

## Resilience and professional quality of life in staff working with people with intellectual disabilities and offending behavior in community based and institutional settings

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### Abstract

Staff in forensic services for people with intellectual disabilities (ID) are expected to deal with a wide range of emotional challenges when providing care. The potential impact of this demanding work has not been systematically explored previously. This article explores the professional quality of life (QoL) and the resilience (hardiness) of the staff in this setting. The Professional QoL questionnaire and the Dispositional Resilience Scale were completed by staff (n=85, 80% response rate) in the Norwegian forensic service for ID offenders. Responses from staff working in institutional settings were compared to those from staff in local community services. Staff in the local community services had higher resilience scores compared to the staff in the institutional setting, ( $t=2.19$ ;  $P<0.05$ ). However in the other QoL and resilience domains there were no differences between the staff in the two settings. The greater sense of resilient control among community staff may be a function of both the number of service users they work with and the institutional demands they face. Even though these participants worked with relatively high risk clients, they did not report significantly impaired quality of life compared to other occupations.

### Introduction

Recent national surveys have indicated that staff providing care for people with intellectual

disabilities faces a high risk of exposure to violence at work.<sup>1,2</sup> Violence and threats are common and 50% of all staff report being exposed to one or more episodes during the last year.<sup>2</sup> The complex and demanding management of violent service users often provokes adverse feelings and contributes to a negative working experience.<sup>3</sup> It often also causes feelings of fear and anxiety.<sup>4</sup>

People with intellectual disabilities (ID) who are also offenders are some of the most difficult health service users to treat and historically they have also received little attention from researchers or the wider society.<sup>5</sup> The research that has been conducted has concentrated on offenders with mild ID within secure placements. Offenders with a moderate or more severe level of ID seldom enter the criminal justice system (CJS), as they are diverted into mental health services, ID services, or forensic mental health services. As a result, there is a dearth of studies exploring the needs and living conditions of offenders with moderate ID compared with offenders with mild ID.

Offenders with ID have many characteristics in common with offenders in the general population.<sup>6,7</sup> They tend to be young and male and have experienced social disadvantage, unstable environments, and financial instability.<sup>8</sup> There is little research on how the characteristics of people with ID who are labeled *offenders* may differ from those with ID who do not *offend*.<sup>9</sup> Holland *et al.*<sup>7</sup> proposed that two groups of offenders with ID can be distinguished according to whether they are known to the ID services. Amongst the smaller group who are known to services the term *offence* may often be confused with *challenging behavior*.<sup>10</sup>

The Norwegian system has quite restrictive policies regarding diversion of offenders with ID from the criminal justice system. There has been some focus on intellectual impairment among offenders,<sup>11</sup> but the government's priorities are focused elsewhere on, for instance, building more prison accommodation, encouraging multidisciplinary cooperation in preventing recidivism, developing alternatives to imprisonment alongside better rehabilitation services and evidence-based research.<sup>12</sup>

Norway's new penal code from 2002, Mandatory care established stringent criteria for bringing people with ID into the forensic services.<sup>13</sup> These include the commission of a serious or life-threatening crime by a person defined as non-responsible due to ID with a level of intellectual functioning corresponding to moderate or severe ID (IQ<55). The risk of reoffending must also be regarded as significant before a sentence can be imposed. Offenders who do not fulfill these criteria are given standard prison sentences with no access to ID specific services.

