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EXPLORING THE PERCEIVED THREATS OF VIOLENCE FROM MALE STATE PATIENTS AGAINST SUPPORT STAFF IN A PSYCHIATRIC INPATIENT FACILITY IN GAUTENG SOUTH AFRICA

A report on a research study presented to

The Department of Social Work

School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand

In partial fulfilment of the requirements

for the degree Master of Arts in Social Work

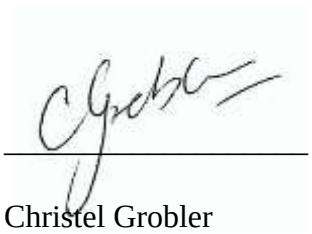
by

CHRISTEL GROBLER

April, 2020

DECLARATION

I, Christel Grobler declare that this research report is my own unaided work. Any part of this study that does not reflect my own ideas has been fully acknowledged in the form of citations. It is submitted in partial fulfilment of the requirements for the degree of Master of Arts in Social Work in Occupational Social Work at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.



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ABSTRACT

This qualitative, exploratory study sought to determine whether non-clinical staff, generally referred to as "support staff", perceived their working environment – a psychiatric inpatient facility in Gauteng – as threatening and, if so, whether this perception could be attributed to constant exposure to male state patients ("MSPs"). The MSPs have a history of violence, with charges of assault with an intent to do grievous bodily harm, rape and murder being the most prevalent. Support staff members (ward clerks, administrative staff, cleaners and groundsmen), encountered MSPs during the execution of their daily duties, but appeared to receive little or no training which could foster the skills needed to interact safely with potentially dangerous MSPs. Data was obtained through in-depth interviews and semi-structured interview guides were used. Twelve participants were recruited through purposive sampling and three key informants provided additional data to support triangulation. During thematic analysis, it emerged that patient unpredictability, having experienced direct threats, having experienced vicarious trauma, an apparent lack of security measures and lack of support from clinical staff and management contributed to the participants' perception of the threat of violence. Findings suggest that frequent exposure to MSPs elicited fear in some of the support staff. Participants expressed the desire for improved security measures, comprehensive training and general education about mental illness in order to empower themselves to better understand mental illness. Moreover, occupational social workers ("OSWs") have a vital role to play in bridging the gap between management and staff, and empowering vulnerable employees. An OSW framework to ensure Employee Wellness and Safety in Safety-Sensitive Environments was designed from the output of this study which might be useful in other safety-sensitive settings.

KEY WORDS: male state patients, occupational social work, psychiatric inpatient facility, threats of workplace violence, vicarious trauma, support staff

ACRONYMS:

CCTV	- closed circuit television
MSP	- male state patient
MSPs	- male state patients
OSW	- occupational social work/er
OSWs	- occupational social workers
PIE	- Person in environment
PTSD	- Post-traumatic stress disorder

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CHAPTER ONE
INTRODUCTION TO THE STUDY:

1.1 INTRODUCTION

The purpose of this exploratory study was to determine whether non-clinical, or "support" workers in a psychiatric in-patient facility felt threatened as a consequence of working among MSPs. Work plays an important role in promoting health and well-being (Kinder & Rick, 2012) which implies that employees should feel safe and equipped to deal with issues arising in their work environment. If these safety needs are not met, employees may experience biopsychosocial problems. The experience of support staff working in safety-sensitive environments such as the psychiatric inpatient facility in question has not been subjected to extensive research. This study hopes to create a better understanding of the experiences of support workers in such environments.

1.2 STATEMENT OF THE PROBLEM AND THE RATIONALE FOR THE STUDY

Anecdotal evidence suggested that support staff at the psychiatric inpatient facility do not possess the necessary skills to manage aggressive MSPs, and are not offered any opportunity to empower themselves with knowledge, as they receive no training. This suggests an inherent vulnerability, leaving support staff incapable of navigating the complicated interactions that arise in a psychiatric inpatient setting.

The psychiatric inpatient facility studied for the purposes of this research is one of the largest psychiatric hospitals in Gauteng, rendering services to approximately 557 mentally ill patients, of whom 204 are general patients (i.e. are likely to stabilise and be released back into the community). An additional 323 are "forensic" or "state" patients (Mafa, hospital report, July 2018). Forensic state patients are patients who have committed serious offences, but were found not to be criminally responsible or medically fit to stand trial in terms of the Criminal Procedure Act 51 of 1977, and thus admitted to the hospital as state patients under the Mental Health Care Act 17 of 2002. Only 10 of the 323 forensic state patients were females, and are housed in a different section of the hospital. Due to the low female state patient numbers (0,03%) they were excluded from the study. At the time of conducting the research, the MSP population of 313 constituted 56% of the overall hospital population. In some instances, stabilised MSPs are permitted to move around freely on the premises, and frequently encounter support staff. Considering that MSPs are generally perceived as more

dangerous than general psychiatric patients (Da'seh & Obaid, 2017), it is reasonable to assume that certain support staff might be apprehensive about encounters with MSPs.

Several studies focus on the experiences of health care workers working directly with psychiatric patients (Anderson & West, 2011; Günaydin & Kutlu, 2012; Inoue, Tsukano, Muraoka, Otr & Okamura, 2006; Nelson, 2014). Workplace violence against staff at psychiatric facilities is a serious occupational issue (d'Ettorre & Pellicani, 2017). Anderson and West (2011) reference an earlier study by Erdos and Hughes, which found that staff members who spent the most time engaging with patients, were at greatest risk of being assaulted. Substance abusers, acutely psychotic patients, and patients who do not adhere to treatment protocols also tend to exhibit a higher incidence of violent behaviour (Anderson & West, 2011). Despite findings that support staff (i.e. non-clinical personnel), such as secretaries and receptionists, had the highest incidence of endangerment (Privitera, Weisman, Cerulli, Tu & Groman, 2005), there appear to be few studies investigating the impact of exposure to psychiatric patients on support staff such as cleaners, ward clerks and administrative staff. This study aimed to bridge this gap and complement the limited body of knowledge on the subject.

Laypersons generally stereotype mentally ill patients as violent, which prompts hostility and distrust (Pilgrim, 2014). Support staff at the psychiatric inpatient facility are laypersons with regard to psychiatric patients and have expressed a sense of trepidation in the presence of psychiatric patients. Stabilised MSPs are encouraged to sell items from the tuckshop at the psychiatric inpatient facility as part of their occupational therapy and rehabilitation. These MSPs freely move between the offices where they encounter support staff members. As will be demonstrated in the data analysis chapter, support staff in these areas are fearful and are unsure how to respond, should the MSPs become violent or make threats. These employees do not possess the same knowledge and skills as professional healthcare workers who have been trained to interact with MSPs on a daily basis. Despite often having to work in close proximity to such patients, for example when cleaning wards, support staff are not empowered to deal with these patients or any threat of verbal, psychological or physical violence they might pose. Cleaners, for instance, are not permitted to have physical contact with patients, and are excluded from the in-house calming and restraining course, yet they work in close proximity to such patients. Prior to conducting this research study, a thorough needs assessment was conducted by the researcher in 2018 and a subsequent assessment was

conducted during early 2019 at the facility for the purposes of the practical component of the OSW course. The needs assessment included focus groups with nurses and support staff as well as interviews with senior managers of the facility. During this assessment, it emerged that requests for training were generally ignored, and support staff were denied the opportunity to empower themselves, which resulted in a sense of exposure and added vulnerability. The researcher observed that support staff were unsupported in terms of potential workplace violence, which indicated a potential OSW function the researcher was keen to explore.

It is reasonable to assume that the presence of a threat, whether real or fictitious, would contribute significantly to work-related stress, which brings the scope of this study into the realm of Occupational Social Work. An occupational social worker (OSW) should assume responsibility for educating staff members on mental illness, reducing stigma and removing unwarranted fear. The OSW could also empower support staff to deal with threats of violence and advocate for adequate training programmes aimed at equipping them with the necessary skills.

Findings from this study would contribute to the body of knowledge on the impact of workplace violence on support staff, and could add value to any subsequent strategy and policy formulations aimed at addressing this issue in this or other similar psychiatric inpatient facilities. Naturally an extensive literature review was conducted, as will be discussed next.

1.3 LITERATURE REVIEW

A literature review provides context and structure to the proposed study while benchmarking against earlier research in order to compare, supplement or augment existing knowledge about the area or subject under consideration (Creswell, 2009). This contributed to the identification of a suitable theoretical framework based on international studies, African studies and South African studies concerning workplace violence against healthcare workers. Research done at correctional facilities was also incorporated, as prison populations are prone to violence, and all of the MSPs at the research facility spent time in prison prior to being admitted to the psychiatric inpatient facility. Finally, research on the experience of support staff who were exposed to potentially violent psychiatric patients was also

incorporated. Important themes that emerged during the data analysis were also included in the literature reviewed.

It appears that research on the subject of violent psychiatric experiences tends to investigate the experiences of clinical staff such as doctors and nurses in psychiatric facilities, while support staff, who frequently interact with such patients, have been ignored. Studies that considered the experiences of support staff were rare, which suggests an inherent assumption that only clinical staff interact with potentially dangerous psychiatric patients. This does not reflect the full reality. Given the absence of robust studies on this issue, it was essential to formulate a clearly defined research question, and articulate the aim and objectives of the study.

1.4 RESEARCH QUESTION

In broad terms, the study set out to answer the following research question:

"What are the perceptions of support staff at a psychiatric inpatient facility about the perceived threat of violence from MSPs"?

To fully interrogate this research question, it was necessary to establish research aims and objectives that would guide the analysis and empirical process.

1.5 PRIMARY AIM AND SECONDARY OBJECTIVES

1.5.1 Primary Aim

To explore the perceptions of support staff about the perceived threat of violence by MSPs.

1.5.2 Secondary Objectives

- To gain insight regarding the experiences of support staff being exposed to MSPs in the workplace in order to assess if this has an impact on their perception.
- To describe the effect potential workplace violence has on the functioning/wellbeing of the support staff.
- To obtain suggestions from support staff about how to manage the perceived threat of workplace violence.

In order to achieve these goals, a robust and valid research design was necessary, as is discussed below.

1.6 RESEARCH STRATEGY AND DESIGN

Qualitative research designs are better suited to exploring a new, relatively unknown topic from an "inside" or "emic" perspective (Padgett, 2008). Qualitative researchers collect an extensive amount of verbal and visual data from a small number of participants, organise the data and rely on verbal descriptions to portray the situation they have studied (de Vos, Strydom, Fouché & Delport, 2011). A qualitative research design was regarded as preferable for the purpose of this study, given its inherent propensity to extract rich data.

The research strategy, also referred to as research "methodology" or "approaches to inquiry" (Creswell, 2009), determines the general research design. In this instance, an exploratory case study appeared most appropriate. As such case studies provide "a type of qualitative research in which in-depth data are gathered relative to a single individual, programme, or event, for the purpose of learning more about an unknown or poorly understood situation" (Leedy & Ormrod, 2015, p. 102) they appeared best suited to augment the qualitative research design selected. Exploratory studies of this nature seek to explore and ask questions about events, phenomena or circumstances about which little is known (Gray, 2009), and are appropriate, given the general lack of empirical research into the perceptions of threat experienced by support staff in psychiatric inpatient facilities.

When using a qualitative research design, prudent researchers remain cognisant of the fact that they are extracting the rich and detailed information from participants, which might cause some participants to discover things about themselves of which they were unaware (de Vos, et al., 2011). To mitigate this risk, provision was made for participants to be debriefed and/or referred for further intervention. However, none of the participants expressed a need for such interventions. A brief explanation of the population sample will be discussed next.

1.7 POPULATION, SAMPLE AND SAMPLING PROCEDURES

A population is the total number of possible elements or units that are included in a study. In certain circumstances, it may be impossible to evaluate an entire population, due to its size or lack of resources (Gray, 2009). In a qualitative study, the participants and documents must be purposefully selected, to best assist the researcher in understanding the research

question and problem (Creswell, 2009). Given the stated purpose and research question, the population selected for the study comprised of support staff members; administrative workers, cleaners, ward clerks and groundsmen who work at the psychiatric inpatient facility.

The researcher used non-probability sampling as there was no way to ensure that each segment of the population would be represented in the sample. As such, purposive sampling, a type of non-probability sampling, was used, as people or units were chosen for a particular purpose (Leedy & Ormrod, 2015). The researcher compiled a sample of 12 support staff participants; three participants from each category (i.e. three administrative workers, three cleaners, three ward clerks and three groundsmen).

Key informants are "knowledgeable individual who can supply valuable information" (Padgett, 2008, p. 89). To corroborate findings and triangulate themes, separate interviews were conducted with three key informants, who were selected based on their knowledge about a certain area and influence they have in decision making in that area (de Vos, et al., 2011).

Having selected an appropriate sample size and research population, it was necessary to ensure valid and reliable testing instrumentation. The following discussion briefly outlines what measures were taken to achieve this.

1.8 RESEARCH INSTRUMENTS

The researcher used two different sets of semi-structured interview guides to obtain information from study participants; one guide was used for the key informants, and the other for participating support staff. The participation information sheet (Appendix A) informed participants of the nature and purpose of the study, and was discussed and signed prior to the interview. The participant consent form (Appendix B) was provided to all participants, and signed prior to the interview. Participation was voluntary, and interviews were recorded and transcribed. The interview guide (Appendix C) consisted of seven open-ended questions which sought to fulfil the research aim and objectives.

Because information extracted from key informants served a different purpose (to corroborate participant submissions and triangulate themes), a customised interview guide

(Appendix D) was constructed for the three key informants. An incident register was obtained from the psychiatric inpatient facility (Appendix F)

Prior to conducting the interviews, meticulous pre-testing was conducted, as briefly discussed below.

1.9 PRE-TESTING OF THE RESEARCH TOOL

Pre-testing entails the execution of the whole data collection process on a small scale (de Vos, et al., 2011). During the pre-test the researcher interviewed two support staff members by making use of the proposed interview guide and asking their views before conducting the actual study. These staff members were a male and female, who were not part of the selected sample. Once the research tool was determined to be appropriate, it was necessary to assure accurate data collection, analysis and reliability. Measures taken to do so are described briefly below.

1.10 METHODS OF DATA COLLECTION

Interviewing is the predominant mode of data collection in qualitative research (de Vos, et al., 2011), which is why face-to-face interviews were conducted with the selected participants. Interviews were structured, and the researcher used the semi-structured interview guides (Appendix C and Appendix D). All interviews were recorded on a digital voice recorder, and transcribed for thorough analysis. Data from the incident register was also obtained in an effort to triangulate participant feedback.

1.11 METHOD OF DATA ANALYSIS

The researcher made use of thematic analysis, which enables the identification and description of implicit and explicit ideas and emerging themes within the data (Guest, MacQueen & Namey, 2012). The guide developed by Braun and Clarke (2006) was followed. In order to add additional depth to the themes and participant feedback, content analysis using frequency counting was employed to demonstrate the prevalence of certain responses and themes. Chapter 3 outlines the limited extent to which such content analysis was employed and explains the scope and breadth of the thematic analysis technique utilised.

1.12 TRUSTWORTHINESS

To ensure the trustworthiness Guba's four criterion for trustworthiness were employed: credibility, transferability, dependability and confirmability (Shenton, 2004).

1.13 LIMITATIONS OF THE RESEARCH STRATEGY, DESIGN AND METHODOLOGY

The researcher is employed at the psychiatric inpatient facility where the study was conducted. This was not viewed as a limitation, however, as the study pertains to concerns that do not fall within the core operational function of the researcher. Researcher objectivity was therefore not compromised. Conceivably, the fact that potential participants were hierarchical subordinates and of a different race than the researcher might have impacted on eventual responses, but the researcher felt that these limitations were mitigated through the establishment of rapport and by guaranteeing participant anonymity. It was anticipated that participants would be reluctant to consent to an audio recording of their interviews. However, none of the participants raised any objections. Confidentiality and pseudonyms were used to mitigate concerns. The researcher ensured that informed consent was obtained. Participants were informed about all the aspects of the research, which might influence their willingness to participate (Monette, Sullivan & DeJong, 2011).

1.14 DEFINITION OF KEY CONCEPTS:

The term **psychiatric inpatient facility** could be used interchangeably with "psychiatric hospital", which is defined in the Mental Health Care Act 17 of 2002 as "a health establishment that provides care, treatment and rehabilitation services only for users with mental illness". Within the context of such psychiatric inpatient facilities, services rendered typically include "treatment for serious mental disorders … short-term or outpatient therapy for low-risk patients [and] long term care or permanent care such as routine assistance, treatment or a specialized and controlled environment" (US legal, 2016). This research was conducted at an inpatient psychiatric facility accommodating general psychiatric patients, as well as state patients (as discussed below). Patients at the psychiatric inpatient facility are admitted for extended periods of time and receive continuous care at the hands of all employees.

State patients, often also referred to as forensic patients, are individuals who have been charged with offences involving serious violence and who have been declared unfit to stand

trial and/or who are not criminally responsible because of their mental illness or defect. State patients are referred to a forensic psychiatric inpatient facility (such as the psychiatric inpatient facility) by the courts for treatment, rehabilitation and indefinite detention. Given the potential risk such patients may pose to themselves, their community and society, rates of relapse and recidivism warrant close scrutiny (Marais & Subramaney, 2015). State patients are mentally ill, have impaired judgement and an increased propensity for violence, with many having committed serious offences such as rape, murder and robbery (Marais & Subramaney, 2015). Compared to non-violent, general psychiatric patients, state patients are assumed to have lower impulse control and frustration tolerance. The mere fact that they were declared as state patients by the highest legal authority is testimony to their dangerousness. When state patients become mentally stable, they might present with less of a risk of displaying aggressive behaviour. However, the fact that they have been diagnosed with mental illness means that they remain unpredictable, a theme that emerged during the research and will be discussed in greater detail in this report.

Support staff refers to "the people who work for an organization to keep it running and to support the people who are involved in the organization's main business" (Cambridge Dictionary, 2018). In a hospital setting the support staff are frequently referred to as non-clinical staff members. Santiago (2018) explains that while non-clinical workers do not generally contribute to patient care, the nature of their work tends to predispose them to direct and indirect patient interaction. For the purpose of this study, the term "support staff" includes administrative workers in the offices, cleaners, ward clerks working in the offices or wards, as well as groundsmen responsible for maintaining hospital infrastructure. The term applies to all such non-clinical employees coming into contact with MSPs during the course of their duties.

Workplace violence can be defined as "violent acts directed toward workers, which includes physical assault, the threat of assault, and verbal abuse, and it is widely recognised as having far-reaching consequences for workers' health and safety" (Magnavita & Heponiemi, 2011, p.203). Workplace violence includes a wide array of different behaviours ranging from threats, intimidation and mobbing to physical attacks, wounding and battery (Chappell & Di Martino, 2006). Workplace violence also includes acts such as sexual harassment, which may present in many different forms, for example: physical, verbal, gestures, written, coercive behaviour or a hostile work environment (Chappell & Di Martino, 2006). Incidents

of this nature occur frequently at the psychiatric inpatient facility. General reports of workplace violence at the psychiatric inpatient facility include: staff members being attacked and assaulted by patients, indirect sexual harassment (indecent exposure), and exposure to verbal aggression and verbal abuse from patients. It is possible that close proximity to psychiatric patients may contribute to a higher frequency of workplace violence. According to Chappell and Di Martino (2006) it should not be assumed that all psychiatric patients are prone to violent behaviour. These researchers acknowledge, however, that some mental diagnoses indicate a predisposition to violent behaviour.

The American Psychological Association defines "**threat**" as: "a condition that is appraised as a danger to one's self or well-being or to a group, or an indication of unpleasant consequences used as a means of coercion for failure to comply with a given request or demand" (APA Dictionary, 2018). Threats usually entail the risk of death, or the verbalising of an intention to harm an individual, or to damage their property (Chappell & Di Martino, 2006). According to a 2003 survey conducted by the International Labour Organisation, 20% of employees indicated that they had experienced workplace violence in the form of threats (Chappell & Di Martino, 2006). The MSPs at the psychiatric inpatient facility might not always necessarily act on their threats towards staff members, but the psychological effect that such threats might have on staff members cannot be denied or ignored, and forms an integral part of this research.

