



ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES, DEPARTMENT OF PSYCHIATRY

PREVALENCE, FORMS AND CONSEQUENCE OF VIOLENCE
AGAINST HEALTH PROFESSIONALS IN AMANUEL MENTAL
SPECIALIZED HOSPITAL, ADDIS ABABA, ETHIOPIA 2017

A Partial Fulfillment of the Postgraduate Program in Psychiatry

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ABSTRACT

BACKGROUND

Workplace violence (WPV) is defined as physically and psychologically damaging actions that professionals face in the workplace or while on duty. Violent behavior caused by people with mental illness regularly leads to involuntarily admission to a psychiatric ward, to avoid the risk of serious harm to others. However, this risk may remain during hospitalization, resulting in violent incidents in clinical practice. Revealing the prevalence, nature and consequences of violence in psychiatry is a necessary step to instigate the development of useful interventions, policies and guidelines to protect mental health workers from violent incidents

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OBJECTIVE;

To describe the prevalence, forms and consequences of violence against health professionals in Amanuel specialized mental hospital, Addis Ababa

METHODS;

A hospital based descriptive survey done in AMSH among professionals using a questionnaire developed from the research instrument for workplace violence in the health sector by ILO/ICN/WHO/PSI, adopted in a way suitable for this study and translated into Amharic. The data sheets were coded and data entry, cleaning and analysis was done using the Statistical Package for the Social Sciences (SPSS) version 20, bivariate and Multivariate logistic regression was done to see sociodemographic determinants of workplace violence.

RESULT

One hundred eighty one participants were involved in this study among whom 95(52.8%) were females and majority 80 (44.4%) of the participants were 25-29 years of age 108 (59.7%) has less than 5 years of work experience. Around 30% were clinical nurses and 4(2.2%) psychiatrists. Over two third of participants 140 (77.3%) had been victim of one form of violence or another in their workplace. The risk of being a victim is not associated with any of the socio-demographic characteristics. Most of the victims of workplace violence, 112(80%), have experienced verbal violence

CONCLUSION;

This study makes clear that the amount of violence with which health professionals have to cope is a substantial and sever problem. To develop effective strategies of violent event management it is important to favor incident reporting by staff for all violent episodes, from verbal offenses or threats to dangerous physical attacks.

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ACRONYM

WPV.....Workplace Violence

PVPhysical Violence

ILO..... International Labor Organization

WHOWorld Health Organization

ICNInternational Counsel of Nurses

PSI..... Public Service International

PTSD.....Post-Traumatic Stress Disorder

BLS.....Bureau of Labor and Statistics

MHWMental Health Workers

ASMH.....Amanuel Specialized Mental Hospital

CORCrude Odds Ratio

AOR.....Adjusted Odds Ratio

INTRODUCTION

Violence is defined as being destructive towards another person.¹ It is expressed in the form of physical assault, homicide, verbal abuse, sexual harassment and threat. Violence is an increasing phenomenon in many areas of social life and workplace violence (WPV) is often considered to be just a reflection of the more general risk in the society, which has to be dealt with at the level of the whole society.¹

WPV is defined as physically and psychologically damaging actions that professionals face in the workplace or while on duty.² WPV affects the dignity of millions of people worldwide. Violence, aggression, and harassment exist in almost all workplaces and this affects the individual's health, productivity due to reduced morale and motivation³ and quality of care and treatment which in turn cause longer periods of absenteeism and deteriorate the work climate⁴ and it is a major source of inequality, discrimination, stigmatization and conflict at the workplace.

Examples of WPV include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide, which involve an explicit or implicit challenge to safety, well-being or health of professionals.⁵ Only in recent years, physical or psychological WPV, for long a "forgotten" issue, has become an emerging problem in different work settings and among professional staff of both industrialized and developing countries.⁶ and increasingly it is becoming a central human rights issue.

Violence is common in the health sector workers who have direct contact with people in distress, which made it to be considered an inevitable part of the job.¹ Patients are usually under stress and in pain or are financially handicapped and so they transfer their aggression to health workers. Patients and clients themselves may have personality and behavioral issues such as alcoholism and drug abuse while some hospital members of staff have poor attitude and approach in relating with patients.⁷ Violence against health care workers is currently a subject of concern in clinical practice as well as in politics and society.

This study will focus on a specific group of health care professionals, mental health care workers where violence is often seen as part of the job.⁸ Violent behavior caused by people with mental illness regularly leads to involuntarily admission to a psychiatric ward, to avoid the risk of serious harm to others. However, this risk may remain during hospitalization, resulting in

violent incidents in clinical practice. As a result, violence committed inside inpatient facilities against mental health professionals has received little attention outside the field.

Although only a relatively small group of people with mental health problems seems to be violent, research shows that some subgroups have a greater tendency towards violence when compared with the general population. For example, people suffering from schizophrenia appear to have about four to five times higher propensity for violence⁹, especially when they experience specific positive psychotic symptoms.¹⁰ Moreover, for patients with schizophrenia, the risk of becoming violent increases substantially in comorbidity with substance abuse¹¹ and/or (antisocial) personality disorders. Also a history of violent behavior and a long stay in an inpatient clinic are factors that are associated with an elevated risk of inpatient assaults.¹²

Besides concern about the human right of health workers to have a decent work environment, there is concern about the consequences of violence at work. Violence has a significant impact on the effectiveness of health systems, particularly in developing countries.

The negative consequences of WPV impact heavily on the delivery of health care services, which could include deterioration in the quality of care provided and the decision by health workers to leave the health care professions. This in turn can result in a reduction in health services available to the general population, and an increase in health costs.

In developing countries the equal access of people to primary health care is endangered if a scarce human resource, the health workers, feel under threat in work situations where transport to work, shift work and other health sector specific conditions make them particularly vulnerable to violence. Besides the negative consequences for the victims, violent incidents also affect their colleagues, employers and other patients.