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### Psychological vulnerabilities of staff working with intellectually disabled offenders

Work-related stress may occur when the perceived demands of the job exceed an individual's resources to cope and do the job.<sup>14</sup> The stressors typically reported by intellectual disability support staff include challenging behavior,<sup>15</sup> interpersonal issues with colleagues and organizational concerns (*e.g.* inadequate staffing).<sup>16,17</sup>

Professional quality of life as conceptualized by Stamm incorporates both positive and negative aspects.<sup>18</sup> The negative aspect includes both burnout symptoms and secondary traumatic stress. While the incidence of developing problems associated with the negative aspects of providing care seems to be low, they can be serious and can affect the individual, their close relationships, the care that they provide, and their organizations.<sup>18</sup>

Burnout is a psychological syndrome that can occur in response to chronic, uncontrollable work demands when providing a service to people in some way.<sup>19</sup> It is most common in workers who give of themselves emotionally and especially when they give out more than they get back.<sup>19,20</sup> The quality of services with fewer positive interactions and less staff con-

tact has been found to be correlated to staff burnout symptoms.<sup>21</sup>

Staff in services for adults with intellectual disabilities seem to be at no higher risk of burnout compared to staff in other caring services according to a systematic review.<sup>15</sup> However, those staff most vulnerable to developing burnout tend to be the workers most valued by the services and burnout often indicates poor organizational support.<sup>15</sup>

Resilience (hardiness) is a personality trait which may moderate the relationship between work demands and work related quality of life.<sup>22</sup> It has been described as a set of personality characteristics that function as resources to draw upon when encountering stressful demands.<sup>22</sup> The key elements are control, commitment and challenge. Research with social workers has suggested that older individuals may well have a more effective and mature repertoire of coping styles.<sup>23</sup>

In this study, we describe the self-reported experience of work related quality of life and resilience among caring staff in the national Norwegian ID offender services. Local community based services are compared with their counterparts who are institutionally based. While the institutional staff emphasize the assessment and initial treatment issues during the acute period, the local community staff have to cope with lasting and more pervasive needs alongside the challenges of social integration.

Given these differences, the purpose of this study therefore was to compare the staff in ID offender institutional services to the staff in similar local community services in terms of professional quality of life and resilience.

## Materials and Methods

### Setting and participants

The study was conducted in 2012 among staff in the Norwegian National Unit for Mandatory Care. The penal code was set in 2002, and at the time of data collection, 10 offenders with ID were serving a sentence. Nine of these had a local community placement and one was incarcerated at the institution for assessment and treatment planning. The institutional setting also serves as a custody unit for ID offenders/alleged offenders.

A total number of 106 staff members were given a set of questionnaires covering professional quality of life, and resilience. The response rate was high (80%) with 85 completed questionnaires returned; 69 were from the locally based services and 16 from the institutional setting. The participants (36 women, 49 men) had a modal age category of 40-45. There were 38 registered nurses (45% of the sample), 15 licensed practical nurses (18%), and 25 unqualified staff (29%). Seven (8%) were

professionals from other professions or students. The mean length of work experience within ID forensic services was 2.56 years (standard deviation=1.0). These demographic data was based on aggregated information from each setting rather than individual data in order to maintain confidentiality.

### Instruments

Two self-administered questionnaires were used. A short registration form to obtain some basic demographic and occupational data was also distributed with these questionnaires.

Assessments of professional quality of life were made using the Professional Quality of Life Scale (ProQOL).<sup>18</sup> ProQOL is a 30 item self-report measure designed to assess the following dimensions: compassion satisfaction, burn-out and compassion fatigue. The compassion satisfaction dimension (CS) measures the degree of pleasure derived from being able to do one's work well. High scores represent greater satisfaction related to this ability to be an effective caregiver. The burnout dimension (BO) in this scale is associated with feelings of hopelessness and difficulties in dealing with work demands. Higher scores indicate a higher severity of burnout. The compassion fatigue dimension (CF) relates to secondary exposure to extremely stressful work-related events (*e.g.* experiencing the trauma of someone one helped, even to the extent of avoiding activities to avoid reminders of the trauma). High scores on this dimension indicate significant exposure to frightening experiences at work. The alpha reliabilities for the scales of the ProQOL have been found to be high:  $\alpha=0.88$  (CS), 0.75 (BO) and 0.81 (CF). The construct validity is good with over 200 published papers.<sup>18</sup> A Norwegian translation of the ProQOL was used in the study.<sup>24</sup>