1.15 ORGANISATION OF THE RESEARCH REPORT:

Chapter one outlined the problem statement and rationale for the study and provided a brief overview of existing relevant literature. It defined the key concepts, outlined the research questions, aim and objectives of the study, the research methodology relied on and limitations of the study. Chapter two elaborates on the literature reviewed and the theoretical model underpinning the study, whilst the research methodology is discussed in chapter three. The data analysis is discussed in chapter four and the findings, recommendations and conclusions are discussed in chapter five.

It is important to consider relevant literature when conducting any research study, the literature review is discussed in the following chapter.

CHAPTER TWO
LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this literature review is to provide context and structure to the study while benchmarking against earlier research in order to compare, supplement or augment existing knowledge about the area or subject under consideration (Creswell, 2009). The theoretical framework underpinning the study is discussed, and key concepts are defined. International studies, African studies and South African studies about workplace violence against healthcare workers, are considered. The review also incorporates research done at correctional facilities, as all of the MSPs at the psychiatric inpatient facility are detained in prison prior to being admitted to the psychiatric inpatient facility. Research conducted on the experiences of support staff who are exposed to potentially violent psychiatric patients is of particular relevance, with an emphasis on the dangerousness and unpredictability of such patients, as well as the threats made by state patients. In addition, literature concerning secondary, or "vicarious" trauma to staff members was scrutinised, as well as the potential value in occupying MSPs with stimulating activities in order to mitigate violence or the threat of violence. Research regarding the potential gender differences between exposure to violence was evaluated, and the necessity of management support, appropriate training and orientation programmes as well as the impact of environmental factors on the prevalence of violence in forensic units is discussed. Lastly, the role of the OSW in psychiatric and forensic facilities will be discussed.

There is a dearth of research on the experiences of support staff, as existing research appears to concentrate on the experiences of clinical staff such as doctors and nurses in psychiatric facilities. This suggests an inherent assumption that only professional staff are exposed to potentially dangerous psychiatric patients, which does not reflect the full reality. To better articulate the justification and underlying paradigms that inform this study, a discussion of the biopsychosocial theoretical framework relied on is necessary.

2.2 THEORETICAL FRAMEWORK

The Biopsychosocial Model was developed in 1977 by George Engel, a specialist in internal medicine and psychiatry, who identified the value of integrating biological, psychological and social factors with the existing medical model to prevent and treat diseases (Havelka, Lučanin & Lučanin, 2009). Unlike the medical model, the Biopsychosocial Model also

incorporates factors such as ill-health, coping, and work environment and recognises the complex interactions between the person's "physical, psychological, social and environmental factors" (Kant & van Amelsvoort, 2017, p.149). This model acknowledges and incorporates the impact of biological factors with that of psychological and environmental factors and is suitable to use in this setting to explore the effects of exposure to threats on support staff. Psychological dynamics in the Biopsychosocial Model include cognitive, emotional, motivational, attitudinal and behavioural systems that have an impact on health (Lehman, David & Gruber, 2017). As demonstrated in Chapter four, support staff at the psychiatric inpatient facility were interviewed in this research study to understand their environmental stressors in the workplace. Factors that may contribute to workplace stress could include limited resources and inadequate training, as well as psychological stressors as a consequence of the perception of imminent threat and exposure to violent patients during the course of their daily duties. As a consequence, the comprehensive approach dictated by the biopsychosocial framework enabled the researcher to identify and interrogate the complex interplay between the psychological, social and environmental factors which confront the support staff working at the psychiatric inpatient facility. It also assisted in developing a comprehensive understanding of the impact of perceived or actual incidents of violence experienced by support staff e.g. the experience of hypervigilance and fear when working in close proximity to MSPs. The Biopsychosocial Model therefore provided an appropriate theoretical framework within which the research should be conducted, because it promotes the understanding of elements that need to be addressed by therapeutic interventions (Steinert & Whittington, 2013).

A biopsychosocial perspective allows researchers and practitioners to design and endorse preventative measures for health-related problems (Zittel, Lawrence & Wodarski, 2002). In chapter five, the Biopsychosocial Model provides an essential foundation for the development of the researcher's own unique integrated model called the OSW Framework to ensure Employee Wellness and Safety in Safety-Sensitive Environments. This model, which is an additional output of the study, acknowledges the multi-faceted impact that working in a safety-sensitive environment has on support staff at the psychiatric inpatient facility where the research was conducted.

The PIE (Person-In-Environment) approach emphasises the fit between staff and their work environment and complements the Biopsychosocial Model. The PIE model was developed

by Jane Addams and Mary Richmond, both social workers, during the 1920's when it was used to emphasise the importance in working with individuals and families but it also took note of the interaction between the person and the environment (Cornell, 2006). The focus shifted from the individual as having a problem to their environment. This approach views the person and their various different environments as a dynamic interactive system where the different factors simultaneously affect each other (Weiss-Gal, 2008). PIE assessment is especially helpful to social workers as it collects and orders relevant information to formulate a comprehensive image of the client's problem within a social context, allowing for appropriate interventions to relieve or solve them (Karls & Wandrei,1994). The PIE approach also focuses on the strengths of clients when formulating interventions. When applied to the psychiatric inpatient facility where the research was conducted, PIE enabled the researcher to determine the different factors (parts) affecting the staff members, while considering how such factors exert influence on each other. These insights generate a holistic view of the dynamic interplay between personal and environmental factors and their impact on support staff. As demonstrated by the content and thematic analysis in chapter four, support staff who believe that their personal safety and security needs are being ignored experience a negative impact on their emotional well-being, which ultimately impacts negatively on their overall functioning at work. These observations illustrate the ripple-effect caused by the interconnectivity advocated from the PIE paradigm and substantiate the need for a more comprehensive intervention as proposed in chapter five.

The social dimension is marginal and when applying the PIE approach the aim is to improve the inner resources of individuals, protect the vulnerable and those at risk, and to promote social justice, community development and policy formation when needed (Weis-Gal, 2008). The PIE approach can therefore be applied by OSWs to foster change in employees and the environments within which they function. In this study the PIE approach was also applied in terms of the formulation of the OSW framework by the researcher, as the focus of the OSW framework is the employee in their work environment and ensuring their safety and wellness. The aim of the OSW framework, developed with the PIE approach in mind, is to promote social justice and protect the rights of employees by ensuring the dynamic interplay between the different components do not have a negative impact on each other or on the employee.

As is evident from the following section, workplace violence within the health sector is a global phenomenon.

2.3 THE GLOBAL INCIDENCE OF WORKPLACE VIOLENCE IN THE HEALTH CARE SYSTEM

Spector, Zhou and Che (2013) conducted a quantitative review of literature from 136 articles regarding violence experienced by nurses in the workplace, noting that exposure rates varied by geographical regions, and that physical violence and sexual harassment as well as non-physical violence such as bullying were common. Irrespective of whether the violence was perpetrated at the hands of patients or their families, a third of nurses worldwide indicated exposure to physical violence and bullying, with physical violence being the most prominent in emergency departments, geriatric and psychiatric facilities (Spector, Zhou & Che, 2013). In America, threats and assaults against mental health staff are prevalent and appear to be increasing in frequency in psychiatric populations (Anderson & West, 2011). In fact, patients with a serious mental condition such as schizophrenia or bipolar disorder were two to three times more prone to violence than individuals without mental illness (Anderson & West, 2011). By 2014, American health care settings had become a common site for workplace violence, and the rate of assaults on health care workers was higher than that of any other occupation, totalling eight assaults per 10 000 workers, compared to two per 10 000 for the general workplace in the USA (Nelson, 2014).

Research done in Istanbul also found elevated degrees of violence against nurses working in psychiatric and emergency units (Günaydin & Kutlu, 2012). Nurses also appeared to be exposed to higher levels of workplace violence in psychiatric settings in Japan (Inoue et al., 2006), Taiwan (Chen, Hwu, Kung, Chiu & Wang, 2008) and Hong Kong (Kwok, Law, Ng, Cheung, Fung, Kwok, Tong, Yen & Leung, 2006). Studies done in Italy, also reported that violence was a prevalent phenomenon and that all health care workers were at risk of suffering aggressive assaults (Ferri, Silvestri, Artoni and Lorenzo, 2016; Magnavita & Heponiemi, 2011). A Ghanaian study concluded that workplace violence impacts negatively on nurses and that strategies should be put in place to curb this violence (Boafo & Hancock, 2017).

South African experiences appear to correlate with international research. A ground-breaking study on workplace violence in the health sector in South Africa was published in 2003 by Susan Steinman. Psychiatric wards in particular were indicated to be one of the hospital risk sections for physical attacks, bullying/mobbing incidents and sexual harassment

(Steinman, 2003). Her study found that health care workers developed varying degrees of tolerance for patients with violent tendencies, particularly when violent patient behaviour was attributed to the patient's mental illness. This individualised tolerance did not, however, negate the negative impact such violent behaviour had on health care workers.

Borcherds (2015) conducted a study at a hospital in Gauteng and concluded that workplace violence prevailed in the health sector due to, *inter alia*, the fact that it was a female dominated environment, and that staff were exposed to mentally ill patients, or patients who abused alcohol or illicit substances. It is estimated that an average of 11.5% of healthcare workers in South Africa have been victims of assaults by patients and that female workers were more at risk than male workers (Malangu, 2012). This is of particular relevance at the psychiatric inpatient facility, because the majority of the staff members who interact with MSPs are female, which may predispose them to increased risk of being threatened or assaulted by a patient.

Evidently workplace violence is a real and ongoing concern in health, and specifically psychiatric environments. While several studies have noted the increased risk of violence to staff in such environments, limited information is available about support staff who come into contact with patients in psychiatric facilities. A study by Cooper and Inett (2018) considered the experiences of different staff members, e.g. a psychologist, domestic staff, health care assistants and an occupational therapist in a low security forensic inpatient facility in the United Kingdom. It was established that the most prevalent form of harm experienced from patients in such a facility was verbal abuse, followed by physical assault, damage to property and sexual assault. It was also reported that the psychological health of staff members was adversely affected when they witnessed colleagues being abused (Cooper & Inett, 2018).

Published research suggests that working with psychiatric patients increases the risk of exposure to workplace violence. There seems to be a need for further information about the experiences of support staff, who either work with, or often interact with psychiatric patients during their admission to and stay at a psychiatric facility. This study has aimed to bridge that gap, which warrants a specific narrowing of scope to consider violence directed at health care workers in psychiatric settings specifically.

2.4 VIOLENCE TOWARDS HEALTH CARE WORKERS IN PSYCHIATRIC SETTINGS

An Australian study conducted in an acute psychiatric setting found that, within a period as short as one year, more than half of the nurses working in this setting experienced physical violence, while 80% experienced psychological harm, primarily perpetrated by patients, followed by the family members of patients (Niu, Kuo, Tsai, Kao, Traynor & Chou, 2019).

In another study conducted on American inpatient psychiatric staff members, it transpired that 98% of staff members experienced verbal aggression from patients, and 70% of staff members experienced physical assaults in the previous year. Interestingly, male staff were assaulted slightly more frequently than female staff members (Kelly, Fenwick, Brekke and Novaco, 2016). It is known that exposure to conflict and assault impacts on the wellbeing of individuals, and when this occurs in the workplace, measures must be introduced to manage this (Kelly et al., 2016).

Different types of psychiatric ward staff members might experience their psycho-social work environment differently, due to not having the same job descriptions and responsibilities. Some studies considered the experiences of professional nurses and nurse assistants in psychiatric wards and found no difference in their experiences of stress and burnout in the workplace, while small differences were noted in their experiences of stressors. High work demands and lack of resources were recorded as stressors for professional nurses, whereas client-related difficulties and work relationships were noted as stressors for the assistants (Tuvesson, Wann-Hansson & Eklund, 2011).

According to a Nigerian study, staff members who spent the most time with psychiatric patients had the highest incidence of being assaulted by patients. The victims were usually older staff members who had been working at these facilities for longer (Akanni, Osundina, Olotu, Agbonile, Otakpor & Fela-Thomas, 2019). This trend appears to be consistent with findings in other studies (Owens, Tarantello, Jones & Tennant, 1998).

A phenomenological study conducted at a psychiatric facility in Canada sought to describe and understand the ways in which acts of aggression from a patient might affect workers in a psychiatric institute, their relationships with the patients and the services offered. Four themes emerged: hypervigilance, caring, specific fear of the aggressor and generalised fear

of all patients. Hypervigilance was present among all participants. This study sampled seven orderlies, five nurses, two educators and one auxiliary nurse (Forté, Lanctot, Geoffrion, Marchand & Guay, 2017). This study is significant as it incorporated other health care workers. Although the psychiatric inpatient facility does not employ "orderlies", it could reasonably be argued that support staff are likely to experience similar frustrations. Much like orderlies, support staff at the psychiatric inpatient facility have no formal professional education, yet work in an environment where they are exposed to potentially violent MSPs on a frequent basis, and are likely to experience similar levels of hypervigilance.

A study conducted in an acute psychiatric ward at a hospital in Gauteng confirmed that violence perpetrated by psychiatric patients affected the mental health of nurses (Nguluwe, Havenga & Sengane, 2014). The main forms of violence experienced by these nurses included: physical, sexual and psychological violence, which had a negative effect on their mental health and affected the quality of care they provided to patients (Nguluwe, et al., 2014). The study did not, however, consider any other staff who also interact with these patients. Another South African study indicated that psychiatric nurses not only experience violence and aggression from patients, but also from colleagues who gossip or make inappropriate comments, while the lack of support from management in dealing with such matters was highlighted (Roets, Poggenpoel & Myburgh, 2018). This illustrates the difficult and challenging work environment that prevails in some psychiatric facilities in South Africa, and it can reasonably be assumed that other, non-nursing staff members working in such environments, are likely to experience similar problems.

As is evident from the above discussion, staff members in psychiatric facilities are exposed to verbal, physical and psychological violence on a daily basis. It would also appear that psychiatric patients tend to antagonise staff members with whom they frequently interact and are most familiar. South Africa appears to be no different in this regard. As alluded to earlier, there are similarities between workplace violence at psychiatric facilities and workplace violence in correctional facilities. This link is expanded on below.

2.5 VIOLENCE TOWARDS STAFF WORKING IN CORRECTIONAL FACILITIES

One would assume a reasonable correlation between threats to staff working at a correctional facility and threats to staff working with psychiatric patients, as both environments are assumed to house dangerous individuals, either in the form of inmates or patients. A study

conducted at an Australian correctional facility reported that workplace violence directed at correctional health professionals appeared to be common, but that physical abuse was more prevalent in health staff practising in community settings. The study concluded that the factors influencing workplace violence risk in correctional health settings remained under-researched, but noted the significance of organisational and environmental factors (Cashmore, Indig, Hampton, Hegney and Jalaludin, 2016).

Steiner and Woolredge (2015) conducted a study among 1800 prison officers in America and noted a possible correlation between higher levels of stress, and incidences of assault, being threatened, or the perception that their environment was unsafe. This study reported that nearly 35% of prison officers had been assaulted by inmates, with more than 30% having been threatened by an inmate in the month preceding the study. This study expanded on the accepted relationship between direct exposure to violence and workers' perceptions of safety and stress was noted.

An explorative study with forensic patients, prisoners and soldiers in Germany found that forensic patients described themselves as more violent and unprincipled, with a pessimistic outlook on life and possessing low self-confidence These sentiments corresponded with the responses from the prison inmates who participated in the study (Stupperich, Ihm & Strack, 2008), thus suggesting that comparisons may be drawn between the two groups. It argues that staff working in environments with individuals with such personality traits, might be more at risk of experiencing violence at the hands of patients and inmates. It is evident that proximity to work-based threats to personal safety correlates with higher levels of work stress. Arguably, this correlation applies to forensic/state patient wards where the MSPs are admitted at the psychiatric inpatient facility.

As many of the MSPs admitted to the psychiatric inpatient facility have prior criminal convictions, the prevalence of threats of violence and violent acts is unsurprising. These are discussed further below.

2.6 THREATS OF VIOLENCE TOWARDS SUPPORT STAFF

A study conducted in Denmark (Clausen, Hansen, Hogh, Garde, Persson, Conway, Grynderup, Hansen & Rugulies, 2016) attempted to establish a causal link between exposure to negative acts in the workplace (bullying and threats of violence) and staff turnover in three

occupational groups - human service and sales workers, office workers, and manual workers. While it did not establish direct causality, it noted that lower level workers were less likely to leave following such negative workplace acts, as they were heavily dependent on income and job stability. While this study was not conducted in a psychiatric setting, the finding that lower level workers, (like support staff studied for purposes of this research report) are less likely to leave their jobs despite experiencing threats or violence is particularly relevant in the current South African economic climate. Presumably, retaining one's income trumps the trauma associated with exposure to workplace violence, leading to support staff being forced to endure frightening and intimidating circumstances. From this perspective, the need for appropriate support and training becomes apparent.

Another study conducted in 2010 by Rasmussen, Hogh and Anderson (2013), investigated threats and physical violence in the workplace by comparing four areas of human service work, namely psychiatry, eldercare, prison and probationary services, and special schools. The results revealed that there were statistically significant differences in the frequency of threats and violence among these areas of human service work. In particular, employees in psychiatric facilities indicated that the types of workplace violence they experienced the most were threats from patients, which included: threats of beating, threats in a scolding, and threats in an insulting manner (Rasmussen et al., 2013). Interestingly, the second highest occurrence of physical violence was at psychiatric facilities, while the highest number of occurrences were reported at special schools (Rasmussen et al., 2013).

An American study conducted at a university department of psychiatry, revealed that professional staff were at more risk than non-professional staff, but that support staff who work in clinical areas, were at higher risk than previously acknowledged (Privitera et al., 2005). The study found that work experience was a protective factor but could not necessarily mitigate incidents of violence.

At the psychiatric facility where this research was conducted, support staff are not considered part of the multi-disciplinary (treatment) team, yet they remain exposed to patients due to having to render services in these wards. In addition, support staff might witness threats or actual acts of violence against nursing or other professional staff, adding a layer of perceived, or vicarious threat and work-related stress. Considering that threats of violence typically materialise in actual violence, often within 24 hours of making such a

threat, (Mitchell, Palk & Kavanagh, 2019), the anxiety associated with such threats is understandable. Staff at psychiatric facilities are therefore unlikely to dismiss threats from patients as insignificant, and may legitimately interpret a threat of violence as a precursor to actual violence, particularly when verbal aggression accompanies such threats (Hillbrand, 2001).

Unlike clinical staff, who tend to incorporate doctors, nurses, psychiatrists and other formally trained professions, support staff typically lack formal tertiary education, and are likely to adopt a less informed, layman's perspective when interacting with psychiatric patients. Such views may well exacerbate the perception of fear, which is why a discussion on this layman's view is needed.

2.7 LAYMAN'S VIEW OF PSYCHIATRIC PATIENTS

Research suggests reasonable justification for the belief that mentally ill patients are dangerous, but this perceived danger often exceeds actual evidence, particularly when measured in members of the public who have no personal experience with mentally ill patients (Jorm, Reavley & Ross, 2012).

The perception and understanding of mental illness is shaped by an individual's personal knowledge about mental conditions, by their personal experiences and interaction with a family member or friend with mental illness, by cultural stereotypes about mental illness, media coverage, and familiarity with institutional practices, for example health insurance restrictions imposed on certain conditions (Choundry, Mani, Ming & Khan, 2016). Support staff at the psychiatric inpatient facility are regarded as laymen in terms of mental illness, as they receive no prior training, and generally have no work experience in dealing with mental illness.

A literature review of population-based studies conducted in the United States of America found that the public generally associated individual criminality with mental illness, and that the stigma of a stereotypical, dangerous mental patient had grown more severe over time (Parcesepe & Cabassa, 2013). Other elements commonly associated with individuals with mental illness included shame, blame, incompetence, and a need for punishment.

In general, it appears that lack of information and insight fosters a view that psychiatric and forensic/state patients are dangerous. This begs the question; how dangerous are MSPs perceived to be from the layman's perspective of support staff?