There is, however, a shortage of research on violence by individuals with mental illness from Africa, even though Africa carries 25% of the world's disease burden, with only 3% of the world's health workforce and 1% of the world's economic resources to meet these challenges.¹³ Sub-Saharan Africa, including Ethiopia with fewer than one psychiatrist per million population, also suffers from a severe shortage of mental health personnel.

Revealing the prevalence, nature and consequences of violence in psychiatry is a necessary step to instigate the development of useful interventions, policies and guidelines to protect mental health workers from violent incidents. Employers and workers are equally interested in the prevention of violence at the workplace. Society at large has a stake in

preventing violence spreading to working life and recognizing the potential of the workplace by removing such obstacles to productivity, development and peace.

It is therefore the aim of this study to examine the frequency, type and severity of violence and to investigate the consequences of such behavior toward health professionals in Amanuel Specialized Mental Hospital.

LITRATURE REVIEW

There are number of studies done on workplace violence, violence against medical professionals and violence against mental health professionals in different countries. Data presented by the United States Bureau of Labor Statistics (BLS) in 2003 indicate that out of 449 occupations, health care aides rated 2nd and nurses rated 10th for jobs with the most lost-time injuries. In the health care setting, mental health workers (MHWs) experience the majority of violent victimizations because of patient assaults. Mental health work placed 4th as a dangerous occupation, behind police officers, taxi drivers, and bartenders in a survey of nonfatal workplace violence.¹⁴ between 2011 and 2013, the Bureau of Labor Statistics (BLS) in the USA reported that workplace assaults ranged from 23,540 - 25,630 annually, from which more than 70 % of these were in healthcare and social service settings.

In addition, workplace violence in the medical occupations represented 10.2% of all workplace violence incidents.¹⁵

A cross-sectional study was done in Italian general hospital to assess workplace violence among various health professionals on more than 700 health care professionals in 2016 and revealed 45% of workplace violence. The study also showed that significantly higher violent episodes in psychiatric ward compared to other health units, and nurses and nursing assistants were the professions with the highest risk of being assaulted.

Frequently males were the assailants whereas assaulted professionals more often were females. Physical violence (49%) was most often perpetrated by assailants affected by dementia, drug and substance abuse, or other psychiatric disorders. Aggressive episodes were registered in all shifts, more frequently in patient's room (53%), at the moment of patient's interview (32%), and medical treatments and/or nursing care (26%).The majority of professionals (72%) were not able to forecast violent episodes and 73% developed psychological consequences from aggressions, but did not report the incident (84%).¹⁶

A study from Palestine on workplace violence against physicians and nurses in public hospital in 2011 with the aim to assess the incidence, magnitude, consequences and possible risk factors for workplace violence against nurses and physicians working in public hospitals on 240 physicians and nurses in five public hospitals showed majority (80.4%) of the respondents reported exposure to workplace violence. Of them, 20.8% reported exposure to physical violence, 59.6% reported non-physical violence that included 38.3% verbal abuse, and 1.7% sexual harassment. No statistical difference in exposure to violence between physicians and nurses was observed. Males significantly experienced higher exposure to physical violence in comparison with females. The assailants were mostly the patients' relatives or visitors, followed by the patients themselves.¹⁷

A relatively older study done at tertiary care center on 163 emergency department employees in Vancouver, Canada in 1996 revealed a total of 68% of participants reported an increased frequency of violence over time and 57% were physically assaulted. Overall, 48% reported impaired job performance for the rest of the shift or the rest of the week after an incident of violence, 73% were afraid of patients as a result of violence, almost half (49%) hid their identities from patients, and 74% had reduced job satisfaction. Over one-fourth of the respondents took days off because of violence. Some of the respondents reported that they had left the job at least partly owing to violence. Twenty-four-hour security and a workshop on violence prevention strategies were felt to be the most useful potential interventions. Physical exercise, sleep and the company of family and friends were the most frequent coping strategies.¹⁸

There are number of studies done in psychiatric hospitals to assess the risk of violence among mental health professionals. A study done on more than 1500 Dutch mental health professionals to examine the prevalence, nature and consequences of violence against mental health care professionals in 2013 showed that 67% of the respondents were victim of at least one physical violent incident in the past five years. The highest rates of victimization were found in general psychiatric hospitals about 68.6%. Some groups of professionals like male and younger respondents appear to have an increased risk of being victimized. Psychiatric nurses have increased risk of being victimized. Physical violence occurred in almost half of the incidents. The study also revealed almost one-third of the incidents resulted in physical injuries, with commonly reported physical injuries included bruises, whereas more severe physical injuries such as back or neck injuries, biting wounds, concussion and fractures or torn muscles were also

reported. For one-fifth of the incidents, the victims reported mental health problems including fear or panic, sleeplessness or reliving the experience (11%) as a result of the violent incident. Some victims (7%) reported they suffered from 'burn-out' due to the incident.¹⁹

Another cross-sectional study done in Germany on aggression and violence against health care workers in 2010, on 123 professionals in nursing homes and a psychiatric clinics showed only 5.7% of the participants did not encounter WPV but 70% of the respondents experienced physical and 89.4% verbal aggression. The Violence caused impairment in the physical (55%) and emotional well-being (77.2%) of the employees. Nursing staff are frequently exposed to physical aggression.²⁰The study also showed 60.3% of the respondents reported the incidents with aggressive behavior by patients to the superiors. Sexual harassment (20.7%) and racial statements (11.2%) occurred less frequently. Almost half (44.7%) experienced physical impairment as a consequence of aggression. This most commonly led to short term pain (60.0%). About 10% received medical treatment after an assault. Anger or rage, insecurity, self-doubt, and anxiety were reported by those who indicated emotional reactions. Around 62% of the respondents felt that the social support offered at work to cope with such situations was good. However, only 30.1% of the respondents felt that the preparation for such situations provided by the institution was good. Colleagues are the most important source of social support (83.6%).²⁰

