Stigma: the reporting of workplace violence and mental health nursing

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In 2014 a story run in the Age and by the ABC asserted that 'mental health nursing' is the 'most dangerous profession' in Victoria, with one in three mental health nurses having been assaulted in the past year. Whilst violence against health professionals in the conduct of their work is a real problem that needs careful analysis and a considered response, this reporting likely contributed to stigma of those with mental illness (who are more likely to be victims rather than perpetrators of violence) and mental health nurses (who are but a small number of nurses who work with people identified as mentally ill).

As a front-line mental health professional working in a busy emergency department, I am well acquainted with aggressive customers. More often than not the aggressive service user is intoxicated or in a state of withdrawal from illicit drugs, and occasionally they have an antisocial personality structure born of a lifetime of poor attachment, abuse and being dealt a poor deck of genetic cards. Only occasionally is the aggressive individual classically mentally ill or is the aggression a consequence of illness. The sometimes coercive manner in which people are brought to hospital may contribute to aggression in otherwise placid individuals who, quite reasonably sometimes, respond with anger at being detained, forcibly treated and told what to do. I won't belabour the point that mental illness is unfairly conflated with violence (notwithstanding some individuals are at increased risk). This perpetration of stigma should be of central concern to mental health nurses, as should the unsophisticated mythology about mental illness that people are somehow generally out of control and insightless.

The professional mental health nurse, amongst other specialists, is imperfect but better than most at teasing out risks of violence and responding appropriately and in a timely manner to mitigate risks to protect others, whilst upholding the dignity and humanity of service users. More particularly, the way that mental health nurses intervene in crisis and work with people towards recovery can make a crucial difference to their trajectories. The mental health nurse has proven expertise in managing (for want of a better word) aggression in the context of providing holistic care. Whilst difficult to evaluate and draw firm conclusions, mental health nurse-led programmes such as 'Safewards' (Bowers et al, 2014) demonstrate that violence and coercive responses can all be reduced even in acute environments. A key problem, however, is that only a small number of nurses working in mental health service in Australia are indeed mental health nurses and their impact on workplace culture is arguably commensurate with their numbers. The assertion that 1 in 3 mental health nurses were assaulted in 2014 just does not stack up and further stigmatises mental health nurses who, through their training, supervision and experience, might claim some considerable expertise in addressing violence.

Who is a mental health nurse?

In the absence of specific registration or statutory endorsement for mental health nurses in Australia it poses a problem differentiating the 'mental health nurse' from the wider pool of registered nurse. According to Health Workforce Australia (2013) in 2011, 13,252 registered nurses identified that they worked in a mental health setting. That is roughly 6% of the working registered nurse work force. Nurses accounted for 64% of those professionals who work in the mental health field (a figure which is diminishing as a percentage of the overall workforce). The majority of these nurses work in either hospitals (56%) or in state community mental health services (29%).

A serious problem and challenge for the very survival of the specialty is that merely working as a nurse in a mental health service setting is frequently conflated with being a mental health nurse. Presently the only formal recognition that someone has post-registration training in mental health nursing and has sustained some degree of relevant professional development is the ACMHN's voluntary Credential for Practice Program.

In 2014, the number of Credentialed Mental Health Nurses stood at 1320. While this understates the number of eligible people, only 1 in 10 of those who work in mental health settings and 0.6% of the registered nursing workforce are entitled to be called Credentialed Mental Health Nurses.

No one should be in a teaching or leadership position in mental health nursing without holding appropriate qualifications, and presently the only reliable way of demonstrating this in Australia is through Credentialing. I'd go further: no one should even hold the drug keys in a hospital or be employed at all, in any capacity in community mental health settings without being Credentialed.

Presently, the media, our medical colleagues and the general public perceive that nurses who work in mental health are mental health nurses. We face a serious image problem as our medical colleagues' exposure to quality mental health nursing practice is limited. During their brief exposure to mental health settings as trainees and junior doctors, they are unlikely to encounter many actual mental health nurses, and rather will base their impressions on their encounters with the sometimes servile, or coercive individuals who have a limited repertoire of skills to deal with people who have complex mental health needs beyond administering drugs. Thus, we have an uphill public relations battle to convince others of the value and unique contribution of mental health nursing. Indeed, programs such as the Mental Health Nurse Incentive Program are based on a 'practice nurse model', in which the nurse is seen as enacting a medically formulated plan, rather than being treated as specialists or professionals (Lakeman, Cashin and Hurley, 2014).