2.8 THE PERCEPTION OF THE DANGEROUSNESS OF MSPS

Prerequisites for forensic care are mental illness and the commission of serious offences, coupled with a potential future risk for the public (Stupperich et al., 2008). Owens, et al., (1998) state that a patient's history of violence plays an important role in the prediction of future violence and aggression. Literature on the subject matter supports the notion that MSPs are likely to be dangerous. A study done by Sowislo, Gonet-Wirz, Borgwardt, Lang and Huber (2016) noted that familiarity with mental illness decreased perceptions of dangerousness. However, the study emphasised that individuals who displayed psychiatric symptoms or were committed to psychiatric facilities were still perceived to be dangerous by the general public. MSPs are admitted to psychiatric inpatient facilities by court order, often following the commission of a criminal offence. To support workers who are not familiar with the impact and effect of mental illness on human behaviour, they are generally perceived as dangerous. Research also suggests that forensic mental health environments generally experience more frequent incidences of violence from patients (Da'seh & Obaid, 2017). As such, this instinctive fear appears to be justified in similar environments.

A South African study conducted at the psychiatric inpatient facility between 2005-2006 indicated that the combination of 1) a prior history of violence, 2) serious mental illness and 3) substance abuse yielded a risk for future violence almost ten times greater than suffering from mental illness alone. Having a prior forensic history was also thought to increase the recidivism risk (Marais & Subramaney, 2015). In terms of the offences committed by the male state patients included in the aforementioned study, assault with intent to do grievous bodily harm (19%) was the most common offence, followed by rape (18%) and murder (13%) (Marais & Subramaney, 2015). These circumstances and patient demographic factors still prevail at the psychiatric inpatient facility today, and support workers typically encounter patients with similar violent histories on a daily basis.

It has also been suggested (Schomerus, Matschinger & Angermeyer, 2013) that the geographic isolation of psychiatric facilities, which are often located outside of cities, might evoke sentiments of deliberate isolation and confinement, which further perpetuate the

notion that patients are regarded as extremely dangerous. The psychiatric inpatient facility in question is situated on the outlying areas of Gauteng, which fits within the isolated paradigm proposed by Schomerus et al., (2013), and likely contributes to the perception that patients at this facility are dangerous or pose a threat to others.

Given the apparent link between poor judgement and mental illness, it is unsurprising that MSPs have prior history of aggression, and frequently commit offences. This reinforces the perception that they are dangerous and unpredictable. While limited research on this issue is available, studies have suggested that financial incentives, such as danger allowance might compensate for the risk staff members face when working in psychiatric hospitals (Jack, Ofori-Atta, Canavan, Taylor & Bradley, 2013 and Netshakhuma, 2016). This was noted by some of the participants during this research, as will be discussed later. The general unpredictability of MSPs will be discussed next.

2.9 UNPREDICTABILITY OF MSPS

A South African study by Sobekwa and Arunachallam (2015) made reference to the unpredictability of psychiatric patients, and how this affected nurses working with them. MacKinnon and Cross (2008 as cited in Nguluwe, et al., 2014) stated that violence caused by mentally ill patients was often tolerated more readily because their behaviour was viewed as more unpredictable and because of the assumption that they could not control their actions. Individuals' assumptions about psychiatric patients' offences and unpredictability tend to elicit rejection and fearful attitudes from society (Levey, Howell & Levey, 2008). This is relevant to the current project, as support staff at the psychiatric inpatient facility do not have access to the files of the MSPs, meaning that they have no information about the offences committed by MSPs. This leads to a reliance on hearsay, which likely contributes to the perception that MSPs are unpredictable and dangerous. A recent Canadian study (Marshall, Adams & Stuckey, 2019) affirmed this argument by demonstrating empirically how patient unpredictability affected employee views of safety in their work area.

A South African study conducted during 2018 measured the challenges faced by psychiatric nurses at work. It indicated that the second greatest common challenge experienced was unpredictable patient behaviour, followed by increased levels of patient violence and aggression. These factors frustrated attempts to provide adequate care to patients and resulted in heightened levels of burnout and frustration among the nurses (Joubert &

Bhagwan, 2018). Given that support workers are exposed to the same patient profile and working environment, it is reasonable to assume that the experiences reported by nurses in Joubert and Bhagwan (2018) are similar to those experienced by support workers in psychiatric facilities.

Literature demonstrates how patient unpredictability influences the perception of compromised safety for those who provide care to, or work in close proximity to psychiatric patients. It can reasonably be argued that this sense of fear might be greater among staff working with psychiatric patients in forensic units. As noted earlier, support staff are often also exposed to secondary, or vicarious trauma when they witness violent patient actions perpetrated against colleagues or other patients. The impact of such vicarious trauma warrants consideration.

2.10 VICARIOUS TRAUMA

Post-Traumatic Stress Disorders (PTSD's) do not only occur in some individuals who have experienced violence or trauma first-hand, but may also occur in those who witness it, for example witnessing somebody else being emotionally or physically abused (Patki, Solanki & Salim, 2014). As mentally ill patients often perpetrate acts of violence against psychiatric staff, the violent incidents are not only experienced by the victims, but also observed by other staff members working in such wards. The negative effects of secondary trauma are often referred to as vicarious trauma (Patki et al., 2014).

According to the Canadian study conducted by Forté et al., (2017), hypervigilance was experienced by all the participants who were exposed to serious violent incidents at the psychiatric facility where they worked. Hypervigilance involves an acute and increased level of responsiveness to any factors that might possibly be associated with a traumatic event (Forté et al., 2017). The state of hypervigilance can be reactivated by any stimuli related to the context in which the violence occurred, and it is often extended to other areas of the individual's life beyond the workplace. When violence was expected, hypervigilance tended to surface only in the workplace, but if the violence was unpredictable, it extended to the personal lives of the participants (Forté et al., 2017). Participants of the Forté et al., study indicated that they felt a need to increase their sense of security at work. Some of the measures taken included increasing the number of security guards and camera surveillance, and improving personal preparedness through physical intervention strategies (Forté et al.,

2017). The results of the Canadian study indicated that the participants developed hypervigilance, in order to prevent the experience of further violence.

An individual's perception of the severity of threat to which he is exposed is an important predictor of the severity of a reaction at a later stage. For instance, the more threatening a person finds an event, the more anxiety they may experience as a result. In other words, the way in which victims appraise traumatic events during the aftermath, influences the severity of the symptoms they might experience following such trauma (Lerias & Byrne, 2003). The likelihood of experiencing trauma is higher when the person believes that their life is in danger (Lerias & Byrne, 2003). As MSPs are viewed as unpredictable, victims of vicarious trauma might instinctively assume an omnipresent threat to their lives, which exacerbates the trauma they experience when exposed to incidents of violence in the workplace.
Lerias and Byrne (2003) reviewed the literature of several authors and compiled a list of predictors of vicarious trauma, some of which included the following: empathic engagement with the victim, previous trauma, external locus of control, life experience, age, the perceived threat and appraisal of the stressor, the degree of exposure, negative coping styles, education and socio-economic status and a previous psychological diagnosis. These authors concluded that, for victims, vicarious trauma equated to the same experience as direct trauma, but remained undetected because victims continue to function relatively well despite suffering. Typically, symptoms were less pronounced than those experienced by PTSD sufferers.

Brophy, Keith and Hurley (2017) also made reference to the negative long-term consequences of witnessing a violent incident without addressing any resultant PTSD. It can be concluded that the experience of vicarious trauma in the workplace has a detrimental effect on the psychological health of affected employees and that it might manifest in other forms, for instance absenteeism from work.

It is necessary to determine whether gender differences exist in terms of the likelihood of exposure, or the extent of exposure to violence. In particular, the facility where this research was conducted, support staff comprise of both male and female workers, all of whom are frequently exposed to MSPs.

2.11 FEMALE STAFF MEMBERS WORKING WITH MSPS

In general, a review of literature suggests that female mental health care workers are at a lesser risk of experiencing physical violence in the workplace than their male counterparts. Some literature indicated that the de-escalation techniques used by female staff members were less threatening to patients, which might reduce the likelihood of patient aggression. However, research also suggests that females are more likely to experience sexual harassment at work, while men encounter more physical assaults (Hatch-Mailette, Scalora, Bader & Bornstein, 2007). These authors reported that 100% of their participants who were nurses had a history of being threatened, whilst over 60% reported a sexual threat and 84% reported a past physical or sexual assault. They postulated that it was the level of patient contact that placed the nurses at risk, rather than the gender of the nurses. Psychologists, for instance, were targeted less than other professions, which suggests the profession of an individual, rather than gender plays a role (Hatch-Mailette et al., 2007).

However, a study among female nurses working in a forensic setting in the United Kingdom indicated that female staff working in such units were regarded as "outsiders" due to their gender, which increased the likelihood of violence against them (Mercer & Perkins, 2018). This appears to suggest that patients who regard female staff as "outsiders" would be more likely to react violently towards them. No research studies could be obtained regarding the experiences of female support workers working specifically with MSPs in an inpatient forensic psychiatric facility, but Owens, et al., (1998) found in their study that female staff members were at greater risk of experiencing violence when working in psychiatric units.

Although these findings are arguably inconclusive, there is some suggestion that female workers in psychiatric facilities might be more vulnerable, particularly when interacting with patients with a criminal and violent history. This theme emerged during the research project. Because the manner in which MSPs are treated or responded to would conceivably influence their reaction, it was necessary to determine the impact of adopting respectful and non-threatening attitudes towards them.

2.12 THE VALUE OF MAINTAINING A NON-THREATENING AND RESPECTFUL APPROACH TO MSPS

A systematic literature review by Greenwood and Braham (2018) found that patients viewed negative staff attitudes as a contributory factor to patient aggression in the ward, whereas helpful and encouraging attitudes from staff reduced the frequency of violence.

Harrow (2017) highlighted the value of open and positive communication with psychiatric patients and reiterated that staff must remain polite, friendly and respectful during their interactions with psychiatric patients to create rapport, act in a non-threatening way and show genuine care. Unsurprisingly, causing patients embarrassment or humiliation, and engaging in direct confrontation tends to elicit aggressive patient retaliation (Harrow, 2017). As will be discussed, this sentiment emerged during the interviews conducted with support staff at the facility where the research was conducted, along with suggestions that MSPs might benefit from structured leisure time activities.

2.13 THE VALUE OF OCCUPYING MSPS MEANINGFULLY

Two different research papers; Greenwood and Braham (2018) and Bowser, Link, Dickson, Collier and Donovan-Hall (2018), emphasised the role of boredom and a lack of stimulating activities in incidents of violence and aggression. The study by Bowser et al., (2018) indicated that the risk of incidents was especially high over weekends when there were no formal activities or programmes.

A systematic review of 37 studies on preventative measures for violence and aggression among psychiatric patients reported similar correlations, noting that organised activities offered a distraction from boredom and frustration, and that this deterred possible patient violence (Hallet, Huber & Dickens, 2014).

Antonysamy (2013) described how the decision to take patients on weekly excursions to the local zoo decreased violent incidents dramatically. Patients provided positive feedback about such outings, and initial reluctance from staff soon dissipated, while the incidence of violent incidents in the unit dropped significantly within a year. Staff absenteeism due to ill health also reduced dramatically (Antonysamy, 2013). This indicates the positive effect a meaningful activity can have on psychiatric patients as well as staff members.

These findings are of immense value, particularly given that the psychiatric inpatient facility utilises Occupational Work Programmes for this purpose. It needs to be remembered, however, that these are MSPs with criminal records and violent pasts. Programmes such as weekly excursions to the zoo are therefore not feasible. However, the apparent link between offering stimulating or meaningful activities in their wards and reducing violence and aggression cannot be ignored.

The immediate question this presents is whether or not adequate support for these and other helpful measures exists from within the psychiatric inpatient facility's management structures, and whether or not this support would moderate the impact of such a treatment approach.

2.14 *THE EFFECT OF LACK OF SUPPORT FROM MANAGEMENT ON PSYCHIATRIC STAFF*

Reports alleging a lack of management support in the workplace appear to be common in psychiatric units (Sobekwa & Arunachallam, 2015), particularly because the primary focus appears to be on the patient and not on the staff members who experience violence. Similar findings were reported by Sherring and Knight (2009) who stated that the perceived lack of support and lack of appreciation prompted demotivation and burnout among nurses, who often had to endure severe resource constraints and unfavourable working conditions.

Frustration as a consequence of lack of management support and disregard for injuries suffered appears to be universal. Participants to a study of health care staff in Canada were of the view that management and supervisors should undergo sensitivity training to understand the needs of their staff members who had been subjected to violence in the workplace (Brophy et al., 2017). An American study confirmed that management's involvement and commitment to safety of staff correlated with fewer incidents of patient violence (Arnetz, Hamblin, Sudan & Arnetz, 2018).

The literature appears to suggest that management apathy or limited management support, which contributes significantly to employee stress and frustration, is a theme among staff in psychiatric units. It is plausible that appropriate training and orientation programmes may mitigate such feelings of abandonment. It is therefore necessary to consider existing research findings on this issue.

2.15 THE IMPACT OF APPROPRIATE TRAINING AND ORIENTATION PROGRAMMES ON DEALING WITH POTENTIALLY VIOLENT PSYCHIATRIC PATIENTS

Aggressive psychiatric patient behaviour should be regarded as a preventable occupational hazard, and training programmes and support measures addressing this issue should be part of any workplace (Salerno, Dimitri & Figa-Talamanca, 2009). A narrative literature review of training programmes offered in psychiatric facilities between 1990 and 2007 (Livingstone, Verdun-Jones, Brink, Lussier & Nicholls, 2009) noted that training staff to properly utilise prevention strategies and understand the impact of environmental and clinical factors to manage aggressive patients was vital. A study in Ghana by Alhassan and Poku (2018) recommended ongoing training in psychiatric hospitals, arguing that non-professional nursing staff are not provided with the necessary training about psychiatric patients, which increased their risk of experiencing workplace violence at the hands of patients.

Clear organisational policies, for instance training about psychiatric conditions and de-escalation techniques, are essential for employee safety in any psychiatric inpatient facility. Knowledgeable and appropriately trained staff might rather attempt pro-active interventions to minimise aggressive behaviour, than allowing behaviour to escalate to the point where interventions such as restraint and seclusion are needed (Marshall et al., 2019). Orientation about the profile of patients in certain wards where staff must work should ideally also be part of organisational policies, to ensure that all staff members are prepared and equipped to deal with the patients they are likely to encounter in their work areas.

Terblanché and Borcherds (2018) stated that training in the health sector should not only focus on frontline staff, but also on those who are affected vicariously. They recommended a comprehensive workplace training programme about the management of workplace violence that focuses on aspects such as its impact, the organisational culture in the management of such violence, coping behaviour and action plans (Terblanché & Borcherds, 2018). This aligns with the current research project and its focus on support staff at the psychiatric inpatient facilityReceiving comprehensive training and orientation prior to working in specific units or with a certain patient-profile will enable all hospital employees to work with psychiatric and forensic/state patients in an appropriate and confident manner, and it will assist in preventing or de-escalating instances where workplace violence arises.

Continuous interventions must cater for the needs of all staff members. Next, environmental factors that could assist in minimising the threat experienced due to MSPs will be covered.

2.16 ENVIRONMENTAL FACTORS WHICH COULD ASSIST IN MINIMISING THE THREAT EXPERIENCED BY MSPS

The psychiatric patient's physical environment (including structural factors such as locked doors and barred windows) exerts great pressure on the patient–carer ecosystem. (Greenwood & Braham, 2017). Overcrowding is often a concern in psychiatric facilities which might contribute to patients displaying aggressive behaviour. Generally, solutions such as adequate space in bedrooms, smoking areas and an increase of nursing staff to supervise patients are recommended to reduce violence (van Wijk, Traut & Julie, 2014).

Kennedy (2002) emphasised the need for appropriate environmental safety and security measures, which includes escape-proof parameters such as high walls, controlled access to the unit, CCTV and floodlights on the premises. This author also noted that long-term inpatient facilities required larger grounds and up to 30% more floor space for the patients (Kennedy, 2002).

Physical security in forensic wards, which includes aspects like safety windows, locks, walls and doors provides a positive and supportive framework for staff members to provide services to patients (Seppänen, Törmänen, Shaw & Kennedy, 2018).

As the MSPs at the psychiatric inpatient facility are involuntarily admitted, often for permanent duration, it can be assumed that they will try and abscond if certain environmental factors do not meet the required standards. This may contribute towards the aggression and violence they display as they might attempt to break out of the ward or become more aggravated due to overcrowding and restricted movement. It is reasonable to assume that support staff members are at risk when they have to execute their work duties among potentially agitated patients in overcrowded wards with limited space, and that they should be assisted when working in such areas. As this emerged as a theme during the interviews, the suggestion that other staff members must occupy the patients in another area, or move the patients out of the area where the support workers must work will be elaborated on in chapter four. The obvious question that arises is whether or not preventative measures could be employed to mitigate or reduce the likelihood of violent outbursts among MSPs.

2.17 SUGGESTIONS REGARDING THE PREVENTION OF VIOLENCE IN PSYCHIATRIC AND FORENSIC UNITS

Psychiatric nurses at a Finnish hospital provided the following suggestions for minimising violence in psychiatric units: in-service training of all staff members (particularly regarding de-escalation techniques), security improvements (for example: single rooms for patients, avoidance of one-to-one situations with patients, effective communication skills and treating patients with respect), an effective reporting system, compliance of security instructions (keeping certain areas locked), surveillance cameras and metal detectors at the entrances of the wards (Lannta, Antilla, Kontio, Adams & Valimaki, 2016). As discussed earlier, the attitude and approach of staff members working with psychiatric patients appears to contribute substantially to the reduction of aggression in patients. It is essential for staff members to display a caring attitude as this is the foundation in caring for psychiatric patients and will promote positive outcomes. Unfortunately, this aspect is often neglected because the focus is on behaviour modification and discipline in forensic settings (Hörberg, 2018). A positive psychiatric work environment necessitates ongoing education about triggers and warning signs of patient aggression, as well as managerial support and medical management of patients (Lannta et al., 2016).

Kennedy (2002) commented on the significance of the security of forensic units and patients. Notable interventions include 1) relational security which incorporates the staff-to-patient ratio and trust between patients and staff, 2) procedural security, which includes policies and practices for controlling risk and 3) specialist management arrangement, which pertains to the established lines of reporting and responsibility, monitoring of admissions, transfers and discharges. Finally, compliance with legislation is of paramount importance.

The results of a British study conducted in forensic and psychiatric wards across 16 hospitals indicated the importance of an organisational culture that promotes a positive safety climate, ensuring there are relevant policies in place, that ongoing training is provided to all staff members and that all incidents of violence and aggression are taken seriously (Haines, Brown, McCabe, Rogerson & Whittington, 2017).

It is evident from literature that a variety of factors play a role in the prevention of psychiatric patient violence and aggression. Notable factors include improved security measures, effective interpersonal skills of staff members in direct contact with the patients, ongoing

training to staff members, appropriate policies, procedures and an operational reporting system and a conducive work environment where staff members feel supported by management.

2.18 ROLE OF THE OSW

The OSW is the link between the employees and the employer and must always strive towards maintaining a balance in promoting the interests of both parties. In safety-sensitive environments the OSW must assess the impact of potential safety concerns, such as workplace violence, on the employees, and assist in formulating guidelines to equip the employees to deal with such difficulties. According to Maiden (2001), OSW is based on a continuum of practice from micro (clinical) to macro (organisational) interventions, which are characterised by individual interventions on the one end, and organisational change on the other end of the continuum.

In terms of van Breda's model (2012) the OSW can deliver interventions to staff members on all four positions. On position one, restorative interventions, the focus is on assisting employees resolving psycho-social problems. Position two entails promotive interventions, where the focus is not only on case work and group work, but also on pamphlet and poster campaigns and exhibitions (van Breda, 2012). In a safety-sensitive workplace, the main role of the OSW will be to render services in terms of position three and position four of the model. On position three (work-person interventions) the aim is to ensure a healthy work-person interface. This incorporates group work, team building, negotiation, mediation and participation in committees and workgroups. When this is applied to a psychiatric and forensic work environment, the role of the OSW will be to facilitate debriefing group work sessions with staff members who have experienced vicarious trauma, team building among staff members working in specific units, orientation of new staff members, and the establishment of and involvement in committees and workgroups to advocate on behalf of the employees in terms of the risks they are exposed to in their work areas.