A study done in 1986 among 270 psychiatrists in Oregon using a questionnaire concerning patients threats and assaults against psychiatrists revealed 61% of the responding psychiatrists indicated that they had been threatened by patients in ways that did not involve physical harm.²¹The study also showed 70% responding psychiatrists considered the threat of physical harm made against them to be serious but only half reported the threat to the authorities. The typical patient was a relatively young male with schizophrenia or a personality disorder who was being evaluated by a psychiatrist for the first time. An analysis of the most serious events revealed that in 54 percent both the patient and the psychiatrist were male. Half of the most serious events were direct physical attacks against the psychiatrists. Of the physical attacks, patients used a part of their body such as a hand or a foot in 72 %, some type of object such as a chair or an ashtray in 23 percent. Thirty-eight percent of the most serious assaults took place on a psychiatric ward, 33 percent in a psychiatrist's office, and 16 percent in an emergency room. The most frequent effect of the assault on their practice included being more alert and cautious around patients (33%), making sure that help was always readily available (20%), employing

more strict security policies and procedures in their clinical work (14%), and refusing to see potentially violent patients (6%). Thirty-five percent of the psychiatrists believed their most serious event did not have an effect on their practice.²¹

Another study done on prevalence and determinants of workplace violence of health care workers in a psychiatric hospital in Taiwan using a questionnaire to survey the one year prevalence rates of violence revealed about a quarter of the participants reported workplace violence during over one year with prevalence rate of physical violence being 35.1%, verbal abuse 50.9%, bullying 15.8%, sexual harassment 9.5% and racial harassment 4.5%.²²

The study done in a psychiatric hospital in Taiwan showed a weapon was used in 7.7% of physical violence and 46.2% resulted in a physical injury, of which 30.8% needed medical treatment. About 70% of such incidents occurred in the daytime. Fewer than 20% of the victims suffered from PTSD symptoms for all types of WPV. More than half the respondents considered these events to be preventable.²²

Another study from Taiwan in 2009 on incidence and risk factors of workplace violence on nursing staffs caring for chronic psychiatric patients revealed a total of 971 events were reported with incidence rates of 1.7 physical violence, 3.7 verbal abuse, and 0.3 sexual harassment per staff-year. Young age, female sex, lower education, shorter duration of employment, and high level of anxiety of staff seemed to be the determinants of violence.²³

A study done in US in 2015 to evaluate risk factors associated with patient aggression toward 284 nursing staff in psychiatric units found that 20% of psychiatric nurses were physically assaulted, 43% were threatened with physical assault, and 55% were verbally assaulted at least once during the equivalent of a single work week. The overall rate was 0.60 for verbal aggression incidents and 0.19 for physical aggression, per nurse per week. For physical incidents, the evening shift (3 pm – 11 pm) demonstrated a significantly higher rate of aggression than the day shift.²⁴

A multicenter study done on frequency and severity of aggressive incidents in 12 psychiatric hospitals' acute wards in Switzerland reported a total of 760 registered aggressive incidents. The incidence rates found per 100 treatment days were between 0.60 for physical attacks and 1.83 for all aggressive incidents (including purely verbal aggression). Over half (53%) of the aggressive incidents were followed by a coercive measure, mostly seclusion or seclusion accompanied by medication, Involuntary admission, longer length of stay, and a diagnosis of schizophrenia was

associated with a higher risk for aggressive incidents, but no such association was found for age and gender.²⁵

Another study was done in Germany to assess the prevalence of PTSD following patients assaults among staff members of mental health hospitals in 2006. A total of 46 assaulted staff members were reported by the nine hospitals, the majorities were nurses (70%). After the incident, seven of the 46 participants suffered from severe physical lesions (e.g. lack of consciousness, broken bones). At baseline it was revealed that 17% met criteria for PTSD diagnosis. At the two and six months follow-ups, the number of subjects with PTSD diagnosis had decreased from 6 to 3 (9%) and 4 (11%), respectively. One subject who did not have a PTSD diagnosis at baseline and 1st follow-up, but was severely re-assaulted afterwards, subsequently met criteria for the diagnosis at the 6th month follow-up.²⁶

Two separate studies from Nigeria revealed nurses were primary target for violence against health professionals. The survey conducted in 2009 to investigate physical assault against mental health professionals reported almost half, 49.5%, of the staffs had been physically assaulted by psychiatric patients and 88.2% had received medical attention following the incident. They didn't find significant difference between male and female professionals on the risk of being victim. The majority of assaults, 44.3%, occurred during routine in patient assessment and during routine admission of an outpatient.²⁷ The other study done in 2014 on prevalence and forms of violence against health care professionals showed verbal abuse as the commonest form of assault 64.6% followed by physical abuse 35.4%.²⁸

There are 2 separate studies done on prevalence of workplace violence in public health facilities in southern and northwest Ethiopia. The aim of the first study was to assess the prevalence and associated factors of workplace violence among nurses working at health care facilities in Hawassa City Administration, Southern Ethiopia. An institution-based cross-sectional study was conducted on 660 randomly selected nurses working at public health facilities in Hawassa City Administration in April 2014 revealed the prevalence of workplace violence being 29.9% of which physical violence accounted for 18.22%, verbal abuse for 89.58% and sexual harassment for 13.02%. Female sex, short work experience, age group of 22–35, work in emergency and work in the Inpatient Department were the factors positively associated with workplace violence. Nearly three quarters of them reported that they were worried about violence in their workplaces; and more than half (51.2%) reported that there were

no procedures for reporting violence incidents in their workplace. About forty five percent of the incidents were caused by patients and half of the physical violence happened on the evening shifts.²⁹

Another hospital based cross-sectional study was done to assess the prevalence of workplace violence and associated factors among 386 nurses in northwest Ethiopia within three public referral hospitals of Amhara regional state Ethiopia, University of Gondar Teaching and Referral Hospital, FelegeHiwot referral hospital, and Debreberhan referral hospital using self-administered questionnaire in 2015. The overall prevalence of workplace violence was 26.7% and 38.8% of the study participants were dissatisfied with the manner how the incident was handled. About 36.9% of them were in need of time off up to one week to recover from the insult. Majority 52.9% of the attackers faced no action from anyone for the unacceptable act.³⁰

OBJECTIVE

GENERAL OBJECTIVE

- To describe the prevalence, forms and consequences of violence against health professionals in ASMH, Addis Ababa

SPECIFIC OBJECTIVES

- To determine the prevalence of violence against health professionals in ASMH
- To compare the risk of violence among different health professions in ASMH
- To describe the consequences of violence on the health professionals working in ASMH
- To compare the prevalence of different forms of violence in ASMH

METHODS

STUDY DESIGN

This study is a hospital based cross-sectional descriptive survey to describe the prevalence, form and consequences of violence against health professionals.