The Mental Health Nurse Incentive Program might be small and poorly conceived in its design, but nevertheless it is the only program which is comprised entirely of a Credentialed workforce and is thus particularly worthy of our critical gaze. From research on the MHNIP (Lakeman, 2013) we can extrapolate that mental health nurses in Australia are by and large highly experienced, qualified, with often multiple postgraduate qualifications with considerable expertise in one or more forms of psychotherapy.

They are able to work flexibly and collaboratively to assist people with the most complex psychosocial needs and problems of living. Their pathway to becoming a mental health nurse is often long and torturous, and few identify their basic training as particularly useful to their roles (Lakeman, 2013).

Making mental health nurses

The move to comprehensive nursing preparation and the loss of specialist endorsement for psychiatric or mental health nursing is widely recognised (at least within the small mental health nursing fraternity) as being, to a large part, responsible for the de-skilling of the mental health workforce. In Australia, generic comprehensive nursing programs offer a dismal preparation for a career as a mental health professional with research (McCann et al, 2009) demonstrating a mean of 106 hours (range 15 to 359) of mental illness specific theory across comprehensive programs. Most people who work in mental health services are a product of this system of training and, despite being comprehensively trained, it is not uncommon for nurses working in mental health to claim they can't nurse people with complex physical health problems. The recent Mental Health Commission Review of Mental Health Programs (2015) even referred to comprehensive nurses as 'general' nurses and called for a thousand of these nurses to be trained as mental health nurses as a matter of urgency.

This of course begs the question: what does it mean to be a mental health nurse? What particular skills should they possess? A postgraduate qualification in mental health nursing is presently poorly defined and at the very least using the vernacular of the time a Credentialed Mental Health Nurse ought to be able to provide 'focused psychological strategies', but presently they are not recognised as possessing these basic skills despite sometimes decades of practice and multiple postgraduate qualifications.

The Australian Standards of Practice for Mental Health Nurses (ACMHN, 2010) has some quite explicit and unambiguous statements about what it means to provide mental health nursing:

A mental health nurse is a registered nurse who holds a recognised specialist qualification in mental health. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual (ACMHN, p.5)

As Barker and Buchanan-Barker (2011, p.342) note, the Standards give value and prima-facie significance to partnerships, personalised notions of recovery and respect for human rights, but they '…might fly in the face of contemporary forms of evidence-based practice', which remain 'patient focused' and 'paternalistic, where they are not actually coercive and dehumanising'.

A mental health nurse is not merely a nurse who works in a mental health setting, nor is it reasonable to claim that an undergraduate mental health nursing qualification obtained in another century or country is sufficient to lay claim to that title. If the specialty of mental health nursing is to survive, then mental health nurses need to play their role in addressing stigma associated with mental illness and critically consider the role of various professional discourses in shaping it. Mental health nurses are tainted by stigma, along with service users, when they are portrayed as hapless victims of violence or indeed when their specialist status is not recognised or conflated with nurses who simply work in mental health settings. Promoting a Credentialed workforce and practice that conforms to our professional Standards will go a considerable way to improving services generally and reducing stigma.

References

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Stock photo stigma

UK charity Time to Change recently launched an anti-stigma campaign to change the way in which mental health stories are illustrated in the media.

The campaign, called 'Get the Picture' and backed by Stephen Fry, aims to change the type of images used for stories about mental health. The commonly used solitary figure, with their head in their hands - known as the 'headclutcher' - is a familiar sight when the media are portraying mental illness.

These images have the potential to be harmful and aren't accurate examples of people in distress.

One consumer who was interviewed as part of the campaign's background says the 'headclutcher' shots "reduce the personhood of whoever is photographed, as their face is barely seen. The face is exactly where we should be looking if we want to check how someone we know is feeling".

The Director of Time to Change, Sue Baker, says, "One in four of us will have a mental health problem in any year, and our responses are remarkably varied. We don't all spend our time slumped in a corner with our heads in our hands".

The Get the Picture campaign conducted research which found that 80% of the 2,000 respondents felt the 'headclutcher' image didn't convey how it feels to have a mental health problem.

As part of the campaign, Time to Change has made available a series of photos that are free to use by the media. Time to Change feel that these photos more accurately portray mental illness and mental health.

The available photos include images of mental health consumers doing every day activities and anonymous pictures (sensitively shot) that show more face than usual.

The ultimate goal of Time to Change is to end mental health stigma.