Position four (workplace interventions) will focus on interventions that will benefit the employees and the organisation. At this position, the OSW acts as a change-management consultant, policy maker, systems analyst, researcher and organisational development consultant (van Breda, 2012). The OSW must assist the organisation in developing ways to optimise the productivity, raise morale and improve the social well-being of staff members.

This includes assisting with the development and implementation of relevant policies, procedures and practices that will be beneficial to the organisation and employees. In a psychiatric and forensic setting such as the psychiatric inpatient facility, the OSW will have an important role to play in terms of developing orientation and training material for support staff to improve their knowledge and minimise potential exposure to workplace violence. The OSW also has an important role to play in the facilitation, development and implementation of a workplace violence prevention programme.

2.19 CONCLUSION

This chapter considered literature pertaining to the problem of workplace violence' specifically in the health care setting, and the problems employees working with forensic/state patients may encounter. The theoretical models used in the studywere discussed, as well as the role of the OSW. In the following chapter the research methodology of the study will be discussed.

CHAPTER THREE
RESEARCH METHODOLOGY:

3.1 INTRODUCTION

This chapter outlines the research methodology utilised to determine the most appropriate research design, and includes discussions on sampling features, research instrumentation, pre-testing, data collection and data analysis. Ethical considerations and potential limitations are discussed to conclude this chapter.

3.2 RESEARCH APPROACH

Qualitative methodologies focus on certain phenomena that exist or have existed in natural settings, which enables capturing phenomena and analysing the complexity of such phenomena (Leedy & Ormrod, 2015). Such a qualitative approach enabled the researcher to obtain rich data and gain insight into the real perceptions and experiences of participants working in close proximity to MSPs. It further allowed the researcher to verify the data obtained with key informants. Given the prevalence of certain themes, the decision was taken to incorporate counting in order to corroborate and supplement the qualitative findings. While often regarded as unconventional, counting in qualitative research often assists readers to gain richer evidence-based insights into lesser-known social phenomena (Sandelowski, 2001); in this instance, the experiences of support staff in a psychiatric inpatient research facility. It provides more accurate and interpretive information of occurrences and assists researchers by verifying and increasing the accuracy of conclusions drawn (Fife, 2020).

Sandelowski (2001) emphasised the significance of counting in qualitative research to ensure descriptive, interpretive and theoretical development, which encourages the researcher to account for all emerging data. Because participants functioned in different job categories, frequency counting enabled the researcher to demonstrate the themes as they emerged and overlapped, adding depth to the research findings. Hannah & Lautsch (2011) discuss four types of counting in qualitative research. However, for this study, the researcher only relied on corroborative counting, which "is typically associated with a conventional triangulation approach involving a combination of qualitative and quantitative methods." (Hannah & Lautsch, 2011, p. 16). Corroborative counting aids in the verification of conclusions reached

by a pure qualitative analysis, which was the main method of analysis (Hannah & Lautsch, 2011).

Creswell (2009) stated that qualitative research is essentially interpretive, as researchers interprets data and draw appropriate conclusions. Qualitative research extracts information about problems, obstacles and paradoxes that exist within or because of specific phenomena (Leedy & Ormrod, 2015). Considering that the study pertains to the challenges and difficulties associated with working in close proximity to MSPs, it was expected that data could be utilised to develop overarching frameworks to assist participants, while addressing potential inefficiencies and safety concerns that have not been revealed to management. Corroborative counting therefore allowed for a limited measure of quantification of emerging themes and recommendations, thus facilitating a richer understanding of participant experiences.

3.3 RESEARCH DESIGN

Strategies of inquiry contribute to the overall research process (Creswell, 2009). The chosen research design was an exploratory case study, and exploration or description of the phenomena was done via detailed, in-depth data collection methods, including multiple sources of information which are rich in context (Fouché & Schurink, 2011). Participants from various different categories of support staff were invited to be interviewed. Key informants (managers from different departments of the facility) provided valuable sources for triangulation of data. Exploratory case studies expect researchers to record details about the context surrounding the cases, for instance from the physical environment, as well as political, economic and social factors that might influence the situation or study participants (Leedy & Ormrod, 2015). As the researcher is employed at the facility, there is an in-depth understanding of prevailing logistical challenges, for instance staff shortages, and economic factors, such as budget constraints, that influence the environment.

The researcher remained cognisant of the fact that case study data is usually not generalisable to environments outside that where the research was conducted (Manuel, Fang, Bellamy & Bledsoe, 2011).

3.4 POPULATION AND SAMPLE

A population refers to the universe of units from which a sample is selected (Bryman, 2008). In this instance, staff members at the psychiatric inpatient facility constituted the study population.

The sub-set, or "sample" (Strydom, 2011) comprised of support workers from the inpatient psychiatric facility in Gauteng, divided into the following groups: cleaners, ward clerks, groundsmen and administrative workers. In addition, three managers who either supervise support staff or oversee general staff activities were interviewed as key informants to provide management's perspective and triangulate data obtained from the participants. Key informants generally have knowledge and influence in their area of expertise (de Vos et al., 2011), thus enabling the researcher to produce more valuable and complete qualitative data. The key informants were selected based on recommendations from the clinical manager of the psychiatric inpatient facility.

3.5 SAMPLING PROCEDURES

Sampling ordinarily occurs through random selection or through purposeful selection of an appropriate number of representatives of each subgroup from the overall group to be studied (Leedy & Ormrod, 2015).

Purposive sampling, a type of nonprobability sampling, was utilised to select twelve participants and three key informants. In nonprobability sampling there is no way of anticipating that each element of the population will be represented in the sample (Leedy & Ormrod, 2015). This method allowed the researcher to select participants expected to have the most valuable information to share about the phenomenon to be investigated (Leedy & Ormrod, 2015). It also allows for the creation of a true cross-section of the population (Gray, 2009). Unfortunately, it means that the sample cannot be assumed to be representative of the entire population, a limitation discussed later in this report. The researcher guarded against this disadvantage by inviting all the support staff members for interviews, and then selected an appropriate sample, based on the inclusion and exclusion criteria.

Policy mandates that official communication, from a government facility regarding any research must be disseminated by a senior manager before participants can be recruited. A senior manager informed all staff of the impending research during March 2019. In April

2019, the researcher approached all four relevant departments that employ support workers to recruit suitable participants. The workers of these departments were reminded of the study and offered the opportunity to volunteer. Initially, four participants volunteered, and interviews were scheduled. The remaining eight participants were recruited through word-of-mouth, after the initial participants were interviewed. The researcher also approached the three key informants recommended by the clinical manager to conscientize them about the nature of the study and the valuable contributions they could offer. All three key informants agreed to participate.

The inclusion criteria used to select participants were: support staff that have worked at the facility for one year or longer, male and female staff members, and staff who have direct contact with MSPs. Exclusion criteria were staff who have not worked for a period of a year or longer, and who never come into contact with the MSPs. There was no predetermined expectation as to how many males or females needed to be included. The only requirement was to obtain three representatives from each support staff job category.

With the exception of a fifteenth volunteer, all participants were comfortable to conduct the interviews in English despite not being English-speaking. The excluded volunteer spoke incoherently, was unable to articulate his views, and appeared incapable of answering the questions. These problems appeared to relate to an inability to converse in English. At the time, the researcher had already secured three representative participants from each of the predefined "support staff" groups, and this particular respondent would have been redundant. Given this, and given the apparent language barrier, it was decided to exclude this participant from the study.

The researcher did not have a specific criterion that a certain number of males or females must be selected, the main purpose was to obtain three representatives of each support job category. The fact that the researcher does not work closely with the support staff, or know them personally, allowed for truly unbiased sample selection.

Ensuring congruence of key characteristics between the sample and the population, and the selection of cases which are typical of the experiences of the population increases generalisability (Gray, 2009). Given that support staff at the psychiatric inpatient facility are subjected to the same working conditions and physical environment, and given that

general exposure to MSPs appear to be similar, the researcher believes that the findings from the interviews with the sample were representative of the experiences of support staff working with MSPs, and could be generalised to other support staff at the psychiatric inpatient facility.

3.6 RESEARCH INSTRUMENTS

Semi-structured interview guides (Appendix C and D) and an internal incident register (Appendix F) were utilised to obtain information from the participants. Two different interview guides were created to ensure bespoke and relevant probing; one for the support staff and the other for key informants. Each consisted of seven open-ended questions. Participants received participant information sheets prior to each interview.

The research instruments (interview guides) were pre-tested with one male and one female support staff member, which appears reasonable, as support staff at the psychiatric inpatient facility consist of male and female employees. These employees were not included as participants in the research study. Pre-testing results confirmed that the questions from the interview guides were clear and relevant. Both pre-test participants indicated as such, suggesting that the research tool was reliable.

Content validity refers to the representativeness or sampling adequacy of the content or items of an instrument (de Vos et al., 2011). The same interview schedule was used with all 12 participants to measure the responses and identify correlations. There were similar results among some of the participants, which supported the assumption that participants were exposed to the same work environment. This increased content validity for the research project.

3.7 METHODS OF DATA COLLECTION

Interviewing is the predominant mode of data collection in qualitative research (de Vos et al., 2011). Face-to-face interviews allow researchers to establish rapport with the participants and gain their cooperation, yielding the highest response rates (Leedy & Ormrod, 2015). The researcher was able to build rapport with the participants during the face-to-face interviews. Interviews were conducted in English, on-site, and in the privacy of the researcher's office. Establishing rapport with the participants allowed the researcher to obtain more detailed responses. It also provided an opportunity to encourage participants

to elaborate on unclear responses. To avoid response bias and reflexivity (Gray, 2009), open-ended questions were posed, and the researcher refrained from relating any personal views. The aforementioned interview guides ensured consistency in the line of questioning.

The incident register (Appendix F) proved difficult to procure and was ultimately sourced from a key informant after several requests and after all interviews had been concluded. It constitutes the only documented record of violent patient-staff incidents at the psychiatric inpatient facility between August 2018 and August 2019.

3.8 METHODS OF DATA ANALYSIS

Qualitative data, though insightful, can be difficult to analyse, particularly given nuanced discrepancies in the methodology used to do so. Broadly speaking, two predominant methods prevail; thematic analysis, and content analysis (Vaismoradi, Turunen & Bondas, 2013). Thematic analysis typically strives to identify and understand commonalities across data patterns, called themes (Braun & Clarke, 2006), whereas content analysis allows researchers to extrapolate information by interpreting certain quantitative information that arises from initial coding (Vaismoradi et al., 2013). Core methodologies remain similar for both approaches, because researchers are expected to immerse themselves in the data prior to coding the information which is ultimately interpreted and reported. However, thematic analysis relates codes and eventual themes back to the research question without any concern for the frequency of occurrence of these themes or codes, whereas content analysis permits the researcher to draw certain conclusions from such frequencies (Vaismoradi et al., 2013).

As discussed earlier, this research project uncovered a marked frequency of certain themes, which prompted counting (Fife, 2020; Maxwell, 2010), which is an acknowledged tool of content analysis methodology (Vaismoradi et al., 2013). However, in order to retain the purpose of this research and ensure findings which are relevant to the research question, these frequencies are noted, rather than analysed for significance. Given that research into the phenomenon of the experiences of support workers in an inpatient psychiatric facility is scant, it is foreseeable that future studies of a quantitative nature may arise. The researcher therefore sought to remain true to the construct of thematic analysis (Braun & Clarke, 2006), while noting the aforementioned frequencies for additional context.

In-depth interviews were conducted in order to extract comprehensive and rich data and examples from participants, which informed the themes of this study. Such data were clustered into themes that underscore or support the existing literature and the research question, thus allowing the researcher to add deeper understanding to the scientific area of study and, as is the case here, propose a model to address potential shortcomings or mitigate deficiencies in existing paradigms. Performing thematic analysis allowed the researcher to focus on identifying and describing implicit and explicit ideas and emerging themes within the data to analyse the data obtained (Guest, MacQueen & Namey, 2012).

The six steps of thematic data analysis proposed by Braun and Clarke (2006) guided the process of thematic data analysis. First, the researcher developed familiarity with the data by listening to the recorded interviews, transcribing these interviews, and scrutinising said transcripts. During this phase, patterns and apparent connections between responses were recorded as they emerged, allowing the researcher to correlate these themes with the research question in order to distil information about the perceptions of support workers with regard to their perception of the threat of violence by MSPs.

Secondly initial codes were generated which served to facilitate a more empirical analysis of the data (Braun & Clarke, 2006). The researcher made use of deductive orientation, informed by the research question and objectives of the study. Obvious (semantic) codes, such as "fear" and "safety" were expected and easy to identify during this process. However, peripheral codes such as "lack of training" were flagged for further exploration and helped to inform the eventual identification of themes. All emerging codes were interrogated for relevance and significance, allowing the researcher to make interpretive choices throughout the data analysis process (Braun, Clarke, Hayfield & Terry, 2019). To ensure objectivity and mitigate researcher bias, the researcher also included codes which appeared to be contrary to what was expected. Examples include a stated concern about lack of financial incentives. The recording of all emerging codes continued until saturation was reached.

From there, the researcher set about searching for and constructing themes (Braun & Clarke, 2006) from the codes identified. The different codes were tabulated into broad categories from which thematic mapping allowed the researcher to explore themes and sub-themes visually for conceptual similarities (Braun et al., 2019). Similar codes were clustered together to identify and form themes, which provide meaning and depth to the data. Potential

themes were measured against the research question and data-set to determine relevance (Braun et al., 2019).

Finally, themes were reviewed, defined and refined to understand the conceptual boundaries of each theme and subtheme. By reporting the findings in this document, the researcher achieved the final step dictated by Braun et al. (2019): demonstrating connections between this research and existing research literature with the aim of providing deeper insight into the analysis.

As pointed out earlier, several of the themes and sub-themes reported were identified across the majority of participant interviews. As the high frequency suggested an experiential similarity between participants vis-à-vis their environment, the decision was taken to reflect these frequencies by means of counting (Hannah & Lautsch, 2011) while remaining true to the qualitative purpose of this study.

3.9 TRUSTWORTHINESS OF THE STUDY

Trustworthiness refers to the authenticity of the findings of a qualitative study (Anney, 2014). To ensure the trustworthiness of a qualitative study, Guba's four criterion for trustworthiness were employed: credibility, transferability, dependability and confirmability (Shenton, 2004). **Credibility**, or internal validity, ensures that the research measures what it is supposed to measure (Shenton, 2004). Utilising information from key informants allowed for triangulation of data from interviews, thus contributing to credibility (Leedy & Ormrod, 2015). Participants were given an opportunity to participate voluntarily and could withdraw at any point if they wished to do so. As such, the risk of possible retaliation from management, colleagues and MSPs was mitigated, allowing for honesty and open communication. Participants were allocated pseudonyms to ensure confidentiality and avoid potential victimisation or intimidation. There is an audit trail, as all the procedures were documented and are traceable. The researcher executed this study under the supervision of a university appointed research supervisor who was granted access to all verbatim transcripts. The researcher also kept a reflective diary commenting on all aspects of the research journey.

Transferability, also referred to as external validity, is whether the findings of one study could be applied to other situations (Shenton, 2004). By relying on purposive sampling,

transferability was increased, as rich data was obtained from participants who exhibited most characteristics of the population being studied and had direct exposure in the matter being researched. The researcher expects that similar results would emerge if the study were repeated at another psychiatric institution, due to the overarching similarities from a PIE perspective. It should be noted, however, that further research would be required before definitively stating that the findings reported here are equally relevant and applicable in other psychiatric inpatient facilities.

Dependability refers to whether repeating the study in the same context, with the same methods and with the same participants, would yield similar results (Shenton, 2004). The researcher ensured that the processes followed, and methods used were meticulously documented to ensure dependability. Records of the steps followed during the data-analysis process were also kept and are available to the supervisor to check for dependability. The researcher made use of the reflective diary to assess what methods worked and which were less successful.

Confirmability refers to ensuring objectivity, and includes steps taken to ensure that the study's findings are the result of the experiences and ideas of the informants, and not the characteristics and preferences of the researcher (Shenton, 2004). Data triangulation and semi-structured interview schedules assisted in this regard, while an in-depth methodological description enabled objective scrutiny of the integrity of the research (Shenton, 2004). The audio-recordings of the interviews, interview transcripts and all raw data can be made available for review, subject to appropriate approval.

3.10 ETHICAL CONSIDERATIONS

There are important aspects to consider during each step of the research process. According to Strydom (2011), efficient and ethical research requires mutual trust, acceptance, and cooperation, among all parties. Ethical issues which were considered in this study included:

3.10.1 Voluntary participation

Participants should never feel pressured to participate in a study and any participation should be voluntary (Leedy & Ormrod, 2015). The researcher explained the purpose of the study to the participants. In addition, a participant information sheet was provided to each voluntary participant, and the researcher availed herself to answer any questions that might

arise from this information. No coercion occurred, and no participants withdrew from the study despite being informed of their right to do so at any stage.

3.10.2 Informed consent

Informed consent means that prospective research participants must be provided with as much information as needed, which allows for an informed decision about their willingness to participate in the study or not (Bryman, 2008). The participants were provided with a participant information sheet, which contained information about all the aspects of the study. They were required to provide written informed consent (sample consent forms are attached as Appendix B). All participants signed these forms voluntarily, and no objections to doing so were raised at any time. The participants also consented to audio recordings, which were later transcribed.

3.10.3 Avoidance of harm

In the social sciences, harm to participants might be of an emotional nature, and this might be difficult to predict (Strydom, 2011). When discussing the matter of voluntary consent, the researcher informed the participants that follow-up counselling services would be made available, should the need arise. Arrangements were made with two social workers at the psychiatric inpatient facility to assist if this was needed. None of the participants requested a follow-up counselling session. Participants were also informed that they could withdraw from the study at any point, if they wished to do so. No participants withdrew from the study.

3.10.4 Confidentiality

The researcher assured participants that their identity would remain confidential and that interview transcripts would be stored in a locked cupboard and on a password protected laptop. To this end, pseudonyms were allocated to each participant and key informant, which reduced the risk of a breach of confidentiality. Having the reassurance of confidentiality contributed towards the participants providing valuable information about their experiences and perceptions. The interviews were conducted in the privacy of the researcher's office at the social work department of the psychiatric inpatient facility. Interviews were conducted over several different days and the appointments were not sequential. As such, participants would not encounter one-other when arriving at or leaving the researcher's office.

3.10.5 Feedback to participants

The researcher undertook to provide feedback to the facility and study participants. Findings of this study will be made available to participants as a form of recognition for their contribution and in the interest of maintaining good relationships and learning from each other (Strydom, 2011).

3.10.6 Ethical clearance and permission

Ethical clearance for this study was obtained from the departmental ethics committee of the University of the Witwatersrand and from the research committee at the facility where the research took place (Appendix E). A copy of the ethical clearance certificate is attached as Appendix G.

3.11 LIMITATIONS OF THE RESEARCH STRATEGY, DESIGN AND METHODOLOGY

The researcher attempted to minimise the limitations as far as possible. When using qualitative methods, it is difficult to analyse data with total objectivity and it is a complex and time-consuming process (Leedy & Ormrod, 2015). The researcher attempted to minimise the possible impact of subjectivity by triangulating the data with key informants and carefully documenting all the data analysis procedures (Leedy & Ormrod, 2015). While English was not the first language of the participants or researcher, English was used as the common language for the interviews. Participants chose to speak in English and there was no need for the services of an interpreter. While it was anticipated that the incident register (Appendix F) would bolster data triangulation, this did not materialise, as the incident register did not appear to provide a true reflection of actual incidents at the psychiatric inpatient facility. As discussed in chapter five participants indicated that incidents are often not reported to management and would therefore not appear in this incident register.

3.12 CONCLUSION

This chapter outlines and justifies the qualitative research approach and exploratory case study design utilised for the purpose of this study. Sampling features, the research instruments applied, methods of data collection and the thematic data analysis process were also outlined. Finally, the ethical considerations and limitations of the study were highlighted. The following chapter focuses on the analysis and discussion of the findings of this study.