STUDY SETTING

The study was conducted in ASMH which is the only psychiatric specialized hospital in Ethiopia with a capacity of 261 beds and with total number of 953 employees among which over 500 are clinical staffs including psychiatrists, general practitioners, MSC and BSC psychiatry professionals, clinical nurses and psychologists. The hospital gives the service in different case teams including outpatient, inpatient and 24 hours emergency psychiatry units.

STUDY POPULATION

There are 329 clinical staffs currently working in Amanuel specialized mental hospital, which includes 10 psychiatrists, 60 MSC psychiatry professionals, 14 BSC psychiatry professionals, 7 health officers, 16 BSC nurses, 192 diploma nurses, 2 anesthetist, and 28 psychologists.

SAMPLE SIZE

All 329 health professionals working in ASMH were targeted to participated in this study

INCLUSION AND EXCLUSION CRITERIA

INCLUSION CRITERIA

Mental health professionals who volunteer and give verbal consent to participate in study.

Professionals with at least 1 year of experience

Professionals who are available during the study period

Professionals who can read and answer questionnaire in Amharic

EXCLUSION CRITERIA

Professionals who decline to give consent

Professionals who can't read and answer the questionnaire in Amharic

DATA COLLECTION TOOL

We used a questionnaire for workplace violence in health sector. The questionnaire was developed from the research instrument for workplace violence in the health sector by ILO/ICN/WHO/PSI, adopted in a way suitable for this study and translated into Amharic. The questionnaire contains personal and workplace data, and about experience with violence in workplace. The questionnaire doesn't include name in order to keep the confidentiality of participants.

DATA COLLECTION

A self-administered questionnaire was distributed among the health professionals working in ASMH and who were willing to participate in the study during the data collection time, September 1, 2017 to September, 30 2017.

DATA ANALYSIS

The collected questionnaires was checked for completeness and filled on a data sheet. The data sheets coded and data entry, cleaning, recoding and analysis was done using Statistical Package for the Social Sciences (SPSS) version 20, bivariate and Multivariate logistic regression was done to see socio-demographic determinants of workplace violence.

Factors that were significantly associated with being attacked by male patients at bivariate analysis with $p < 0.05$ were entered into the multivariate linear logistic regression to avoid effect of confounding and determine predictors through controlling other independent predictors.

ETHICAL CONSIDERATION

The research was approved by the scientific committee of Department of Psychiatry, College of Health Sciences, Addis Ababa University, and ethics committee at ASMH prior to the commencement of the data collection. Study participants were informed about the purpose of the study and verbal consent was obtained from each participant. Names of professionals are not mentioned in the study to keep the confidentiality.

RESULT

SOCIODEMOGRAPHIC CHARACTERISTICS

One hundred eighty one participants were involved in this study among whom 95(52.8%) were females and 85(47.2%) were males. Majority, 80(44.4%), of the participants were 25-29 years of age and only 4(2.3%) were older than 50 years of age. See table 1 for detail of socio-demographic characteristics of participants.

VIOLENCE VICTIMIZATION

Nearly half of the respondents 88(48.8%) were always worried about workplace violence, 49(27.2%) were worried most of the time and only 2(1.1%) were never worried about violence in their workplace. Over two third of participants 140 (77.3%) had been victim of one form of violence or another in their workplace. Majority 111 (61.3%) do not know if there are any procedures to report workplace violence and only 19(10.5%) of the respondents knew about the procedures. We did not found significant difference between male and female professionals on the risk of being victim. The risk of being a victim is not associated with any of the socio-demographic characteristics. Majority 95(78.5%) of the responders thinks the incidents were not preventable. See table 2 and 3 for the details.

Table 1 socio-demographic characteristics

SOCIODEMOGRAPHIC	CATEGORY	NUMBER(N)	PERCENTAGE(%)
AGE	19-24	45	25%
	25-30	80	44.4
	30-35	39	21.7
	35-50	12	6.7
	>50	4	2.3
Sex	Female	95	52.8
	Male	85	47.2
Marital status	Single	108	61
	Married	68	38.4
Work experience	1-5	108	59.7
	6-10	49	27.1
	11-15	18	9.9
	>15	6	3.3
Current working unit	Emergency	24	13.6
	Outpatient	64	36.4
	Inpatient	72	40.9
Profession Mental health professionals	Psychiatrists	4	2.2
	MSC psychiatry professionals	21	11.6
	BSC psychiatry professionals	27	14.9
	Psychologists	16	8.8
Non mental health professionals	Health officers	16	8.8
	BSC nurses	32	17.7
	Clinical nurses	55	30.4
	OTHERS	10	5.5

Table 2 Violence victimization

Characteristics	category	Number (N)	Percentage(%)
Worried about Workplace violence	Always worried	88	48.8
	Most of the time	49	27.2
	Occasionally	19	10.6
	A little	22	12.2
	Never	2	1.1
Are there procedures To report WPV	Yes	19	10.5
	No	51	18.2
	Do not know	111	61.3
Ever been a victim of Violence in work place	Yes	140	77.3
	No	41	22.7
Was it preventable	Yes	26	21.5
	no	95	78.5