Resilience was measured using a Norwegian version of the Dispositional Resiliency Scale (DRS).<sup>25</sup> The DRS is recognized as the best available measure of hardiness,<sup>26</sup> and the Norwegian version is based on Bartone's short 15-item version (DRS-15).<sup>27</sup> The DRS-15 consists of 15 statements requiring respondents to indicate agreement on a 4-point scale (*not at all true to completely true*). To create hardiness scores, six negatively keyed statements are reversed, and all items are added. In addition to a total score, three subscale scores can be creat-

ed by adding the relevant five items for each of the facets: commitment, challenge, and control. The alpha reliability of the total resilience score of the Norwegian version have been found to be  $\alpha=0.79$ .<sup>25</sup>

### Procedure and ethics

All executives in the local units and the institution were informed about the study and gave consent for their service to be accessed. The questionnaires were then sent to the executives for onward distribution to their staff members. The executives collected the completed questionnaires and returned them to the research group. The Regional Committee for Medical and Health Research Ethics approved the study (reference 2011/1321).

## Results

The sample was divided into two comparative groups; staff in the local community services ( $n=69$ ) and staff in the institutional services ( $n=16$ ). The institutional group tended to be slightly younger with higher proportions of male and qualified staff (Table 1).

In both groups the respondents scored very similarly to the instrument norms for all three PROQOL subscales (Figures 1-3). The total score of the DSR is also presented in a boxplot, although no norms were found in the literature (Figure 4).

Independent t-tests were conducted to compare scores on the measures in the two groups (Table 2). No significant differences were found for any of the PROQOL subscales but overall resilience and perceived control were significantly higher in the community staff group.

The internal consistency of the PROQOL subscales and total resilience (DRS-15) was high (Cronbach's alpha: CS=0.83, BO=0.70 CF=0.74 for CF, DRS=0.74).

## Discussion and Conclusions

The staff participating in this study were compared according to the nature of their relationship with the ID offender. The institutional and the local community services are inter-

**Table 1. Age structure, qualification and gender in the compared groups.**

	Modal age group	Qualification as nurses	Male/female proportion
Institution staff ( $n=16$ )	35-39 years	57%	82/18
Community staff ( $n=69$ )	45-49 years	45%	54/46

linked but they are distinct in several respects as described in the introduction.

There were no significant differences between the local community staff and the institutional staff on any of the PROQOL subscales. This may be due to low statistical power, especially with regard to the small group of institutional staff. The scores were close to the normative data derived from extensive studies of 1187 people who worked in various helping professions.<sup>18</sup> Although not significant, the results suggested somewhat greater compassion satisfaction alongside lower burnout symptoms and fatigue among the institutional staff. This may relate to the differing mandates of the two groups. Local community staff have a more stable relationship with the offender and his or her natural environment. Their capacity to focus on a single person may enable a stronger relationship to develop. The more technical and procedural approach to treatment in the institutional setting may set up a more cognitive, less emotional relationship.

Different ways of working in the two settings may also explain the differences in resilience (DRS-15), some of which were statistically significant. The Control subscale indicated a significantly greater sense of control in the community group, and this may reflect greater independence in working practices among local community staff. Institutions are often more focused on routines, rules and hierarchical systems compared to local services where emphasis is more directed to the service users. The community staff consequently would be expected more often to trust his/her own evaluations. The normative data for the Norwegian DSR-15 was based on a sample of military cadets and indicated a mean of 30.03, (standard deviation=4.42).<sup>28</sup> Both groups in the present study scored within these norms suggesting unremarkable levels of resilience.