CHAPTER FOUR
DATA COLLECTION AND ANALYSIS OF FINDINGS:

4.1 INTRODUCTION

This study sought to explore the perceived threat of violence experienced by support staff members who have daily contact with male state patients (MSPs) at a government inpatient psychiatric facility. The relevant findings are presented in this chapter. Participant and key informant demographic information will be discussed, followed by an analysis of the data obtained. Three main themes are identified and analysed, while sub-themes that emerged during data analysis are articulated.

The responses have been analysed and substantiated through verbatim quotes, to reflect all participants' experiences and emotions when encountering MSPs. The participants were offered an opportunity to recommend changes that would improve their current circumstances. Such recommendations were cross-referenced with concerns expressed during the interviews in order to validate or exclude concerns, depending on whether such concerns correlated with themes identified. Recommendations which did not speak to any of the themes were excluded and regarded as irrelevant for the purpose of this study.

As explained in Chapter 3, the researcher utilised frequency counting (Hannah & Lautsch, 2011) to demonstrate the prevalence of certain themes which could inspire future research. Conclusions drawn, however, remain tied to the themes identified and analysed. Tables and diagrams were used to illustrate the data obtained. This chapter concludes with a brief summary of the main themes and sub-themes. Triangulation of data occurred via analysis of the responses obtained from key informants. Principles from the Person-In-Environment (PIE) and the Biopsychosocial Model were used as the underlying theoretical framework to shed light on the possible psychological effects exposure to violent MSP might have on the participants.

4.2 DEMOGRAPHIC AND BACKGROUND DATA OF THE PARTICIPANTS

The participants were all permanent staff members at a government facility in Gauteng. The following table provides some demographic details.

Table 1: Demographic and background data of participants: N=12

Demographic details	Sub-category	No: ___
Gender of participants	Male	5
	Female	7
Age	30 - 39 years	4
	40 - 49 years	5
	50- 59 years	3
Job description	Administration (office)	3
	Cleaner	3
	Facility management unit	3
	Ward clerk	3
Years working at the facility	1 – 5 years	2
	6 – 10 years	5
	11 – 15 years	4
	21 – 30 years	1

Table 1 illustrates that participants comprised of seven females and five males. Participants were mature individuals with an average age of 43 years and working experience at the research facility (as support staff) of between 3 and 30 years. All participants experienced daily interaction with the MSPs. Some of the participants, for example the cleaners and ward clerks, had greater frequency of direct contact with the MSPs, compared to the groundsmen and administrative staff from the offices.

Table 2: Demographic and background data of the key informants: N=3

Demographic details	Sub-category	No: ___
Gender of key informants	Male	2
	Female	1
Age	40 - 49 years	1
	50- 59 years	2
Job description	Manager	3
Contact with patients	Not on daily basis	3
Years working at the Facility	1 – 5 years	2
	6 – 10 years	1

Table 2 shows the demographic characteristics of the three key informants who were part of the management structure of the facility and had a shared responsibility regarding the wellbeing of all the staff members. The key informants comprised of two males and one female, and had an average age of 50 years. They were mature individuals, but unlike the participants, they did not have daily contact with the state patients. The key informants have been employed at the facility for an average of five years. The information obtained from the key informants assisted in validating the information obtained from the participants.

4.3 THEMES IDENTIFIED

The three main themes identified via thematic analysis were: participants experiencing fear, participants not fearful and recommendations made. Several sub-themes were also

identified, for example: unpredictability of MSP, experience of direct threats and vicarious trauma. Participant responses were analysed, and themes were grouped together by making use of thematic data analysis. As indicated in the research methodology chapter, the researcher also made use of corroborative counting which allowed a measure of quantification of emerging themes and recommendations, and this assisted in creating a more comprehensive understanding of participant experiences. Counting was prompted by the repetition of similar responses and themes from different participants. By highlighting the number of participants who reported elements about a specific theme, the researcher drew a clear distinction between the experiences of the different types of support staff who come into contact with the MSPs. The use of frequency counting did not detract from the in-depth thematic analysis conducted, but added an additional layer of insight, because "the use of numbers is a legitimate and valuable strategy for qualitative researchers when it is used as a complement to an overall process orientation to the research." (Maxwell, 2010, p. 6).

4.4 THEMES INDICATING THAT THE PARTICIPANTS EXPERIENCE FEAR

Specific themes denoting fear were identified during data-analysis and these were grouped together. One of the main themes was the experience of fear, as several sub-themes were identified which all related to the experience of fear, for example: the perception of imminent threat by MSPs, the unpredictability of the MSPs and having experienced direct threats from MSPs. A broader discussion of the different sub themes that contributed to the conceptualisation of the main theme, the participants' of experience fear, is explored next.

4.4.1 The perception of imminent threat from MSPs

Responses from seven of the twelve participants revealed a theme focussed on the perception of imminent threat from the MSPs that arose during their daily work routines, as they interact with MSPs while performing daily tasks. These participants experienced the threat of violence as real. These responses were mostly from three ward clerks, followed by two groundsmen, a cleaner and an administrative worker, see Figure 1.

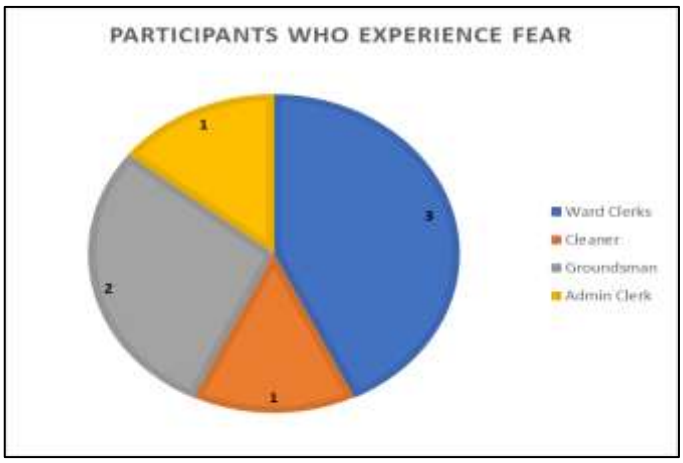

Figure 1: Indication of number of participants experiencing fear, according to job category.

A quote that illustrates the perception of the imminent threat of violence from MSPs appears below:

> *And then that patient, sometimes they* [MSPs] *are okay, sometimes, sometimes they are ill. Like they are mentally ill. Sometimes they are fighting with others* [patients and staff]*, and I'm scared* [opening her eyes widely and raising her eyebrows]*, I'm really scared for them* [MSPs]. *Sometimes they can hit you* [the staff], *or they can kill you, but it is dangerous for us.* [Zuki, female, ward clerk].

This spontaneous response by Zuki was provided when questioned about the frequency of her encounters with MSPs at work. During the interview, Zuki mentioned the dangerousness of the MSPs a total of 14 times, which may be indicative of the magnitude of her fear (Hannah & Lautsch, 2011). The statement and non-verbal behaviour (wide, anxious eyes) demonstrates an awareness of potential threats to her personal safety when performing her work tasks, and articulates her hypervigilance when around MSPs. Hypervigilance is an increased level of awareness to any element that might be potentially linked to a traumatic event, and is generally a consequence of working in an environment considered to be stressful, dangerous and unpredictable (Forté et al., 2017). Zuki appeared to be experiencing hypervigilance due to her awareness of the dangerous nature of MSPs and the unpredictability of their behaviour, which caused her stress and anxiety.

Even though the support staff have limited knowledge about the details of the offences perpetrated by MSPs, they are aware that these offences tend to be of a serious nature, and

that the MSPs are not only mentally ill, but may be prone to violence. The most prevalent finding about the predication of violence in the psychiatric framework has been that past incidents of violence predicts future violence, and that long-term psychiatric patients in hospitals are the most at risk of violence, due to their altered cognitive ability and lack of coping skills (Kruger & Rosema, 2010). It is commonly known among the staff at the psychiatric inpatient facility that MSPs have committed serious offences such as rape and murder and therefore have an inclination towards violence. This quote by Zuki reinforces her perception of being fearful in her workplace when surrounded by MSPs.

Similar remarks were made by the six other participants who also perceived the threat of violence from MSPs as imminent. Moreover, this concern for personal safety was unanimously corroborated by the key informants. One key informant said: "*they* [the MSPs] *see vulnerability in a person, they smell it* [the fear], *it's like they know and then they will attack* [the staff]". [Joan, key informant]. This particular response by Joan suggested that some members of management were aware that the MSPs could present a threat to staff. However, as will be discussed later, the view that MSPs posed a threat to support staff was not shared by the other key informants.

This fear expressed by the participants is similar to research done by Sowislo et al., (2016), whose study indicated that patients in psychiatric hospitals within a forensic unit were viewed as more dangerous, in comparison to a general hospital with a psychiatric unit.
The next theme identified will focus on the unpredictability of MSPs.

4.4.2 Unpredictability of the MSPs

The theme of unpredictability appeared frequently during the data-analysis and eight of the participants highlighted an awareness of the unpredictability of the MSPs. As Khaya put it: "*… But I hear most of the staff, they say a psych patient* [MSP] *is never stable, so any time you must expect something, so don't be too relaxed when around them* [the MSPs]". [Khaya, male, ward clerk].

The participant made this statement when describing his experiences in the ward. The quote acknowledges his feelings of uncertainty and hypervigilance around patients who may relapse without warning. A relapse is defined as a "set back" and usually occurs when psychiatric patients have an episode of mental illness, due to various environmental,

psychological or biological factors. Khaya's quote shows his hypervigilance when working in the wards in close proximity to the MSPs. Here too, the issue of unpredictability and perception of potential danger (Forté et al., 2017) exacerbates this participant's hypervigilance.

Literature suggests that male patients evoke greater feelings of dangerousness, than female patients (Sowislo et al., 2016). The fact that Khaya works in an MSP ward might therefore contribute towards the fear and hypervigilance he is experiencing. One of the main conceptions of the mentally ill is that they are unpredictable and unable to stick to social norms (Angermeyer & Matschiger, 2004). The unpredictability of the MSP is also evident in the following statement:

> *What I've realised is they* [MSPs] *are very short-tempered. That is why* [when] *we talk to them, make sure that you* [support staff] *select the words that you use to* [with] *them, and sometimes, you can come the following day, they change almost like the weather, every time. Next time you come* [see them], *they are all right.* [Tau, male, cleaner].

Tau appears conscious of the unpredictability of the MSPs when he works. Quotes such as these suggest that some participants experience fear and hypervigilance as a consequence of an unsafe working environment. Participants reported a constant awareness of their surroundings when around the MSPs. From a biopsychosocial perspective, if staff members' psychological health (e.g. fear of patients, hypervigilance) is affected in a work environment, it will ultimately require further interventions (Workcover Queensland, 2019). The next logical question then becomes; to what extent do participants experience direct threats from MSPs?

4.4.3 Experience of direct threats

This theme emerged from the spontaneous responses from five participants who immediately volunteered incidents during which direct threats from MSPs were experienced. Threats reported by the participants included threats of violence, sexual harassment and verbal abuse. These threats also included death threats to a male participant who was unable to provide cigarettes for insistent patients. This participant stated: "*Yah, there was one patient* [MSP], *he said 'No* [name withheld] *used to give us teabags, so you, you don't want to give us*

cigarette and teabags. [laughs uncomfortably] *Yah, we're going to kill you".* [Khaya, male, ward clerk].

This quote indicated the direct threat that Khaya reported, over a mere cigarette, which is regarded as an item of real value to the MSPs. It is plausible that MSP addiction to nicotine or tobacco might cause withdrawal when access to these substances is restricted (as is the case in the psychiatric inpatient facility). This in turn may contribute to the levels of aggression expressed to male staff members who are known to be smokers and presumed to be in possession of something of value (cigarettes) to MSPs. A study by Gilbody et al., (2019) showed that smokers with mental illness were more dependent on nicotine and less likely to stop smoking. As the MSPs sometimes only have access to the support workers in their wards, they are likely to ask them for cigarettes, and being denied would likely result in threats towards the support workers, as illustrated by Khaya's experience.

Threats of a sexual nature and inappropriate sexual propositions to the female participants were also reported:

> … *they can come, while you are cleaning, they come, they do stripper* [strip naked]…*they undress themselves, they do something nasty* [sexual thrusting movements], *when we're busy, we are cleaning there* [in the wards], *they come after you* [behind you], *the male patient.* [Lulu, female, cleaner].

Lulu's words illustrate that the threat was real as this cleaner has been exposed to sexual harassment involving MSPs who acted in a sexually inappropriate manner towards her. Whilst she was talking about this, she expressed her emotions by raising her voice and talking with feelings of repulsion. She also illustrated by means of gestures how the MSP would stand behind her and make sexually inappropriate movements. This clearly illustrated the vulnerability of the female cleaners when fulfilling their duties among the MSPs. These quotes by Khaya and Lulu also demonstrate the reality and severity of the threats to which support staff in the wards are exposed.

Interestingly, these threats were contradicted by two of the key informants, who suggested that MSPs were more of a threat to nursing staff. The two key informants also noted that the

only incidents reported were verbal abuse and threats, and that there were rarely any incidents of inappropriate touching.

> *I would make an example of the cleaners, because they spend the entire day, like nurses, in the ward. So, you would expect that such behaviour* [threats from MSPs] *would be directed to them as well, because they* [the cleaners] *are there* [in the wards] *throughout the day. But, with the mental illness of our patients, you don't really see them making any of the threats, or inappropriate behaviour towards the cleaners in particular as part of the support staff. It's mostly directed to nursing.* [Samuel, key informant].

It is evident from this statement that Samuel was not aware of the risks that the participants reported. It would appear that the focus was on nursing staff, as only incidents pertaining to nurses are reported (the apparent inefficient reporting procedures will be discussed later).

However, the key informants do not appear to be completely ignorant of the vulnerability of the support staff. Another key informant stated: "*Everybody, admin, support staff, everybody is very vulnerable, because nobody gave training* [calming and restraint] *to the specific staff we're talking about".* [Joan, key informant]. This key informant displayed insight regarding the fact that all the staff members working in this facility were at risk of workplace violence as they were expected to work among the MSPs whilst executing their duties, and that support staff may often find themselves isolated with the MSP. During such times they are at risk and vulnerable to any form of violence from the MSP.

These contradictory views held by the key informants might be indicative of poor communication channels and lack of knowledge and awareness within the facility. Subsequently, this lack of communication is likely to impact on the work experience of the affected support staff, who do not appear to receive assistance in dealing with such incidents. This theme illustrated that the direct threats experienced by participants are severe, yet remain underreported. Such direct threats are, however, not the only type of threat experienced by support staff. Next, the vicarious trauma participants experience due to the ongoing exposure to MSPs and their behaviour will be discussed.

4.4.4 Experience of vicarious trauma

The theme of vicarious trauma prominently emerged when four of the participants indicated that they had experienced vicarious trauma in the wards where they worked. The vicarious trauma occurred by observing MSPs attacking and assaulting nurses as well as incidents where MSPs were verbally and physically abusive and aggressive towards other staff members. These four participants reported an awareness of the risk of sexual violence in the forensic (state patient) wards and one of the participants of this study who has been exposed to such incident said: "… *they raped a nursing student you know* [moves around uncomfortably in her chair]*, I think seven years back…the wards that are down there* [MSP wards]*, they really need security…If you are working here* [at the facility], *see that thing* [rape incident]*, you are traumatised you too"*. [Zuki, female, ward clerk].

This is yet another example of the type of threat Zuki spoke about. It may be inferred that Zuki's prolonged period as an employee at the psychiatric inpatient facility contributed to her fear when hearing about and/or witnessing MSPs displaying violence towards staff members. She was clearly upset by this event. Witnessing, or hearing about such incidents may have a psychological impact on staff members, especially if they do not receive counselling to address their own feelings after being exposed to such trauma.

The key informants concurred that the support staff do sometimes witness the clinical staff members being attacked in the wards:

> ... *this* [is a] *specialised psychiatric hospital that we're dealing with:* [which includes] *murderers, rapists, druggies, alcoholism, people like that and then, if they* [support staff] *are attacked, they would not know how to do, what to do, so the only thing they can do is to fight back. And, unfortunately, I think some of the nursing staff really, and I'm talking professional nurses, are attacked or verbally abused continuously, continuously.* [Joan, key informant].

This statement indicates that nurses have been attacked by the MSPs in this facility. Support staff members are always nearby and often witness such abuse, or hear of these incidents occurring in the very wards where they work, which may cause or trigger vicarious trauma.

As no specific research could be found about the effects of vicarious trauma on support workers in psychiatric facilities, a study about nurses was consulted, as support staff and nurses work under similar circumstances in the facility. Support staff often witness attacks on nurses, which might add to the vicarious trauma they experience. A 2019 study confirms the risk to nurses, indicating that psychiatric nurses experience physical violence at a rate 20 times higher than their counterparts in public health facilities, and that they experience all types of patient aggression at higher rates than nurses in other fields (Niu et al., 2019). Employees exposed to violent incidents at work need time to heal, and interventions such as support groups or counselling should be offered (Hess & Hess, 2013). Arguably, the same holds true for employees who witness such traumatic attacks. An OSW would be ideally suited to assist staff members who have been exposed to vicarious trauma in the workplace, by rendering work-person and workplace interventions in terms of the van Breda model (van Breda, 2012). With work-person interventions staff members could be empowered and assisted though group work sessions to deal with the vicarious trauma they experienced.

Next, the reported issue of lack of support from the clinical staff and management will be discussed.

4.4.5 Lack of support from clinical staff and management

The sub-theme of lack of support from clinical staff towards support staff in the wards, as well as the sub-theme of lack of management support was identified during data analysis. The general theme among the participants was that they were unsupported in their work environments, but they made a clear distinction between management and the clinical staff they work with directly in the wards. These two sub-themes were grouped together as they were closely related in terms of the information provided from the participants. Two participants reported a lack of support from the nurses in the wards when the MSPs threatened or harassed them, whilst two other participants also indicated a perception of lack of support from management towards support staff. The following quote from one of the participants refers:

> *We* [the support staff] *don't have nowhere to complaining to* [frowns and presses lips together]. *I can come to complaining to you, and say 'Oh, this side* [inaudible] [it is] *difficult, how can I to tell* [name of CEO withheld] *this, or how can I tell my manager about this?' It's a problem. You take this thing*

> [the complaint] *for your own. It's* [the complaint] *end up there* [in the cardex]. *You see?* [Lulu, female, cleaner].

This statement indicates the lack of reporting channels and the powerlessness of the participants, as they feel that they do not have appropriate channels to follow when they have a complaint. As the support staff are low in the hierarchy in the workplace, they are easily overlooked, and it appears that they feel that their interests are not always taken into consideration. Moreover, there is a lack of trust in the existing systems, as also indicated by this participant, when she reported a matter to the nurses:

> *They* [the nurses] *write at cardex every evening, but, they can't give you an explanation, the right explanation* [the next step after the complaint was reported to the nurses]. *Sometimes when you see it* [the complaint being reported] *you'll say 'This one* [the complaint]*, at least it's filed, and I can do this* [knowing what to do] *when a patient comes to me, I can defend myself like this' no … you can't get that report like that* [but no such measures are provided]. [Lulu, female, cleaner].

The cardex is a brief daily and nightly process note written by the nurses, about the patients' behaviour and progress. It is kept in the patients' clinical files in the ward. Lulu seems to feel that information captured in the cardex will not be escalated or reach the multi-disciplinary team or management, therefore problematic behaviour is not addressed. As no feedback is provided to staff about their complaints, Lulu felt that reporting incidents is an ineffective procedural exercise and she appeared to have little faith in the current system of reporting incidents. She felt that complaints would not be escalated and therefore indicated that the reporting system did not work.

One key informant seemed to be unaware of any incidents in the wards involving support staff and the MSPs, as he said that: "…*as far as the actual assaults or attacks, those are, in my records I don't have incidents* [of support staff]. *What I have is going* [incidents reported about] *the clinical staff; nursing and doctors, and other members of the team"*. [Samuel, key informant].

From above statement it seems that some of the key informants are unaware of incidents experienced, and sometimes reported by the support staff, and that the focus is on the clinical staff as complaints about incidents involving patients are only received from the clinical staff members. Moreover, the information provided on the incident register (Appendix F) appears to corroborate such a theory, as all incidents listed record instances where clinical staff were attacked.