Table 3 socio-demographic determinants of being victim of violence

characteristics	category	COR 95% CI	AOR 95%CI	P value
age	19-24	Ref		
	25-29	0.9	0.87(0.27-2.7)	0.82
	30-34	0.21	1.6(0.23-11)	0.63
	>35	0.25	0.24(0.1-5.9)	0.38
Sex	Female	Ref		
	Male	0.89	0.78(0.31-2)	0.61
Marital status	Married	Ref		
	single	0.27	0.37(0.1-1.2)	0,1
Profession	Non mental health professionals	Ref		
	Mental health professionals	0.71	0.4(0.16-1.33)	0.15
Work experience	1-6	Ref		
	6-10	1.7	2.4(0.6-9.8)	0.2
	>11	4.2	6.6(0.3-13.2)	0.21
Night work	Yes	Ref		
	no	0.9	0.4(0.12-1.5)	0.2

FORMS OF VIOLENCE

Most of the victims of workplace violence, 112(80%), have experienced verbal violence. Majority, 109 (77.9%), also had been a victim of physical violence without weapon, and they were attacked by male patients compared to females ($p=0.03$ OR=5.695%CI (1.7-14.7)). There are also reports of physical violence with weapon 7(5%) and sexual violence reported less frequently 5%(3.6%). Almost all 139 (99.3%) of the respondents were assaulted by patients/clients. See table 4 for forms of violence.

Forty four (24.6%) of the respondents were assaulted by both male and female patients. Males were the cause of the violence incidents in 101 (73.2%) of the responders and females contributing for 81 (58.7%) of the incidents. Male professionals were victims of violence predominantly from males($x^2= 12$; $p<0.01$) and female professionals were commonly attacked by female patients($x^2= 13$; $p<0.01$). Table 5 shows factors related with being attacked by male on multivariate analysis.

Table4 forms of violence

Forms of violence	N	%
Physical violence with weapon	7	5
Physical violence without weapon	109	77.9
Pushing	64	45.7
Spiting	46	32.9
Slapping	45	32.1
Kicking	35	25
Pinching/scratching	30	21.4
Punching	22	15.7
Biting	11	7.5
Verbal violence	112	80
Sexual violence	5	3.6
Combined physical and verbal violence	83	59.3
Who assaulted		
Patient/client	139	99.3
Relatives of patients	9	6.4
Male patients	101	73.2
Female patients	81	58.7
Both sex	44	24.6

Table 5 factors associated with being attacked by male

Variables	No n(%)	Yes n(%)	Statistics
Sex			P=0.03 OR=5 *
male	8(12.3)	57(87.7)	95%CI(1.7-14.7)
female	29(40.3)	43(59.7)	
Profession			X ² =2.6; p=0.102
mental health	18(36)	32(64)	
non mental health	19(21.6)	69(78.4)	
Marital status			X ² =1.17; p=0.2
single	17(22.4)	40(67.8)	
married	19(32.2)	59(77.6)	
Work at night			X ² =1.1; p=0.29
yes	31(29.5)	74(70.5)	
no	6(18.2)	27(81.8)	
Work experience			X ² =3.4; p=0.179
1-5years	18(23.4)	59(76.6)	
6-10 years	15(37.5)	25(62.5)	
11-15years	4(19)	17(81)	
Physical violence without weapon			P=0.03 OR=5.6*
yes	19(17.8)	88(82.2)	95%CI(1.8-17.4)
no	18(58.1)	13(41.9)	
• P<0.05 statistically significant			

Nearly half of 71(50.7%) the violence incidents occurred in the patients room, 53(37.9%) of the incidents occurred in the examination room, 51(36.4%) occurred in the compound and the corridors or stairs also were the place for 22 (15.7%) of the incidents.

Most of the incidents occurred during working days 107(76.4%) and regular working hours 96(69.1%). There was no any preceding event prior to the 51(36.4%) of the incidents, while 45(32.1%) of the violence were preceded by physical care or examination and conversation 28(20%) and patients made demands 26(18.6%) were also reported as events preceding the violence incidents. Table 6 shows settings of the violence incidents

Table 6 violence setting

Time and place of violence	N	%
where		
Patients room	71	50.7
In examination room	53	37.9
In the compound	51	36.4
Corridor/stairs	22	15.7
when		
Regular working hours	96	69.1
During duty hours	50	36
Working days	107	76.4
Weekends	23	16.4
While working in emergency	25	18
While working in outpatient	40	28.8
While working In inpatient	85	61.2
Preceding event prior to the incident		
No preceding event	51	36.4
Physical care/examination	45	32.1
Conversation	28	20
Patient made demands	26	18.6

RESPONSE

Nearly one third, 45(32.1%), of the victims took no action, and 25(17.9%) pretend it never happened after the violence incidents and 42(30%) tried to defend themselves physically.

Colleagues and family/friends were source of support for 45(32.1%), 17(12.1%) of the responders told friends/family. There was no report of transfer to another position, persecution or compensation claim. Only 20(11%) report to hospital authorities. See table7 for responses of victims to violence incidents

Table 7 Response of victims to the violence incidents

characteristics	Number(N)	Percentage(%)
Took no action	45	32.1
Told a colleague	45	32.1
Tried to defend physically	42	30
Told the person to stop	40	28.6
Pretend it never happened	25	17.9
Report to hospital authorities	20	11
Told friends/families	17	12.1
Sought counseling	1	0.7
Transferred to another position	0	0
Pursued persecution	0	0
Completed a compensation claim	0	0

COSEQUENCES FOR THE VICTIMS

As table 8 shows nearly half 69 (49.6%) of the incidents result in fear and physical injury was reported by 32(23%) responders. Anxiety 31(22.3%), humiliation 30(21.6%), anger 29(20.9%), helplessness 28(20.3%) and guilt 2(1.4%) were also reported by the responders. Six(4.3%) reported no reaction as a result of the violence. Thirty two (23%) reported injuries following the incident and half (16) required treatment for the injury. among the professionals who were victim of violence only 12 (8.6%) needed a time off and nearly half (n=5, 45.5%) took just a day off and only 2(1.4%) took more than a week.