Looking specifically at the community staff, they are older, less educated and had higher proportions of women. The higher scores on

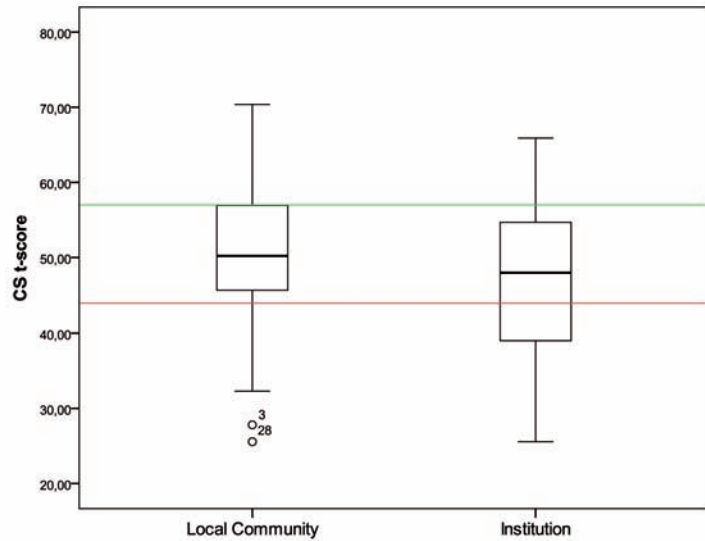


Figure 1. Box plot indicating median, quartiles and extreme values for scores on compassion satisfaction dimension (CS) at the two groups. Horizontal colored lines indicate bottom quartile and top quartile from normative data in the Professional Quality of Life Scale manual.

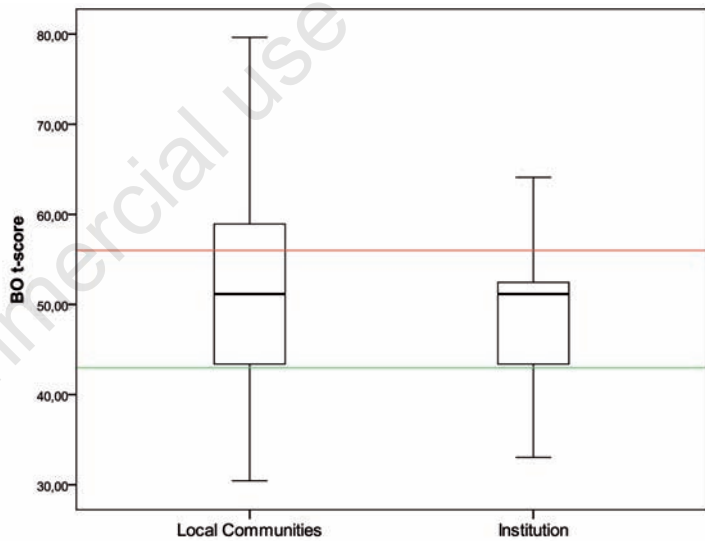


Figure 2. Box plot indicating median, quartiles and extreme values for scores on burnout dimension (BO) at the two groups. Horizontal colored lines indicate bottom quartile and top quartile from normative data in the Professional Quality of Life Scale manual.

Table 2. Mean scores on Professional Quality of Life Scale subscales and Dispositional Resiliency Scale (total and subscales in community and institutional staff).

	Institution staff (n=16)		Community staff (n=69)		Total (df)	P-value
	Mean	SD	Mean	SD		
ProQOL compassion satisfaction	47.1	11.3	50.7	9.6	1.28 (83)	0.20
ProQOL burnout symptoms	48.4	8.0	50.4	10.4	0.71 (83)	0.48
ProQOL compassion fatigue	48.1	7.9	50.4	10.4	0.84 (83)	0.40
DRS resilience total	31.6	4.9	33.9	4.3	1.9 (81)	0.06
DRS commitment	11.0	1.9	11.7	2.0	1.3 (81)	0.20
DRS control	10.9	2.5	12.2	2.0	2.19 (81)	0.03
DRS challenge	9.6	2.4	10.0	2.2	0.53 (81)	0.60

DRS, dispositional resiliency scale; ProQOL, professional quality of life scale; SD, standard deviation.