The fact that this key informant appears to be unaware of incidents involving support staff corroborates the concerns expressed by participants. Management appears to be oblivious to the difficulties the support staff face in the wards. The participants indicated that they report matters to the nursing staff in the ward, but that the nursing staff do not report this further. Research shows that lack of supervisor support at work is a great stressor for employees and one of the highest risk factors in terms of the health and wellbeing of employees (Hammig, 2017). As is evident from her interview, Lulu, found her supervisor unsupportive and lacking understanding. Again, this feeling of being unheard will impact on the overall biopsychosocial functioning of the individual, particularly if they do not feel protected and valued, which could lead to problems with low morale and lack of commitment to work. This might further manifest in the form of physical and/or emotional problems and lead to absenteeism, which has been an ongoing concern at the facility.

What further exacerbates the perception that support staff are not supported by management is an apparent lack of training opportunities to protect themselves, which emerged as a concern during interviews. Lindiwe said: "*And a serious training* [is needed] *for how to handle them* [the MSPs], *even for us* [the administrative workers], *because we don't have no idea, it's only nurses who go to those trainings* [about how to deal with MSPs]. *We don't*". [Lindiwe, female, administrative worker].

The researcher probed about training opportunities for support workers during the interviews with the key informants. From their responses it appeared that management was aware of this shortfall, but seemed to be unable to address it, perhaps due to budget constraints.

Two of the key informants, Innocent and Joan, acknowledged the limited opportunities available to support staff, particularly the lack of a training budget for them, as Joan said: "*No, no training were* [was] *given in the time that I was here* [at the facility] *for*. [Gestures

empty hands] *No budget for any support staff*'. [Joan, key informant]. Another key informant said:

> *But on the other hand, the support staff, they are meant to identify themselves, mostly the need for training. It's a two-way type of a need, or satisfying a need or, like, they need to also identify, as well as managers that also need to identify risk and a need for training.* [Innocent, key informant]

These two quotes from key informants further illustrate the perceived lack of support from management to the support staff in terms of training. The one key informant refers to a limited budget and the other key informant places the onus of identifying training needs on the support workers and their supervisors. This might reinforce the perception of the support staff that they are neglected and excluded from opportunities for advancement.
Next, the gendered vulnerability of staff in the facility will be discussed.

4.4.6 Female staff

The aspect of female staff who work in the MSP wards and female staff being more fearful of MSPs was raised among the participants and identified as a sub-theme. Three participants indicated that the female staff members who worked in the wards were at greater risk of violence and harassment from the MSPs. These insights came from the female participants, who were employed in the capacity of administrative assistant, cleaner and a ward clerk. One of the participants said:

> *… they* [management] *need more male* [nursing] *staff in the wards, who know to, maybe control the patient* [MSP], *because mostly I see more female than more males…when the patient* [MSP], *sometimes they get into a fight, you can see the female staff, sometimes they don't know what to do* [when MSPs becomes aggressive]. [Vuyo, female, ward clerk].

Vuyo's quote suggests an elevated vulnerability of female staff, a legitimate concern, given that the facility employs mostly female staff members, who work with predominantly male patients. One of the key informants, corroborated this, saying "…*the patients* [MSPs] *are verbally abusing them* [support staff in the wards], *women especially being verbally abused by state patients. It's getting out of hand…".* [Joan, key informant].

This statement shows that this key informant was cognisant of the fact that the female staff were more at risk and vulnerable to acts of violence from the patients, and confirms that this was a challenge at the facility. Moreover, a study conducted in Limpopo, South Africa found that female staff members were the victims in more than half of the reported cases of injuries inflicted by patients, and that nurses were the most affected (Malangu, 2012). Thus, it appears that female staff might be more at risk when working in the MSP wards, as reported by the participants and supported by one key informant. This makes appropriate training all the more crucial, which is why the apparent lack of training and knowledge appears to be problematic, as discussed below.

4.4.7 Lack of training and knowledge

A further sub-theme that was identified was the lack of training and knowledge, this theme emerged as participants expressed their fear of MSPs, due to not having the necessary training in skills about how to deal with MSPs.

One participant highlighted the dilemma of not being able to protect themselves against the MSPs, should the need arise, as they might be dismissed, the participant said: "…*if I can take myself, I beat a patient, is a problem* [frowns and shakes head] *I'm going to* [be] *arrested, or I'm going to, they'll* [management] *say the job is finished go home...".* [Lulu, female, cleaner]. Lulu was concerned about the implications of acting to protect herself against an attack from an MSP. She was aware of the fact that she might lose her job and income, should she retaliate.

The following quote from a key informant illustrates an understanding and awareness of the compromising position in which employees might find themselves: "…*I'm attacked, I've got no, nothing, know-how of how to restrain or, what can I do? I'll have to hit back, and then I'll be at home for three months without pay. So, I don't think it's a fair situation*". [Joan, key informant].

This key informant appreciated the dilemma faced by support staff; that they might lose their job and benefits if they try to protect themselves in a physical manner against the MSPs. The lack of knowledge among support staff was validated as they are not equipped to deal with the situation should there be an instance of them getting involved in a physical altercation with an MSP.

Another key informant reinforced the vulnerability of support staff due to lack of training and knowledge:

> *Support staff they are more vulnerable to forensic patients* [MSPs] *or psychiatric patients. One thing with them is they are very low qualified, so they don't have appropriate information or knowledge, or even training* [about] *how to understand behaviour, and also, they are not skilled on how to deal with aggressive, physically or verbally aggressive patients. So, in my opinion, they are one group that is more vulnerable to any type of violence from the psychiatric patients.* [Innocent, key informant].

The statement from this key informant illustrated his understanding regarding the predicament of the support workers. It seems that there was an absence of training programmes to equip support staff so as to offer knowledge and the ability to protect themselves at the facility. Should this lack of knowledge persist, the support staff will remain vulnerable. Based on the above information, it could be established that the support workers were exposed to dangerous situations in their work setting, and that they were not necessarily equipped to deal with such situations.

In the following section, the lack of financial incentives for dangerous work will be discussed.

4.4.8 Lack of financial incentives for dangerous work

The sub-theme of lack of financial incentives for dangerous work was identified as participants raised the issue of clinical staff members who received a financial incentive for working with the MSPs, whilst support staff did not. Having the knowledge that other staff members received "danger pay" contributed to the fear they experienced when working with MSPs.

During interviews it was established that two of the cleaning staff and one of the ward clerks who were in direct contact with the MSPs in the wards perceived their work as dangerous. These participants do not receive a so-called "danger allowance" for working in the facility, whereas clinical staff received a monthly danger allowance. The fact that three participants raised this issue illustrates an expectation of fair compensation for working in a dangerous environment. One of the participants said:

> *…but the worst part of it is, if I can get injured, I don't even get a danger allowance. Now sometimes you have to ask yourself – must I come in between, or must I just...? But as a human being, I have to stop the fight* [shrugs his shoulders]. [Tau, male, cleaner].

Tau's statement demonstrates an awareness of the risk of violence that he could be exposed to, should he intervene in a fight between two MSPs. It also suggests that he did sometimes get involved in breaking up fights, which is beyond his job description. His statement also appears to demonstrate a lack of awareness of the facility's Injury on Duty process and reporting channels. He was also unsure about how to intervene when fights break out between MSPs. He referred to a danger allowance, which suggests such an allowance might mitigate his frustration and uncertainty.

A study conducted with mental health care professionals in Ghana found that healthcare workers expressed a need for danger allowance, as their perception was that staff in psychiatric hospitals should earn more money than those in general medicine, due to the high risk of being injured by aggressive psychiatric patients (Jack et al., 2013). Studies about support staff receiving danger allowance could not be found, therefore, it is argued that whilst healthcare workers at psychiatric facilities feel that they should receive a danger allowance, the same sentiment could be applied to the support workers coming into contact with the same profile of patients. It appeared that the participants might feel more motivated or acknowledged if they were to receive additional compensation for the risk of violence they must endure on a daily basis.

In the following section the perception of the participants that proximity to MSPs creates a greater threat, will be discussed.

4.4.9 Proximity to MSPs creates a greater threat

The sub-theme, that the proximity to MSPs creates a greater threat, was identified as several different accounts were given by the participants about being fearful when having to work in close proximity to the MSPs, in comparison to the general patients.

The general perception was that the threat of violence was mostly in the MSP wards of the facility. Five participants indicated that the risk of being threatened or attacked by MSPs

was the highest in these wards. One participant, who did not work in the wards, has this to say regarding what she had overheard:

> *…I'm not sure about the wards because, I've never been in* [the wards], *but I've heard stories…that it is not safe, safe like you think it is. You must be very careful at the wards, but for us this side* [at the offices], *it is safe...* [Lindiwe, female, administrative assistant].

This participant demonstrated an awareness of the risk that staff members in the wards were exposed to, compared to the staff in the offices who are not as much at risk.

One of the key informants, Joan, admitted to feeling unsafe when entering the wards, while one other key informant stated:

> *…because we know the nature of our hospital* [a facility caring for MSPs who had committed serious offences like rape and murder]*; we're the last stop as we all know, so we get most difficult patients basically, and most dangerous.* [Samuel, key informant].

The most unstable and dangerous MSPs are not allowed to move around freely on the premises, and are detained in the wards where the staff members working in direct contact with them are the most at risk of violence. Samuel's statement validates the fear expressed by the cleaners and ward clerks who work in such wards. Samuel also confirms the dangerousness of some of the MSPs, many of whom have committed serious offences, but were deemed not responsible and/or unfit to stand trial. Staff members in these particular wards appeared to face the highest risk of threats and/or violence, due to their proximity to such MSPs.

The general consensus among participants was that the risk of violence was higher in the wards. However, some of the key informants seemed to be under the impression that the support staff did not experience violence against them directly in the wards. It is important to note that all three key informants exhibited insights regarding the risk support staff were exposed to, as they acknowledged that the support staff were vulnerable. However, they

appeared to be unaware of actual incidents, as discussed under the theme of direct experience of threats.

In the foregoing the different themes that indicated that participants were fearful of the MSPs were discussed, next a contradictory position will be discussed. This theme pertains to those who do not see working in close proximity to the MSPs as a threat.

4.5 THEME INDICATING THAT PARTICIPANTS ARE NOT FEARFUL

Under the main theme of participants who are not fearful, only one sub-theme could be identified. The sub-theme that emerged was that working in close proximity to MSPs was not seen a threat as not all the participants seemed fearful of the MSPs.

4.5.1 Do not see working in close proximity to MSPs as a threat

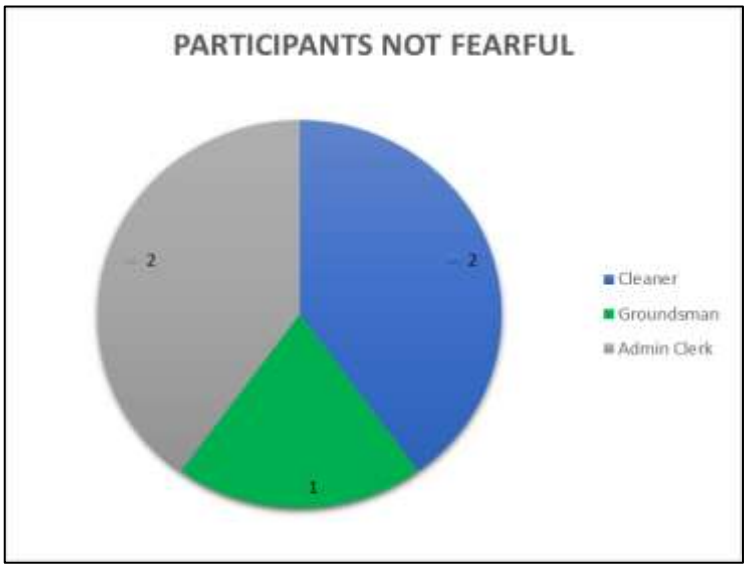

Figure 2: Indication of number of participants not fearful according to job category

The five participants who indicated that they do not experience fear were as follows: two administrative workers, two cleaners and one groundsman, as illustrated in Figure 2.

It is important to note that these participants only interacted with the MSPs at a later stage, when they had been stabilised and were permitted to move around on the premises, or when these stable MSPs come into their offices to sell goods. These participants therefore did not work in close proximity to all MSPs and only had brief interactions with the stabilised MSPs, as opposed to support staff employed in the wards.

It is also significant to note that these particular participants had been working at the facility for a shorter period. One of the participants noted:

> *…No, they* [MSPs] *don't bother me, I feel alright. I think it's a good thing to send them* [MSPs] *to us* [to sell goods in the offices], *because of in future we want them back in the community* [to be rehabilitated]. [Poni, female, administrative assistant].

This demonstrated insight into the fact that the MSPs were receiving treatment, which seemed to reduce her potential anxiety. Another plausible reason for not being fearful, might be because she was only exposed to the stable and higher functioning MSPs, who did not pose a risk and were deemed sufficiently mentally stable to exit the ward without constant supervision.

Four other participants reportedly had the same view about the MSPs. All the key informants corroborated that the support staff working in the wards were at higher risk of being threatened and harassed by the MSPs, and that the administrative staff and groundsmen were not as much at risk to be threatened by MSPs.

Having the knowledge that a mentally ill person is receiving treatment, as well as frequent exposure to individuals who are mentally ill reduces the fear among members of the public (Jorm et al., 2012). The support staff working in the office and on the grounds usually had brief contact with the MSPs only when they were selling goods from the tuck shop, and it appears that these interactions were positive, which might have contributed to their experience of not being fearful. These participants also believed that the MSPs were receiving treatment and were being rehabilitated, which was reported as a predominant reason for not being fearful.

The following discussion sets out the recommendations received from all participants.

4.6 RECOMMENDATIONS ON HOW TO IMPROVE THE CURRENT SITUATION WHEN WORKING WITH MSPs

This main theme emerged as the participants were permitted to share their ideas and recommendations about how the current situation at the psychiatric inpatient facility could

be improved. This theme was divided into different sub-themes as the participants had innovative ideas that ranged from security and logistical aspects, to recommendations in terms of dealing with the MSPs. These aspects were all grouped together in the following sub-themes.

4.6.1 Environmental factors

Due to the responses given by the participants about the security features, comments about the burglar gates and lack of security guards led to the emergence of the sub-theme on environmental factors.

Ten participants indicated the importance of increasing the security measures at the facility. This was evident from this participant's quote:

> *Put more securities* [guards], *when they* [the MSPs are] *at the tearoom, dining hall, there must be a security* [guard] *at that side,* [during] *ward round there must be a security here around them, so* [currently] *security here is only at the* [entry] *gate…and CCTV* [closed circuit television] *we* [do] *have… more securities, yah, and* [a] *locking system. They must include maybe the card system or the fingerprint system* [for staff members], *I think it will be better, there will be no need for keys…No need to say No, I'm waiting for the key* [to unlock],*for staff, don't lock* [me in], *I don't have a key* [to get out]. [Khaya, male, ward clerk].

Khaya's quote indicated the absence of adequate security measures and an obvious need for improvement. Exposure to potential risk situations in the wards as a consequence of these inadequate security measures was also indicated. Moreover, responses suggest that there is a shortage of keys at the facility, which results in staff members being locked in a certain section of the ward with the MSPs. Presumably, this is the result of out-dated security features and it was suggested that biometrics should be used. The likelihood of being trapped with potentially violent MSPs poses a real risk to staff and a liability to the facility.

This was corroborated by two of the key informants. One key informant said:

> *I'll look into the infrastructure, the physical infrastructure* [of the MSP wards]*, for instance the installation of cameras, burglar proofs or burglars in all the risk areas* [for violence] *for proper separation and isolation* [of MSPs] *of* [from] *where the support workers would be, for instance* [be] *cleaning or working….to deploy adequate security* [guards] *around to monitor*. [Innocent, key informant].

This key informant has a clear idea of what measures could be employed to improve the current situation and proposed ideal ward conditions. Methods for the prevention of violence in hospital settings include: installing metal detectors, security cameras, bullet resistant glass around nurses' stations, lighting everywhere, curved mirrors at hall intersections, and card-controlled access to restricted areas (Hess & Hess, 2013). Installing such security measures might contribute towards an increased feeling of security for the participants working at the facility.

From Khaya and Innocent's statements it is apparent that support staff (and clinical staff) are forced to navigate an environment where safety features are inadequate, and pose a material risk to employees.
Next the need for training and education a will be discussed.

4.6.2 Training

The need to receive more information to empower themselves with knowledge about the MSPs was a prominent sub-theme that emerged among the participants. The need for education and training and the need for orientation were divided into two different sub-themes, as the participants had different views about education and training and about orientation.

4.6.2.1 Need for education and training

This sub-theme was identified as the general feeling among the participants was that they were not equipped to deal with the MSPs that they have to deal with directly on a daily basis. Six of the participants expressed a need for education and training about how to manage the MSPs. This illustrates that participants feel that they are ill equipped and lack the required knowledge. One of the participants said: "… *and a serious training for* [us about] *how to handle them* [the MSPs], *even for us, because we don't have no idea, it's only the nurses*

who go to those [calming and restraining] *trainings, we don't"*. [Lindiwe, female, administrative clerk].

Lindiwe's statement captured the need of the support staff to be included in training opportunities on how to deal with the MSPs. Five other participants also expressed a need for education on mental illness in general, as well as, training in restraining and calming of patients.

The following quote by Lulu illustrates what her opinion regarding interventions needed to assist her and other support staff working in the wards:

> *First, they can train us how to handle the patient* [restraint mechanisms]. *Secondly, they can train us how to speak with the patient. Then it will be better, because we speak with the patient like we are at the location, you see? It's not professional words when you* [we] *speak to the patient.* [Lulu, female, cleaner].

Lulu's statement indicated her lack of knowledge and skills, and her desire for training opportunities, in order to deal with the challenges she might face in her line of work. Lulu's lack of understanding about mental conditions and the lack of training of restraint mechanisms contributes to her vulnerability as she does not know how to defend herself against MSPs, and is unsure of the impact her behaviour might have in sparking or avoiding violent patient interaction.

Support staff members of the facility have been excluded from training opportunities such as the calming and restraining of patients, due to the assumption that they do not work directly with the MSPs and the notion that it is not their duty to restrain or intervene with patients. However, they also come into direct contact with the MSPs in unsafe environments and would benefit from training on such matters. When the initial needs assessment was conducted, managers informed the researcher that there was no budget allocated to training of support staff (C. Grobler, personal communication, March 13, 2019). This also emerged as a concern during interviews, and was highlighted as a theme during analysis.

Lacking the necessary knowledge and training jeopardises the safety of support staff. In the absence of appropriate knowledge and safety training, their natural instinct might be to retaliate when attacked. Every facility should have policies and guidelines in terms of violence prevention in the workplace, in order to protect its workers (Brophy et al., 2017). The psychiatric inpatient facility where this research was conducted is no exception.

It was confirmed by all three key informants that the education and training of support staff is an important need. One key informant said:

> *I do believe that the support staff, and other managers, who are also not clinicians or part of the clinical team in the ward, they do need that type of training* [calming and restraint of patients]*, they do definitely need it, because they also go to the wards.* [Samuel, key informant].

This key informant validated the fact that all the staff members needed to receive the relevant training on how to deal with psychiatric patients, as staff and patients interact on a daily basis.

Another key informant said the following:

> *Of course the* [calming and restraining course]*, it has, or it has a relevancy in terms of presentation. It's more structured to meet the criteria of* [needs of]*, for the doctors and nurses and mainly healthcare professionals, of which the, this category of support staff, a minor course or a lesser course can be done, as a part of an awareness of* [treatment of MSPs]*, especially during the orientation and continuous throughout their working time. I think that can, that can work. At least make them* [support staff] *aware or sensitise them aware about risk areas* [for workplace violence]*, risk behaviour* [of MSPs]*, how to identify* [risks]*, how to report it, how to react on it. It might not be as intensive as for the healthcare professionals, which is the doctors, nurses, and OT and social workers in any way.* [Innocent, key informant].