TABLE 8 results of violence

characteristics	Number (n)	Percentage(%)
Physical injury	32	23
Fear	69	49.6
Anxiety	31	22.3
Humiliation	30	21.6
Anger	29	20.9
Helplessness	28	20.3
Guilt	2	1.4
No reaction	6	4.3

Majority 111(81%) knows there was no action to investigate the violence incident and only 11 (8%) says there was an investigation about the incidents. Among these majority 7(70%) donot know the measures taken on the attacker. Majority 96(69.1%) of the victims were not offered counseling and only 7 (5.9%) were offered opportunities to report. Majority of the professionals 122 (89.1%) were not satisfied at all by the measures taken. Most of the Investigation was done by the hospital authorities was 80%.

Nearly half of the professionals 64(45.1%) reported there are no existing measures to deal with workplace violence in the hospital. There are also reported measures available in the hospital, increasing number of staffs and security measures eg guards exists in the hospital. Majority of the professionals considered low number of professional, lack of training and absence of problem solving committee as contributing factors for workplace violence in the hospital. patients illness and psychopathology, environmental and surrounding factors eg stones and other weapons for violence easily available in the compound and inconvenience of the examination rooms (have only one door) and lack of patient screening were also reported as contributing factors for violence.

Most of the professionals proposed providing training for the staff on communication skill, self defense and conflict resolution, increasing the number of staffs and establishing risk avoidance committee and risk payment for the professionals, screening patients, identifying previously violent patients and improving the working environment as important measures to prevent violence in their hospital.

DISCUSSION

This study has revealed a high prevalence, 77.3%, of violence against healthcare professionals in Amanuel mental specialized hospital. This figure is significantly higher than other studies done in general hospitals in our country (29, 30) and high income countries (6, 24), but it is comparable with studies done in psychiatric hospitals (19,20,21). Verbal violence is found to be more prevalent which is consistent with what is found in the literature. Sexual violence and physical violence with weapon are reported less frequently which parallels the finding from other studies. So these findings indicate that WPV is a very important aspect in mental health professionals occupational practice in Ethiopia and it deserves attention

Most professionals were worried about workplace violence and dissatisfied with the situation was handled and these are similar with the local studies (29, 30). A study from a high income country, Germany, showed majority of the victims were offered good support (20) which could be related with the difference in socioeconomic status of the countries, amount of attention given for the subject or understanding about its impact.

This study did not find any association between risk of violence and sex, age, profession or work experience of the professionals. This finding is comparable with the studies from Nigeria, Palestine and Germany (27, 17, 20). A Dutch study (19) and local study which reported young age, short work experience and female sex as risk factors for violence (29).

Majority of the victims of workplace violence in this study did not know about if there are procedures to report violence as a result only few reported the incidents to the hospital authorities, which is consistent with the finding in Italian (16) and the local study (29).

Currently in AMSH violence incidents are registered by infection prevention case team when victims report but there are no procedures to investigate the incidents.

Development of standardized reporting procedure by the hospital would help to provide a more objective and the true picture of violence. Reporting would also not be limited to physical or harmful violence but also verbal and threats of harms.

Majority of the participants in this study reported emotional reactions like anxiety, fear and anger which parallel with the finding in Germany (20). This finding can be taken as an evidence for a negative impact it has on health professionals and in addition of it being distressing, it is more likely to affect their occupational and other areas of functioning after the incident.

Patients were nearly exclusive sources of violence in this study, unlike studies from general hospitals (17, 29), this difference can be attributed to the fact that dealing with involuntarily admitted patients and certain psychopathologies increase patient's potential to be violent in psychiatric hospitals

STRENGTH AND LIMITATION

This is a study stand out from other studies as it is done in the psychiatric hospital where violence is seen as an occupational hazard and it examined prevalence of different forms of violence and consequences on the victims, the result gives a complete picture of violence in psychiatric practice. The study tried to include every health worker in the hospital so can be considered representative. The questionnaire was self-administered so participants were not pressured to respond in a certain way.

However, the method of data collection used in this study (including those who only gave verbal consent and not knowing the reason why they rejected to participate) may have resulted a non-representative sample. As it is possible that health professionals who became a victim of violent incidents or victims who experienced more serious consequences were more interested by the research subject and therefore more inclined to participate in the research, or to the opposite, those who have been victims of serious violence may not want to think about it thus preferred not to participate in the study. This may affect the overall generalizability of the result.

Recent transfer of professionals to the new YekaKotebe hospital and employment of new professionals in the study setting have significantly affected the sample size and made it lower than what was initially intended.

CONCLUSION

This study makes clear that the amount of violence with which health professionals have to cope is a substantial and severe problem. This study has important implications for clinical practice as it highlights the specific characteristics of violence expressed in the hospital, allowing us to tailor preventive interventions. In light of this result, we believe that it is essential to put in place preventive measures not only at organizational and structural level but also at individual level in order to increase the awareness of professionals to WPV risk and to prepare them to manage violence in an ethical, professional, and humanistic way. To develop effective strategies of

violent event management it is important to favor incident reporting by staff for all violent episodes, from verbal offenses or threats to dangerous physical attacks.

RECOMMENDATION

- There is a need for policy to address the issue and formal health facility procedure in handling cases.
- There is a need for record keeping, and reporting process.
- Violence experienced from colleagues, superiors and management should also be researched into.
- Furthermore, attitude of the health workers in ethical relationship with patients and clients should be addressed formally and via mentorship.
- The services in the healthcare facility should also be improved.
- Providing focused training programs aimed at predicting violence in patients, prevention strategies and protecting self from violence.
- Finally, we conclude emphasizing that effective professional training regarding the management of violent events consists of good collaboration and communication among staff members, and constant monitoring and an empathetic approach – never symmetrically aggressive – to the patient, extended to family or caregivers, in order to prevent violence in the health workplace.
- Further studies are needed to investigate the causes and dynamics of violence in health care settings, since the variables related to this phenomenon are numerous and not always clearly identifiable.

