasion" (there had been 213 over the previous year). Unhappy about safety at the unit and lack of support for nurses, she resigned after eight

References

- 1) Sensible Sentencing Trust. (2013) Figures obtained from district health boards via the Official Information Act.
- 2) Hatch-Maillette, M.A., Scalora, M.J., Bader, S.M. & Bornstein, B.H. (2007) A gender-based incidence study of workplace violence in psychiatric and forensic settings. *Violence and Victims*; 22: 4, pp449-462.
- 3) Lanza, M.L., Shattell, M.M. & MacCulloch, T. (2011) Assaults on nursing staff: blaming the victim, then and now. *Issues in Mental Health Nursing*; 32: 8, pp547-548.
- 4) Fisher, D. (2011) Flawed record of staff assaults. *New Zealand Herald*, Sept 4. www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10749310. Retrieved 30/08/13.
- 5) International Labour Organization. (2003) *Code of practice on workplace violence in service sectors and measures to combat this phenomenon*. www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/normativeinstrument/wcms_107705.pdf. Retrieved 30/08/13.
- 6) McKenna, B.J., Poole, S.J., Smith, N.A., Coverdale, J.H. & Gale, C.K. (2003) A survey of threats and violent behaviour by patients against registered nurses in the first year of practice. *International Journal of Mental Health Nursing*; 12: 1, pp56-63.
- 7) Lauaki, E. (2011) Unit 'unsafe' says worker. *East & Bays Courier*, June 29. www.stuff.co.nz/auckland/local-news/east-bays-courier/5207532/Unit-unsafe-says-worker. Retrieved 09/09/13.

months and took her concerns to the media.

Another nurse, Jeffery Lane, said the culture at the unit involved “*psychological abuse from management*”, adversarial responses when seclusion was used to manage violence, and inability of staff to make decisions for fear of losing their jobs.

Kerstens believed because of the labyrinthine nature of violence, changes need to come at ward, hospital and national level. He encourages nurses to establish a base-line position of expecting support/active intervention from leaders, and believes prevention and management of violence has to be shown to be a priority by nursing leaders and hospital managers. “They need to be accessible, pragmatic and effective in their responses.”

The fostering of a work culture where nurses’ concerns about risk are welcomed and responded to, is essential, he says. “Nurses are pivotal to the solution, they have the exposure and knowledge in relation to violence prevention – listen and learn from them.” Commitment to safe staffing of high-risk areas and a review of how the DHB statement of “zero tolerance for violence” can be implemented in a practical and proactive way are other necessary changes. A zero-tolerance policy is aspirational, but its “absoluteness” is not realistic or practical and is a poor fit with everyday reality, Kerstens said.

He favours a national conference on the issue, which would address nurses’ sense of isolation and allow information sharing. And he believes a culture of reality needs to prevail at all levels in relation to violence in the workplace, “not a culture of political correctness”. •

** This article has been reviewed by Auckland University school of nursing senior lecturer Anthony O’Brien, Whangarei mental health nurse Brent Doncliff and the Kai Tiaki Nursing New Zealand co-editors.*

Bernie Burns, RN, is a staff nurse at Hillmorton Hospital, Christchurch, and former editor of the NZNO mental health nurses’ section magazine, *Head 2 Head*.

Nurses ‘encouraged to report’

District health boards (DHBs) work “really hard” to provide a safe environment for staff, and mental health nurses are encouraged to report any incident that affects their own, their colleagues’ or their patients’ safety, according to directors of mental health nursing.

“We believe there is a positive culture of reporting,” said Counties Manukau DHB mental health clinical nurse director Jane Earl, speaking on behalf of the National Directors of Mental Health Nursing group.

She said assaults on staff occurred across all specialties in DHBs, not just mental health, and assaults on staff and patients were always taken seriously and followed up with support. “We are working in a clinically risky part of the health sector, with many influences on a person’s behaviour, whether that is due to mental illness, substance issues or social behavioural patterns.”

DHBs kept figures on reported assaults in mental health, but amalgamated trend figures were not available at the moment. Assault levels varied considerably across the country and were not increasing in all areas, she said. “Some DHBs are reporting a decrease, and some no increase in assaults,” Earl said.

“Canterbury DHB has data showing that as the numbers of seclusions and restraints have decreased, so have the assaults on staff.”

Nursing managers took a variety of measures to protect mental health staff and patients. These included regularly monitoring staff levels, skill mix, and cultural and gender balance.

Alongside reduction in use of seclusion and restraint, workforce development emphasised de-escalation skills and breakaway techniques. Managers promoted supervision and training for staff to maximise their skills and to work towards recovery-focused care. They also promoted the use of talking therapies, trauma-informed care and sensory modulation.

DHBs also used consumer feedback and consumer, family and cultural advisers to help ensure environments, processes and practices were as responsive and friendly as possible, to help minimise frustration and hostility among patients.

Earl said some DHBs had zero tolerance policies, which meant perpetrators were referred to the police; while some had violence reduction groups, including representatives of clinicians, managers, consumer consultants and unions.

The mental health nursing directors were not aware of assaults affecting mental health nurse recruitment and retention. When a nurse was assaulted, nurse managers would ensure they got

the right support, which could include psychological debriefing, occupational health and safety support, private counselling, paid doctor visits, supervision, coaching, mentoring, and a change in clinical area if necessary.

Earl said data did not support accounts that smoking bans increased violence. “Because some staff hold strong views that inpatients should be allowed to smoke, they are unable to consistently offer the support available with NRT [nicotine replacement therapy] and motivational interviewing.”

NZNO’s mental health nurses’ section chair, Tanya Ewart, said assaults on mental health nurses was a serious problem causing ongoing trauma. Nurses were more likely to be assaulted than other mental health staff, as generally they were the only discipline trained in techniques for dealing with aggressive patients.

She said there was an unacceptable expectation in mental health that male nurses should always be involved in restraint situations.

These days nurses were more likely to file charges of assault, if their clinical judgement was that the patient knew what they were doing at the time. In Canterbury, where she worked, patients going through the court system were usually put on a good behaviour bond which went on their record.

Ewart said Canterbury mental health services data showed a downward trend in assaults on nurses in acute inpatient care over the last three years, but figures remained high in intellectual disability services.

She also said the acute adult inpatient unit at Christchurch’s Hillmorton Hospital had a dispensation from the hospital’s smokefree policy, as data had clearly shown a link between increased assaults on nurses and banning patients from smoking in the grounds.

NZNO professional nursing adviser Suzanne Rolls said mental health nurses needed to report assaults and assaults needed to be investigated.

Nurses who were injured at work needed good rehabilitation back into their professional role and they needed to see they were getting good support from their managers. Employers needed to show flexibility to rehabilitating nurses, who might need flexible rosters, a moderated workload, counselling and other additional support.

NZNO supported nurses’ safety via its participation in DHB health and safety committees and by supporting individual nurses, investigating their cases and helping devise return-to-work programmes. •

Report by co-editor Kathy Stodart