Innocent's quote indicated an awareness and acknowledgement of the fact that the support staff need to be included in relevant training. It suggests that the current calming and restraint

programme might not be suitable to their needs, as it was catered to meet the needs of the clinical staff of the hospital. The feasibility of a programme to equip support staff was, however, acknowledged.

Chappel and Di Martino (2000, as cited in Benson, Hanley & Scroggins, 2013) noted that employee training and development programmes were some of the most important elements of any organisation's human resource practice. In the health care sector, it is necessary for such programmes to include training to instil interpersonal and communication skills to defuse threatening situations, training to improve an employee's ability to identify a potential risky situation and training to prepare staff to take responsibility for complicated interactions. Similarly, a South African study in public health conducted by Terblanché and Borcherds (2018) proposed that training should not be limited to those who were directly affected, but ought to be extended to employees who experience violence vicariously as well, as relevant training improved the well-being of all employees. The study also emphasised that a workplace violence training programme was a powerful intervention mechanism, as it expanded knowledge and enhanced skills of all workers (Terblanché & Borcherds, 2018). A workplace training programme which teaches all staff members how to deal with workplace violence would not only empower and equip staff members, but also contribute towards them feeling part of the team and workplace, which in turn would contribute to an improved morale as suggested by the PIE model.
As a further recommendation under training, the need for orientation about the profile of the type of patients in a ward will follow in the next section.

4.6.2.2 Need for orientation

This sub-theme was identified as participants felt that they were not being properly orientated to the profile of the patients they come into contact with. Participant responses suggested that they were of the view that orientation could occur at any time and should not only occur when commencing employment at the facility.

Two participants indicated a need for orientation in terms of the profile of the patients in a ward, prior to going into the specific wards. Participants indicated that they would feel better equipped to deal with state patients if they knew beforehand what to expect from them in terms of their behaviour. One of the participants said:

> [The nursing staff] *don't brief you* [support staff] *about the patient, how patients* [MSPs are] *they're not the same. I think the best thing is to give orientation before you go* [into the wards]*... you know; expect this and that. I think that's the best way.* [Khaya, male, ward clerk].

This participant realised that the patients differed and had different diagnoses. It is evident that he might feel more empowered if he knew more about the MSPs prior to entering the wards. These comments suggest a lack of appropriate orientation programmes to support workers in this facility.

It will be difficult for support staff to render services in a ward if they have not been oriented in terms of the profile of the patients in the ward, as they will not know how to act towards the patients or deal with a situation that might arise.

The need for orientation as expressed by the participants was confirmed by all three key informants. One of the key informants said: "…*they* [the support staff] *don't have appropriate information or knowledge* [about mental illness], *or even training* [on] *how to understand behaviour, and also, they are not skilled on how to deal with aggressive, physically or verbally aggressive patients".* [Innocent, key informant].

This key informant illustrated an understanding of the participants' need for orientation about the profile of the MSPs in the wards where they are expected to work, and he acknowledged the fact that they did not possess the necessary skills to deal with difficult MSPs. Not receiving orientation or having the required skills to deal with aggressive patients would likely exacerbate a participant's perception of threat when exposed to MSPs.

According to the World Health Organisation (the WHO), it is important to ensure that non-professional workers are equally competent and can seek support and guidance from professional staff when having to deal with complex issues in the workplace (WHO, 2007). The WHO further recommends that a mental health component must be included in the curriculum of non-health professionals, as this is in keeping with best practices in terms of human rights (WHO, 2007). Support staff like cleaners and ward clerks are seen as the non-professional workers in the psychiatric inpatient facility, and should be included in orientation and training programmes regarding mental health aspects.

As is apparent from the above-mentioned two themes, the need for training and orientation of support workers are important factors to consider in terms of empowering support workers who are working in close proximity to MSPs. This could assist in decreasing their perception of threat when coming into contact with the MSPs.

The way in which MSPs are treated by staff will be discussed in the following section, as this is also an aspect of training.

4.6.2.3 Approach to patients

This sub-theme was not anticipated but identified as it emerged from the more mature participants. Participants who had been working at the psychiatric inpatient facility for a longer period, realised that the manner in which patients are approached by staff members, makes a difference in the way patients interact with staff.

Some participants expressed concerns over the manner in which staff members treated patients, particularly because such staff members spoke to patients in a disrespectful manner. As indicated by one of the participants: "*...It's a person. If you talking to him as* [like] *a person, then they will understand, no this person is talking to us like a person* [just] *like him. That is why I feel safe* [in this facility]*, because I don't provoke them* [the MSPs]". [Paki, male, groundsman].

This astute participant demonstrated an awareness of the need to treat all patients with dignity and respect, which is in line with the Batho Pele principles which all government workers in South Africa must adhere to (DSD, 2019). In this participant's experience, an MSP would not feel provoked if he was treated with respect, and would thus be less likely to act in an aggressive manner. As this participant is a groundsman, it should be noted that he probably only encounters the more stable MSPs who walk around on the premises, as unstable patients are confined to the wards. This also illustrates the importance of providing orientation, training and education to staff members about mental illness, as all staff members are unlikely to possess the same level of insight and empathy.

Kapungwe et al., (2011) highlighted the importance of treating all patients (particularly psychiatric patients) with dignity and respect, and emphasised that respectful language and

gestures contributed positively to self-esteem and dignity, thus avoiding violent patient outbursts.

Recommendations in terms of training, orientation and the approach to patients were covered in this section, next, a further recommendation, namely to keep patients occupied, will be discussed.

4.6.3 Patient activities

The sub-theme, of occupying patients meaningfully with activities in order to reduce their aggression, was also an unanticipated theme that emerged.

Three participants reported that MSP behaviour and subsequent incidents of violence might be avoided or reduced if the MSPs were kept busy during the day. This recommendation is clearly illustrated by this participant:

> *…like in the morning, they* [the MSPs] *must start* [their day by doing] *gym* [physical activities], *in order they must concentrate in them* [the] *gym, and after the gym, it will be tea, it will be breakfast. After the breakfast they [the nursing staff] must take them* [the MSPs] *for games like football, or games like Dominoes and Ludo, just to keep their* [the MSPs] *minds busy. But, if ever they leave them like that* [without any activities or stimulation in the wards]*, they'll start fighting because the problem is* [wanting] *cigarette[s]…I think just to keep them busy all the time, it will work* [to decrease threats and subsequent violence]*".* [Tau, male, cleaner].

This statement by Tau illustrates the lack of structure in some of the wards, and suggests that the MSPs he encountered would start picking fights over cigarettes when they sat around idly. From his input and experience, it is evident that the MSPs were more prone to violence when they had more leisure time, and were not occupied constructively. It appears that during such times the MSPs would become more demanding of cigarettes. As indicated under the theme of direct threats, having cigarettes was important for the MSPs as the smoking acts as a stress-relieving activity.

Antonysamy (2013) confirmed this, stating that psychiatric patients become more aggressive if they are bored, due to a shortage of structured activities in psychiatric facilities, which leads to violent incidents and assaults. Psychiatric patients expressed the desire for more direct contact with staff, instead of staff spending time doing administrative work (Antonysamy, 2013). MSPs might sometimes act up in order to gain attention from staff members, it is therefore important to keep the MSPs occupied to avoid incidents of violence. When the MSPs are constructively occupied, they would presumably be less prone to violence, and staff members coming into contact with them will feel less exposed and less at risk of being threatened or assaulted.

Another recommendation offered was the removal of MSPs from areas where they might encounter support staff. This recommendation is explored next.

4.6.4 Remove patients from area where staff work

This sub-theme emerged as the participants working in the wards, specifically the cleaners and groundsmen, complained about how much longer it takes them to do their jobs in the presence of the MSPs. A participant said: "*sometimes when you are cutting* [the grass inside of the wards], *"he* [the MSP] *will just sit there, and then you have to look for staff, maybe a nurse or so, that they can remove him there. It's very hard* [shrugging shoulders and looking worried]*"*. [Sizwe, male, groundsman]. This participant felt that he did not know how to approach and address MSPs who would, for instance, sit in an area where he had to mow the lawn. He suggested that, at times, there would be no nurses around to assist by asking the MSPs to move, which made the situation difficult for him to handle as he did not possess the confidence to ask an MSP to vacate the area where he had to work.

This was identified by a key informant as one of the minor, but practical changes that could be implemented at the facility. He said: "…*where the support workers would be, for instance, cleaning or working* [in the wards], *they should be separate*[d] *from the patient* [MSP], *which is not the current status"*. [Innocent, Key informant].

It is clear from Innocent's statement that MSPs should ideally be removed from the areas where the support staff are carrying out their tasks, but he also seems to be aware that this was not currently happening. This was a reasonable and feasible expectation, but clearer communication about the different roles of staff members and appropriate procedures, might be helpful to assist in achieving this.

Other participants (cleaners and groundsmen) reported that having to perform their work duties (such as mopping the ward floors or mowing the lawns at each ward) was complicated as a consequence of having to do in the presence of MSPs, which elevated the risk of an attack. Focussing on one's task meant that one could not monitor MSP movements in the area, which in turn increased vulnerability to sporadic violence.

Risk assessment in a psychiatric facility includes aspects such as an awareness of the extent of the MSPs' risk level and recognition that the MSPs need a consistent approach. Therefore, strategies must be developed that will prevent harmful events and interactions (O'Rourke, Wrigley & Hammond, 2018). Support staff having to fulfil duties amid psychiatric patients poses a risk, which could be minimised if the MSPs were removed from the areas in which support staff must work. This seems to be feasible in the facility and could perhaps occur if there were open communication between the nursing staff and support staff. Support staff members require assistance from the clinical staff members in the wards when they have to execute duties in close proximity to the MSPs, in order to avoid incidents of violence or threats.

All above-mentioned recommendations were not only made by participants, but the key informants actively proposed feasible recommendations to improve the current situation at the facility.

In summary, a need for comprehensive and robust security measures was desired by ten of the participants and all three key informants, suggesting that this was a prevalent and urgent need. Suggestions included more security barriers in the wards, access control to the wards, functional closed-circuit television cameras, more security guards to be employed and to employ more male nurses.

Six participants highlighted a need for education and training about mental illness and access to the calming and restraining course offered to the clinical staff of the facility. Five participants said that removing patients from the area in which they must work will minimise the risk of violence from MSPs. Four of the participants acknowledged that the manner in which staff members approach and treat MSPs also played a role in MSP behaviour. Three participants indicated that involving MSPs in constructive activities would assist in reducing

the risk of threat and two participants indicated the need for orientation as a recommendation, to empower staff members who work in close proximity to MSPs.

4.7 INFORMATION OBTAINED FROM THE INCIDENT REGISTER AT THE FACILITY

According to the register of incidents reported to the quality assurance department between the period of August 2018 and August 2019, there were only seven incidents involving patients and staff members (see Appendix F). It is worth noting that no complaints from support staff are recorded over this period. During the initial needs assessment conducted at the psychiatric inpatient facility (C. Grobler, personal communication, March 13, 2019), it transpired that ten violent attacks had been perpetrated against staff members between August 2018 and March 2019. This discrepancy of information is discussed in more detail in Chapter 5.

This incident register further revealed that five of the incidents originated in an MSP ward, one in an acute male patient ward and another in the acute female patient ward. All seven incidents were recorded as "physical assault", with six assaults against nursing staff and one assault against a doctor. Again, it is worth noting that these details did not appear on the official document. This clarity was provided by the quality assurance department. The researcher was also informed that staff members did not report incidents regarded as "minor incidents", such as verbal abuse. As noted earlier, participants were of the view that clinical staff were not supportive and would not report incidents involving support staff to management. The absence of any such reports from the incident register appears to corroborate this sentiment.

As a consequence, the incident register did not prove to be an important source of information for this study. This register creates an impression that there were no incidents against support staff during the given period, yet feedback provided by participants suggested otherwise. This administrative discrepancy suggests that incidents are not captured meticulously, which in turn appears to corroborate the theme of lack of support from clinical staff and management.

4.8 CONCLUSION

The research question was answered and objectives of the research study were achieved by means of the responses of the participants. By employing frequency counting in this qualitative study, additional insight was gained into the experiences of participants working in various sections, allowing the researcher to obtain a more in-depth understanding of what was happening in a specific setting (Maxwell, 2010) while suggesting possible areas to be considered for future research.

The data analysis revealed that seven of the twelve participants felt threatened by experiencing close contact with the MSPs. That participants were fearful of MSPs emerged as a prominent theme. It is worth noting that even those participants who reported not being afraid were quick to propose changes in order to improve safety and security measures at the psychiatric inpatient facility. This could potentially suggest that the perception of fear might be slightly higher than overtly reported. However, confirmation of this will only be possible with further, more extensive research. It was significant to note that the administrative workers and groundsmen, who had been working at the facility for a shorter period, and did not frequently interact with MSPs, felt less threatened. This was in contrast with the sentiments expressed by staff members who have worked at the psychiatric inpatient facility for longer periods, and came into direct contact with the MSPs in the wards.

The notion that participants feel threatened when coming into direct contact with MSPs was confirmed in several of the themes identified. For example, the unpredictability of the MSPs, the direct threats from MSPs and the experience of vicarious trauma all illustrate such perceptions of fear. The participants reported being excluded from training opportunities regarding mental illness, leaving them disempowered when having to deal with threatening situations or MSPs. Participant responses provided valuable insights regarding their experiences of working among the MSPs, and suggestions on how to improve the situation by increasing security and providing more training opportunities for support staff, thus creating a safer work environment, for them and the MSPs. Key informants validated most of the responses of the participants, with slight contradictions which were articulated. The vulnerability of female staff members in this facility, the participants' experience of lack of support from clinical staff and management and the exposure of participants to vicarious trauma were important themes that emerged which warrant attention. Key findings as well and recommendations are discussed in the following chapter.

CHAPTER FIVE
DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS:

5.1 INTRODUCTION

The research question and aim of the study explored the perception of the threat of violence among support staff members who frequently interact with MSPs in a psychiatric inpatient facility in Gauteng. This chapter provides a summary of the main findings, conclusions and recommendations pertaining to the objectives of the research study.

5.2 SUMMARY OF THE MAIN FINDINGS

Objective 1: To gain insight regarding the experiences of support staff being exposed to MSPs in the workplace.

The finding under this objective was that several participants experienced fear and a sense of imminent threat when coming into contact with the MSPs. From their responses, it would appear that the nature of contact with MSPs, the duration of employment at the facility (specifically being employed for a longer period), the profile of the MSPs, experiencing direct threats, experiencing vicarious trauma, and the unpredictability of the MSPs were all precursors to the perception that MSPs are threatening.

While there were participants who indicated that they were not fearful of the MSPs, such responses do not invalidate or nullify the perceptions of those who emphasised a sense of fear when interacting with the MSPs. It was significant to note that the participants who did not feel threatened were employed for a shorter period of time, were not working in the wards (they are administrative workers in the offices and groundsmen) and were therefore not in close contact with the MSPs. In addition, the MSPs that these participants were exposed to were generally the stable MSPs who had received treatment and were permitted to roam the premises by virtue of the fact that they did not pose any foreseeable risk to themselves or others.

It was evident that the proximity to MSPs during the execution of their work duties, created a greater sense of threat amongst the participants. The key informants concurred that the risk of violence from MSPs was highest in the wards, which validated the participants' feelings of experiencing fear when working in close proximity to the MSPs.

Participants reported a lack of support from the nursing staff and management, which might further contribute to their experience of feeling fearful and at risk of potential workplace violence from MSPs. The absence of any incident reports pertaining to support staff appears to validate this concern, as does the admission from all three key informants that support staff receive no orientation or training. Female support staff were perceived to be at higher risk of exposure to workplace violence at the hands of MSPs.

All three key informants validated the information obtained from the participants, reporting that support staff were vulnerable and that the support workers working in the wards were at high risk of being threatened or harassed by MSPs. They also acknowledged that there were no policies or procedures in place to protect the support workers. According to South Africa's Occupational Health and Safety Act no 85 of 1993, section 8(1) it is the duty of the employer to provide, as far as possible, a work environment that is safe and without risk to the health of its employees. Failure to do so poses a risk to employees and presents a liability to employers.

The incident register provided during the course of this research project only reflects instances of physical assault of clinical staff by MSPs. This appears to corroborate Samuel's (a key informant) suggestion that "minor" incidents such as verbal abuse or verbal threats are not generally reported, as well as the perception that violent acts and threats of violence are generally directed at clinical staff. However, this is at odds with the participant feedback obtained, and raises an interesting question as to why this is the case. It is possible that inadequate training and orientation results in support staff who do not report incidents properly. It is also possible that lack of supervisory and management support results in improper reporting of incidents involving support staff. As incident-reporting procedures and policies were not the focus of this research project, it would serve no purpose to speculate on the discrepancies highlighted. However, these discrepancies appear to validate the notion that support staff operate in a vacuum where they have no or limited access to training and support despite being exposed to potentially dangerous MSPs.

It is also noted that five of the incidents recorded in the incident register occurred in an MSP ward, thus validating the perception that these patients pose a particular risk to staff safety.

Objective 2: To describe the effect potential workplace violence has on the functioning/wellbeing of the support staff.

The participants indicated that a lack of training and knowledge about psychiatric conditions, restraining and calming techniques and the lack of financial incentives for dangerous work contributed to their experience of not being protected from potential workplace violence in the facility. They indicated that this was exacerbated by the lack of support from their supervisors and management, unclear communication channels in the facility and a lack of a functional and operational employee wellness programme or occupational health and safety initiatives to ensure employee wellbeing. Having been exposed to direct incidents of violence, direct threats and vicarious trauma, without receiving any follow-up intervention or support, while being ignored at ward level by nursing staff when they try to report such matters, may further contribute to their feelings of being marginalised.

The participants who had been employed for a longer period (more than ten years) indicated experiences of both direct threats and vicarious threats from the MSPs. Therefore, it can be suggested that the longer an individual is exposed to MSPs, the more incidents they will be exposed to. This appears to be in line with international research on the subject (Akanni et al., 2019).

It was also indicated that participants were fearful of losing their jobs, should they be forced to act when an MSP attacks them. As participants did not have the skills to deal with such a situation, and were of the view that they had no reassurance of protection by management, they felt particularly vulnerable and exploited.

It was established that the key informants were not fully aware of the workplace violence to which support staff were subjected, and were somewhat ignorant of the impact this has on the support workers. Some of the key informants denied that there were direct workplace violence incidents involving support staff, naming inappropriate touching specifically, as they did not receive such reports. This contrasted with the participants saying that they tried to report such incidents, but that it did not go further than ward level. The key informants seemed only to be aware of incidents where the MSPs were verbally abusive and hurled profanity at the support staff members, which seemed to be regarded as the norm. It is

significant to note that the participants did not feel supported or heard by the management of this facility.

Objective 3: To obtain suggestions from support staff about how to manage the perceived threat of workplace violence.

The main finding was that the current security measures were inadequate and needed to be improved in order to ensure the safety of the staff members. Suggestions included: more burglar gates, more burglar proofing and more security guards. This suggests a distinct lack of such security features in the facility. Another significant revelation was the pronounced need and desire for participants to be included in training and education in terms of dealing with the MSPs, and to receive orientation about the different wards, prior to being deployed to such wards. This was triangulated with the key informants, who acknowledged the lack of appropriate security features, and conceded that support staff were not provided with training and education about mental illness, the profile of the MSPs, or restraining training.

Being excluded from training opportunities and orientation are factors which will further contribute towards the support workers feeling marginalised in the facility.

Other important suggestions included practical and feasible solutions, for instance, to move the MSPs out of the area in which a support worker must work, this was confirmed as something that should happen at ward level, by one of the key informants.

Participants also reported that approaching MSPs in a respectful manner, and occupying MSPs with activities, generally presented fewer incidents of threatening behaviour or incidents of violence. It was significant to note that the participants who had been working at the facility for a shorter period of time, and who had not experienced direct incidents of violence by the MSPs, were also the ones who indicated that treating MSPs in a respectful way had more positive outcomes. It could be suggested that support staff who had been working at the facility for a longer period, would have been exposed to more violent incidents without any support or intervention, and that this may have caused them to avoid contact with MSPs or to abandon efforts to alleviate the tension, such as treating MSPs in a respectful manner. This was not a point of focus in the current project, but could perhaps be explored in future research.