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QUESTIONNAIRE IN AMHARIC

አዲስአበባዩንቨርሲቲቴሌናሳይንስኮሌጅሳይካትራዲፓርትመንት

ዶ/ር ደምሴይርጋእባለሁበአ.አ.ዩቴናሳይንስኮሌጅሳይካትራዲፓርትመንት 3ኛ
አመትተመራቂተማሪስሆንበአማኑኤልየአእምሮህክምናሆሰፒታልውስጥየሚሰሩየህክ
ምናባለሙያዎችላይበሚደርስጥቃትዙሪያጥናትእየሰራሁእገኛለሁ
የጥናቱምዋናአላማበሆስፒታሉውስጥየሚሰሩባለሙያዎችበስራላይየሚያጋጥሟቸው
ጥቃቶችብዛት ፤ አይነትእንዲሁምውጤታቸውንመመርመርሲሆን ፤
ለጥናቱምእንዲያግዘኝየተዘጋጀውንመጠይቅእንዲሞሉበትህትናእጠይቃለሁ.
መጠይቁንሲሞሉስምዎንመጥቀስአያስፈልግም
ለትብብርበቅድሚያአመሰግናለሁ

13.2. ጥቃቱ የደረሰበት በማንነው?

ታካሚ/ደምበኛ አስታማሚ ሌላ : _____

13.3. የጥቃት አድራሻ ጾታ ወንድ ሴት

13.4. ጥቃቱ የተፈጸመው የትቦታ ነው?

የምርመራ ክፍል የታካሚዎች መኝታ ክፍል ኮሪዶር/ደረጃላይ ግቢው ስጥ

ሌላ: _____

13.5. ጥቃቱ የደረሰበት ሰአት?

መደበኛ የስራ ሰዓት በትርፍ ሰዓት አላስታውስም

13.6. ጥቃቱ የደረሰበት ቀን?

በመደበኛ የስራ ቀን ቅዳሜ እና እሁድ አላስታውስም

13.7 ከጥቃቱ በፊት የነበረው ሁኔታ :-

መደበኛ ንግግር ታካሚው ጥያቄ አቅርቦ ነበር

ምርመራ/ህክምና/አካላዊ እንክብካቤ

ምንም አልነበረም ሌላ: _____

13.8. ለጥቃቱ የሰጡት ምላሽ ምን ነበር?

ምንም ምላሽ አልሰጡም ምንም እንዳልተፈጠረ መተው

ጥቃት አድራሹን እንዲያቆም መንገር አካላዊ እራስን ለመከላከል መሞከር ለጋደኛ/

ለቤተሰብ መንገር ካውንስለር/አማካሪ ማናገር

ለስራ ባልደረባ መናገር ለሀላፊዎች ሪፖርት ማድረግ የስራ ቦታ መቀየር

ክስ መመስረት የካሳ ጥያቄ ማቅረብ ሌላ: _____

13.9. ጥቃቱን መከላከል ይቻል ነበር ብለው ያምናሉ?

አዎ አይ

13.10. የጥቃቱ ውጤት ምን ነበር

አካላዊ ጉዳት ፍርሀት ቁጣ የጥፋተኝነት ስሜት ውርደት

የተሸናፊነት-ስሜት ጭንቀት ምንም-ውጤት-አልነበረም ሌላ-----

13.11. በጥቃቱአካላዊጉዳትደርሶታል?

አዎ አይ

13.11. 1. አዎከሆነህክምናወስደዋል? አዎ አይ

14. ጥቃት-ከደረሰህት-በካላከስራ-እረፍት-ወስደዋል?

አዎ አይ; አይከሆነውደ ጥያቄ15 ይሂዱ

14.1. አዎከሆነመልሱ-ለስንት-ቀን ?

1ቀን 2-5ቀን 1 ሳምንት 2-3 ሳምንት

1 ወር 2-6 ወር 7-12ወር ሌላ:-----

15. የጥቃቱንምክንያት-ለመመርመርየተደረገጥረት-ነበር?

አዎ አይ አላውቅም

መልሱ-አይወይም-አላውቅምከሆነውደጥያቄ16 ይሂዱ

15.1, አዎከሆነምርመራው-ንያደረገው-ማንነበር:

በሆስፒታሉ-ሀላፊዎች በፖሊስ ሌላ, :_____

15.2.የጥቃት- አድራሾቹላይየተወሰደእርምጃአለ?

ምንምእርምጃአልተወሰደም የቃልማስጠንቀቂያ

ህክምናው-ንማቆም ለፖሊስሪፖርት-ተደረገ ክስመመስረት አላውቅም ሌላ:___

16. ከሆስፒታሉ-ሀላፊዎችየተደረገሎት-ድጋፍ

የምክርድ-ጋፍ አዎ አይ

ሪፖርት-እንዲያደርጉ-መደገፍ አዎ አይ

ሌላ? አዎ አይ

17. ሁኔታውን ለመቆጣጠር በተወሰደው እርምጃ ምን ያህል እረክተዋል?

(1 = በጭራሽ አልረከሁም, 2 = በትንሹ ረክቻለሁ 3 = እረክቻለሁ
 4 = በጣም እረክቻለሁ 5 = እጅግ በጣም እረክቻለሁም)

- 1 2 3 4 5

18. በስራ ላይ የሚደርሱ ጥቃት ለመከላከል በሆስፒታሉ የተዘጋጁ መንገዶች አሉ? አሉ የሚላቸውን ሁሉም ልክት ያድርጉባቸው

- የደህንነት እርምጃዎች (ጥበቃ ማጠናከር, የማሰጠን ቀቂያ ደውሎች,)
- አካባቢያዊ ማሻሻያዎች (ብርሀን ማአካባቢ, ንጹህ፣ ፕራይቪሲ ማመቻቸት)
- ታካሚዎች መለያ (ከዚህ በፊት ጥቃት አድርጎ የሚያውቁ ከሆነ)
- የታካሚዎች ፕሮቶኮል (መቆጣጠሪያ ሂደቶች፣ መድሀኒት አሰጣጥ፣ እንቅስቃሴ የመገደቢያ)
- የባለሙያዎች ቁጥር መጨመር
- ልዩ ልዩ መሳሪያዎች ወይም ልብ ልቦች (የደምብ ልብ ልቦች)
- የስራ ሰዓት ለውጦች
- ስልጠና (እራስን የመከላከል ስልጠና፣ ግጭት የመፍታት፣ የመግባባት ችሎታ ማዳበሪያ ጤና ማአካባቢ ንጥል ስፋት)
- ምንም የለም ሌላ: _____