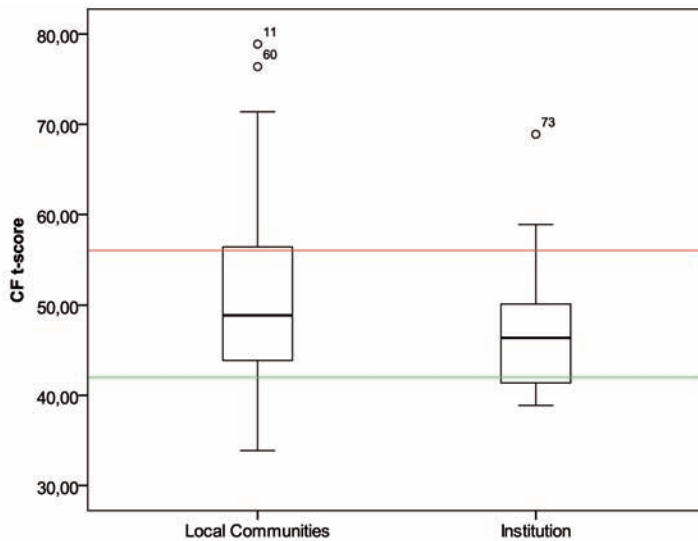


Figure 3. Box plot indicating median, quartiles and extreme values for scores on compassion fatigue dimension (CF) at the two groups. Horizontal colored lines indicate bottom quartile and top quartile from normative data in the Professional Quality of Life Scale manual.

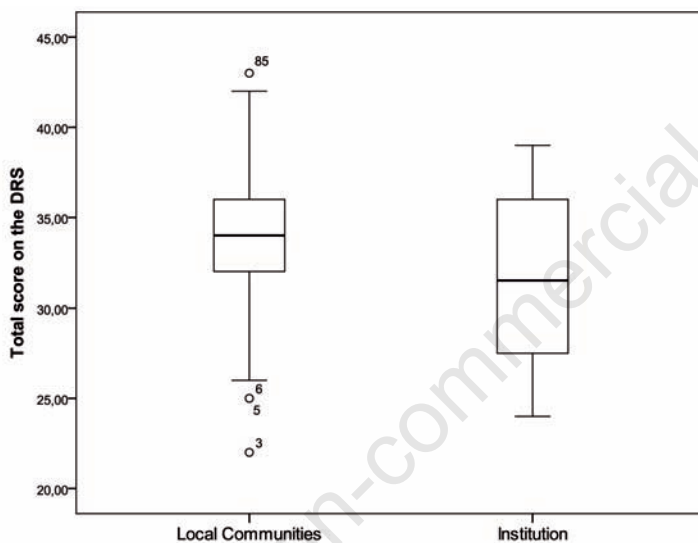


Figure 4. The Dispositional Resiliency Scale (DRS-15) underwent a similar box plot calculation to the Professional Quality of Life Scale subscales. The normative scores were not included in this figure.

resilient control in this group fit with previous findings about age.<sup>23</sup> However the possible impact of gender or education on resilience in health care services has not been studied previously.

The response rate was very high for this sort of survey indicating that the sample is quite representative of the population of staff working with ID offenders. On the other hand, the relatively small institutional sample weakened the analysis and there was also comparison across groups unbalanced in size. The homogeneity of one institutional staff group com-

pared to nine smaller and more differentiated community groups may also be a confounder.

This study was conducted in a sample of staff employed in the forensic services for people with ID. Further research should look at other groups working with challenging behavior in people with ID, or staff in forensic mental health services. A comparison between such larger and more defined groups could also be expedient.

In conclusion, a significant difference was found between staff in institutional and local settings in terms of overall resilience and the

control subscale. It may be worth interviewing community staff about their coping strategies which might underpin such greater resilience and then conveying these strategies to their colleagues in the institutional setting thus potentially improving job satisfaction and care effectiveness.

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