5.3 CONCLUSIONS DRAWN FROM RESEARCH STUDY

The qualitative research findings of this study indicated that more than half of the support workers of the facility who participated in the study experienced fear when having direct contact with the MSPs, and were hypervigilant on a daily basis, when working in close range to the MSPs. The participants who did not feel threatened worked in the safety of their offices and had brief contact with the stable MSPs. It was, however, indicated by almost all of the participants that the environment of the facility in general was not safe and that the MSPs were generally regarded as dangerous. Female staff appear to be at higher risk of experiencing workplace violence at the hands of MSPs in this facility.

There is a definite need for appropriate training, education and orientation of support staff. While management seemed to be aware of this need, no immediate efforts to address this were reported. The constraints reported were lack of budget and the absence of formal requests for training. Arguably, this suggests that the facility is ignorant of the safety experiences of support staff working in or around wards. Key informants reported that there were no reported incidents of MSP violence against support staff. However, the participants provided examples of traumatic incidents, and provided examples of how their complaints would either be ignored, minimised or stopped at ward level. As such matters were never escalated, management might be unaware of these incidents and the safety risks support workers experienced in the wards, which presents a communication challenge to the facility.

As an academic training institution, the psychiatric inpatient facility has the means to provide training, education and orientation to the support staff, but the initiative for this must be taken by senior staff members. The data analysis revealed that the occupational health and safety and general wellbeing of the participants appears to have been neglected. Support staff appear to have been marginalised and do not appear to have a voice or adequate representation in this regard. More than half of the participants felt exposed and fearful on a daily basis in their current work situation. The researcher observed that some participants felt that compensation for dangerous work, for example, a danger allowance, might assist them in feeling more supported or acknowledged in terms of the risk they were also exposed to, as they indicated that clinical staff members received such compensation, despite often not spending as much time in the presence of the MSPs as they do.

The lack of a proper and functional employee wellness programme in the facility was evident. The participants appeared to be unaware of any employee wellness initiatives. Not having access to any resources that would assist them with their experiences of direct incidents of violence from the MSPs, and vicarious trauma, contributed to their perception that their work environment was unsafe and that they were predisposed to potential violence from MSPs.

5.4 RECOMMENDATIONS

5.4.1 Recommendations for support workers

Support staff should be allowed representation at relevant management levels in order to campaign for adequate support and raise issues or concerns regarding their safety conditions at work. Through these formal structures it is hoped that support staff would have a platform and the representation to advocate for orientation, training and education. Another recommendation would be that all support workers familiarise themselves with the complaint and grievance procedures of the organisation they work for, in order to report and escalate incidents of workplace violence.

5.4.2 Recommendations for the occupational social work profession

The role of an OSW in any workplace is to make the organisation aware of their obligation to comply with the regulations of the occupational health and safety act, in terms of ensuring the safety of all workers. A focus on workplace safety policies and procedures for female staff members should be part of workplace interventions, according to van Breda (2012). As it is evident from the findings of this research study, female staff members in this facility appear to be at greater risk and they feel unsafe in this work setting. Advocating on behalf of female staff is within the scope of the OSW profession.

As a contribution to the OSW profession, the following framework, Figure 3, was developed not only from the results of this study, but by extensive reading on the subject and praxis. The proposed framework outlines relevant key elements and directs the OSW involvement required to achieve stated objectives. It is therefore recommended that the proposed OSW Framework to ensure Employee Wellness and Safety in Safety-Sensitive Environments be implemented at other sensitive safety organisations, as a guideline to ensure legal compliance and the wellness and safety of employees.

Further explanation of this framework as a contribution of the study and to the field of OSW follows below the figure.

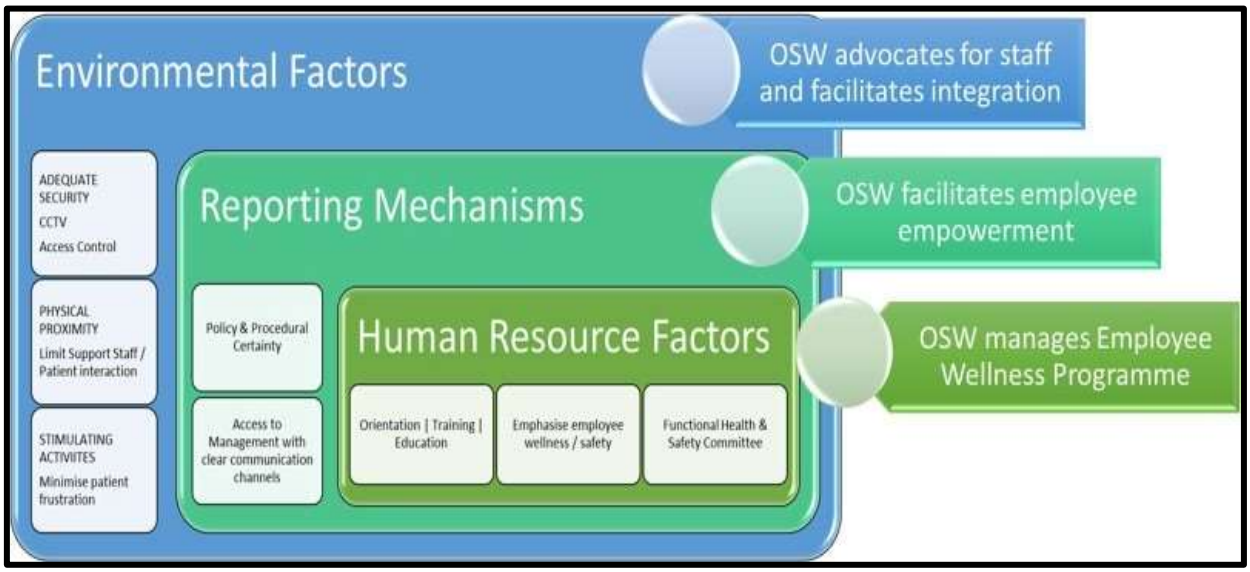

Figure 3: OSW Framework to ensure Employee Wellness and Safety in Safety-Sensitive Environments (Grobler, 2019)

As an integral element of human resource factors at play within an organisation, the OSW should assume responsibility for managing existing employee wellness programmes, ensuring that employees receive adequate orientation, training and education regarding the typical client or patient profile. In instances where such programmes have not yet been established, an OSW should act as change agent in order to facilitate the establishment of such programmes. Similarly, an OSW should garner support from within organisational human resource departments for functional and supportive services and/or counselling in order to address situations where violent incidents occur at work. The OSW would be ideally positioned to facilitate adequate representation of all categories of staff in a health and safety committee of an organisation and facilitate workshops about safety procedures and preventative measures. The OSW should also insist on legal compliance insofar as the work environment and the safety of employees is concerned.

As a functional member within an organisation's established reporting mechanisms, the OSW should empower employees in terms of relevant policy and procedural guidelines and facilitate open communication between employees and management. As was the case during this particular research study, organisations are likely to have employees who are unfamiliar with, or oblivious to internal procedures and mechanisms designed to facilitate efficient

reporting and redress. An astute OSW would traverse any potential gaps in communication and ensure appropriate vertical and horizontal organisational integration of all mechanisms aimed at resolving disputes or addressing work-related incidents.

Finally, when considering the impact of environmental factors, the OSW should advocate on behalf of employees to ensure that the environments they work in have adequate security features, such as security gates and CCTV cameras. Feedback obtained during this research study suggested that minor changes, such as the removal of patients from areas where employees are required to execute their duties could mitigate against potential aggression and violence. Similarly, it transpired that occupational therapy departments and other multi-disciplinary team members would potentially be able to create meaningful, stimulating activities to occupy the patients and minimise adverse incidents. Considering the purpose of OSW within the scope of employee and organisational wellness, an OSW would act as liaison and employee representative within different organisational structures to provide objectivity and holistic appreciation for the impact of various environmental factors.

5.4.3 Recommendations to the organisation

The recommendations to the organisation are the following:

To employ a health and safety officer and to establish a functional health and safety committee, with representatives from all the different departments. This representative committee should be tasked with ensuring a healthy and safe work environment for all the staff members. The employee wellness department to become actively involved to assist the support workers, for example training, education, counselling and support groups for affected staff members. As the psychiatric inpatient facility does not have an OSW, it would be a recommendation that they should employ one. To implement a functional and comprehensive incident reporting system, which will be monitored. To provide training to the support staff about the reporting of incidents procedure. To allocate a budget for the improvement of infrastructure, particularly insofar as access control mechanisms and security barriers are concerned.

5.4.4 Recommendations to the Department of Health

The following are recommendations to the Department of Health: to introduce a formal and compulsory training programme about workplace violence and preventative measures, for all staff members. To consider introducing a danger allowance for all staff members coming

into direct contact with MSPs on a daily basis. The construction and building of better recreational spaces for MSPs, which would allow support workers to execute their duties without disturbance and minimise unnecessary interaction with potentially dangerous MSPs.

5.4.5 Recommendations for further research

A research study to be conducted with a larger sample, which include more support workers, as well as, other health workers coming into direct contact with MSPs on a daily basis.

5.5 LIMITATIONS OF THE STUDY

The researcher had to make assumptions based on the responses of health care workers in other research studies as limited research on the experiences of support workers in psychiatric facilities was available. The psychiatric inpatient facility does not have a dedicated Occupational Health and Safety Officer. As such, obtaining specific data regarding incidents and reports was particularly difficult. If data could have been obtained from such an informant, it could have provided greater insight regarding the reality and extent of violent or threatening MSP behaviour at the facility. The researcher did not get the impression that the participants struggled to express themselves, but the obstacle of a potential language barrier remained present, as the participants did not express themselves in their mother-tongue during interviews. It is possible that even richer data could have been obtained if participants had been able to express themselves in their own languages.

5.6 CONCLUSION

The research question and objectives of the research study were answered and achieved. The research findings shed significant light on the predicament of support workers who work in close contact to MSPs in this psychiatric inpatient facility. The need for greater training and consideration of environmental factors to improve safety should be a concern in any organisation, but this is especially true in a psychiatric facility. Thus, from a social justice perspective, the needs of support staff should be heard.

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APPENDIX A

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

PARTICIPANT INFORMATION SHEET:

"EXPLORING THE PERCEIVED THREATS OF VIOLENCE FROM MALE STATE PATIENTS AGAINST SUPPORT STAFF IN A PSYCHIATRIC INPATIENT FACILITY".

Good day,

My name is Christel Grobler and I am a post graduate student registered for the degree MA in Occupational Social Work at the University of the Witwatersrand. As part of the requirement for the degree, I am conducting research about the perceptions of the support staff of the hospital about the perceived threat of violence from male state patients. I hope that the information obtained will assist in gaining a better understanding of the perceptions and experiences of support staff specifically.

As a support staff member at this hospital, and being exposed to male state patients on a daily basis in your work environment, you are an ideal candidate to participate in this study. I therefore wish to invite you to participate in my study. If you accept the invitation, your participation will be entirely voluntary and you are free to withdraw at any time, without any penalty. There are no consequences or personal benefits of participating in this study. If you agree to take part, I will arrange to interview you at a time and place that is suitable for you. The interview will last approximately twenty minutes. If you choose to participate, you may withdraw from the study at any time, and you may also refuse to answer any questions that you feel uncomfortable with answering. If you decide to participate, I will ask your permission to tape-record the interview. No-one other than the researcher and supervisor at the university will have access to the recordings. The recording will be kept in a locked cabinet for two years following any publications or for six years if no publications emanate from the study. A copy of your interview transcript without any identifying

information will be stored permanently in a locked cupboard and may be used for future research.

Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report. The results of the research may also be used for academic purposes (including books, journals and conference proceedings) and a summary of findings will be made available to participants on request.

Please contact me on (011)951 8325 or christel.grobler@gauteng.gov.za, or my supervisor, Dr. R. Pillay (011) 717 4472 or Roshini.Pillay@wits.ac.za if you have any questions regarding my study. We shall answer them to the best of our ability. If you have any concerns or complaints about the study, please contact Human Research Ethics Committed (Non-Medical) Contact Details: Chairperson: Jasper.Knight@wits.ac.za or the administrator: Ms. Shaun Schoeman, tel (011) 717 1408, Shaun.Schoeman@wits.ac.za.

Thank you for taking the time to consider participating in the study.

Yours sincerely

Christel Grobler

APPENDIX B:

CONSENT FORM FOR PARTICIPATION IN THE STUDY AND CONSENT TO AUDIO RECORDING OF THE INTERVIEW

"EXPLORING THE PERCEIVED THREATS OF VIOLENCE FROM MALE STATE PATIENTS AGAINST SUPPORT STAFF IN A PSYCHIATRIC INPATIENT FACILITY".

I hereby consent to participate in the above research study. The purpose and procedures of the study have been explained to me. I further consent to this interview being recorded.

I understand that:

- My participation in this study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer any specific question asked if I do not wish to do so.
- There are no foreseeable benefits or particular risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me, will be removed from the interview transcript.
- A copy of my interview transcript without any identifying information will be stored permanently in a locked cupboard and may be used for future research.
- I understand that my responses will be used in the write up of a Master's Degree Project and may also be presented in conferences, book chapters, journal articles or books.

I further understand that:

- The recording will be stored in a secure location (a locked cupboard or password-protected computer) with access restricted to the researcher and research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When the data analysis and write-up of the research study is complete, the audio-recording of the interview will be kept for two years following any publications or for six years if no publications emanate from the study.

- The transcript with all identifying information directly linked to me removed, will be stored permanently and may be used for future research.
- Direct quotes from my interview, without any information that could identify me may be cited in the research report or any other write-ups of the research.

Name of Participant: _____

Date: _____

Signature: _____

APPENDIX C

RESEARCH STUDY: "Exploring the perceived threats of violence from male state patients against support staff in a psychiatric inpatient facility:

Interview guide for the participants of the study:

Demographic details:

Age: ___

Gender:____

Highest qualification obtained:

Home language:

Length of service at the hospital:

Employed in which section of the hospital?

Frequency during working hours of meeting male patients?

1. Describe your type of work at the hospital.
2. Describe the type of contact you have with the male state patients.
3. How do you view the male state patients, your feelings about them? (Researcher to probe if participant feel unsafe around these patients, and if they view them as dangerous)
4. Have you ever observed these patients threatening or harming a staff member in any way? Yes or no, if yes, describe in detail.
5. Have you ever been involved in any incidents where any of the patients threatened you, or harmed you in any way? Yes or no, if yes, describe in detail.
6. How do you feel about the safety conditions at the hospital?
7. If you were the CEO of the hospital, what measures will you put in place to make your workplace safer, or non-threatening?

APPENDIX D

RESEARCH STUDY: "Exploring the perceived threats of violence from male state patients against support staff in a psychiatric inpatient facility:

Interview guide for the key informants of the study:

Age:

Gender:

Highest qualification obtained:

Home language:

Length of service at hospital?

For how long have you been in a managerial position?

1. Explore if they think that support staff are more vulnerable, being exposed to male state patients, without having the proper training on how to deal with them?
2. What type of complaints or incidents do support staff report to management, with regards to their contact and exposure to the state patients?
3. Is there a workplace policy in place to protect support staff against threatening patients? Yes or no, if no, what is the reason?
4. Is there a budget for training of support staff? If so, is this budget sufficient?
5. What your feelings about including support staff in workshops regarding personal safety in the workplace?
6. Can you describe what procedures are followed when a patient assaults a member of the support staff?
7. If you were the CEO of the facility, what types of suggestions will you make to improve this situation?

APPENDIX E

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

STERKFONTEIN HOSPITAL
CLINICAL DEPARTMENT
Enquiries: *ProF. U. Subramaney*
Telephone : *(011)951-8341*
Facsimile : *(011) 951-8391*
e-Mail: Hannie.Smith@gauteng.gov.za

Mr. M.J. Mapunya
Chief Executive Officer
Sterkfontein Hospital
KRUGERSDORP

Dear Mr. Mapunya

STUDY : EXPLORING THE PERCEIVED THREATS OF VIOLENCE FROM MALE STATE PATIENT AGAINST SUPPORT STAFF IN A PSYCHIATRIC INPTIENT FACILITY IN GAUTENG, SOUTH AFRICA
RESEARCHER: MS. CRISTEL GROBLER

The above study was discussed at the Research Committee meeting. We recommend that permission be granted that Sterkfontein Hospital be used as a site for the above research.

However, since this is a research project involving voluntary participation, we cannot guarantee participation of individuals/staff members.

Kindly specify who the key informants in your study would be.

Please include in your protocol a distress procedure "i.e. should there be any negative distressed perceived by subjects being interviewed, what cause of action will be taken.

Upon completion of the study, a copy thereof should be submitted to Sterkfontein Hospital

Thank you.

.....
PROF. U. SUBRAMANEY
CHAIRPERSON: RESEARCH COMMITTEE
11/09/2018

Approved.

Mr M.J. Mapunya Dour Edu & Admin (UP)
MEDICAL UNIVERSITY
CHIEF EXECUTIVE OFFICER

.....
MR. M.J. MAPUNYA
CHIEF EXECUTIVE OFFICER
2018/09/11

APPENDIX F

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

[redacted] PERSONNEL SAFETY INCIDENTS

AUGUST 2018 - AUGUST 2019

- **August 2018: Ward 16**

  Type of incident: Physical Assault (Staff pushed by patient and later verbally threatened to kill the staff member)

- **August 2018: Ward 16**

  Type of incident: Physical Assault (two patients hit a PN by two padlocks)

- **September 2018: Ward 16**

  Type of incident: Physical Assault (Patient slept a doctor on the face)

- **September 2018: Ward 08**

  Type of incident: Physical Assault (Patient punched Staff on the left jaw)

- **September 2018: Ward 02**

  Type of incident: Physical Assault (Staff bit by patient on the right upper arm)

- **April 2019: Ward 16**

  Type of incident: Physical Assault (Staff punched by patient)

- **April 2019: Ward 16**

  Type of incident: Physical Assault (Patient punched staff by a fist.

HOSPITAAL
[redacted]
2019 -10- 18
PRIVATE BAG X2010, [redacted] 1740
HOSPITAL

APPENDIX G

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

DEPARTMENTAL HUMAN RESEARCH ETHICS COMMITTEE (SOCIAL WORK) CLEARANCE CERTIFICATE

PROTOCOL NUMBER: SW/18/09/51

PROJECT TITLE: Exploring the perceived threats of violence from male state patients against support staff in a psychiatric inpatient facility in Gauteng, South Africa.

RESEARCHER/S: C Grobler (1963562)

SCHOOL/DEPARTMENT: SHCD Social Work

DATE CONSIDERED: 13 September 2018

DECISION OF THE COMMITTEE: Approved

EXPIRY DATE: 30 November 2019

DATE: 28 November 2018

CHAIRPERSON: Dr E Pretorius

Cc: Supervisor: Dr R Pillay

DECLARATION OF RESEARCHER(S)

To be completed in **DUPLICATE** and **ONE COPY** returned to the Administrative Assistant, Room 8, Department of Social Work, Umthombo Building Basement.

I/We fully understand the conditions under which I am/we are authorised to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the committee. **For Masters and PhD an annual progress report is required.**

SIGNATURE

30 / 11 / 2018
DATE

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX H

1963562:Turnitin_Feb_2020.docx

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APPENDIX I

Editor's Declaration

This is to certify that I have edited the Master's research report of Christel Grobler, student number: 1963562. The report, entitled *Exploring the Perceived Threats of Violence from Male State Patients Against Support Staff in a Psychiatric Inpatient Facility in Gauteng, South Africa* is submitted to the University of the Witwatersrand in partial fulfilment of the Master of Arts in Social Work by coursework.

I completed an edit for language and expression. This included editing for correct grammar, vocabulary, punctuation and spelling. I also edited for clarity, fluency and accuracy of expression.

My qualifications are: a PhD in language and literature (Wits, 2002). I taught for 19 years in the English Department at the University of the Witwatersrand teaching at all levels and supervising post-graduate theses and dissertations and co-taught courses in the Department of Applied Linguistics. I co-authored the books *Read Well* and *Write Well.*

Dr J D Stacey



Date: 14th March 2020