19. የተወሰዱት እርምጃዎች ምን ያህል ጥቃትን ለመከላከል ያግዛሉ ብለው ያስባሉ

	በጣም ያግዛሉ	በመጠኑ	በትንሹ	በጭራሽ አያግዙም
የደህንነት እርምጃዎች				
አካባቢያዊ ማሻሻያዎች				
ታካሚዎችን የመለየት ስ				

ራ				
ስልጠና				

20. በእርሶአስተያየት ባለሙያዎች ላይ ለሚደርስ ጥቃት ሶስት ዋና ዋና ምክንያቶች/ መንስኤዎችን ይጥቀሱ _____

21. በእርሶአስተያየት በስራ ላይ የሚደርስ ጥቃትን ለመከላከል/ለመቀነስ የሚረዱ ሶስት ጠቃሚ መንገዶችን ይጥቀሱ _____

QUESTIONNAIRE IN ENGLISH

I am Dr. Demissie Yirga ,3rd year resident in AAU college of health science, department of psychiatry. I am doing a research on prevalence, form, and consequence of violence against

mental health professionals and this is a questionnaire prepared for this study, I kindly ask for your cooperation to complete the questionnaire. You don't need to write your name in order to keep the confidentiality. Thank you for your time.

1. age:
 19-24 25-29 30-34 35 40-44
 45-49 50-54 55-59 60+
2. sex:- Female male
3. What is your marital status: - single married living with partner
 Separated /divorced widow/widower
4. Which category best describes your present professional group:-
 Psychiatrist Resident Psychiatry nurseclinical nurse psychologist
 Masters psychiatry professional BSC nurse other, please
specify:_____
5. How many years of work experience in the health sector do you presently have:
Under 1 year 1-5 6-10 11-15 16-20 over 20
6. Do you work in shifts?
Yes No
7. Do you work anytime between 18h00 (6 PM) and 07h00 (7 AM)?
Yes No
8. Do you have routine direct physical contact (washing, turning, lifting) with patients/clients?
Yes no
9. Where do you spend most of your time (more than 50%) in your main job?
Please choose the work setting that describes it best.
Hospital, the main service being:
Outpatient clinic inpatient ward emergency other, please specify:_____
10. The number of staff present in the same work setting with you during most (more than 50%)
of your work time is: none 1-5 6-10 11-15 over 15
11. How worried are you about violence in your current workplace? (Please rate: 1 = not worried
at all; 5 = very worried)

1 2 3 4 5

12. Are there procedures for the reporting of violence in your workplace?

Yes No

13. Have you ever been victim of violence in your workplace?

Yes, please answer questions 13.1. - 13.11.

No, if NO, please go to question 20

13.1. If yes,. How would you describe this incident?

Physical violence without a weapon

Physical violence with a weapon

Spiting kicking pinching/scratching slapping/hitting punching

pushing Biting

Verbal abuse

Sexual harassment

other.....

13.2. Who showed violence toward you?

Patient/client relatives of patient/client

other, please specify: _____

13.3 the sex of the person who was violent male female

13.4. Where did the incident take place?

Examination room patient room corridor dining room

Stairways in the compound

13.5. At which time did it happen?

The regular working hours duty hours don't remember

13.6. Which day of the week did it happen?

Working days weekends don't remember

13.7 What activity preceded the incident:-

conversation Patient made demands Examination/treatment/physical care

No activity other

13.8. How did you respond to the incident? Please tick all relevant boxes

- Took no action tried to pretend it never happen told the person to stop
- Tried to defend myself physically told friends/family sought counseling
- Told a colleague reported it to a senior staff member
- transferred to another position sought help from association sought help from the union
- completed incident/accident form
- Pursued prosecution completed a compensation claim other: _____

13.9. Do you think the incident could have been prevented?

- Yes No

14.9 What was the result Physical injury Fear Anger Guilt
 Humiliation Helplessness Anxiety Disappointment No
reaction other

13.10. Were you injured as a result of the violent incident?

- Yes No

13.10.1. IF YES, did you require formal treatment for the injuries?

- Yes No

14. Did you have to take time off from work after being attacked?

- Yes No; if NO, please go to question 15.

14.1. If YES, for how long?

- One day 2-3 days One week 2-3 weeks
- 1 month 2-6 months 7-12 months

15. Was any action taken to investigate the causes of the incident?

- Yes no don't know

IF NO or DON'T KNOW please go to question 16

15.1. IF YES, by whom:

- Management / employer Association community group
- Police other, please specify: _____

15.2. What were the consequences for the attacker?

- None verbal warning issued care discontinued reported to police

Aggressor prosecuted other: _____ don't know

16. Did your employer or supervisor offer to provide you with;
- ✓ Counseling yes No
 - ✓ Opportunity to speak about/report it yes No
 - ✓ Other support? yes No

17. How satisfied are you with the manner in which the incident was handled? (Please rate: 1 = very dissatisfied, 5 = very satisfied)

1 2 3 4 5

18. What measures to deal with workplace violence exist in your workplace?

Please tick every relevant box

- Security measures (e.g. guards, alarms, portable telephones)
- Improve surroundings (e.g. lighting, noise, heat, access to food, cleanliness, privacy)
- Restrict public access
- Patient screening (to record and be aware of previous aggressive behavior)
- Patient protocols (e.g. control and restraint procedures, transport, medication, activities programming, access to information)
- Increased staff numbers
- Special equipment or clothing (e.g. uniform or absence of uniform)
- Changed shifts or rotas (i.e. working times)
- Reduced periods of working alone
- Training (e.g. workplace violence, coping strategies, communication skills, conflict resolution, self-defense Investment in human resource development (training for career advancement, retreats, rewards for achievement, promotion of healthy environment)

None of these Other: _____

19. To what extent do you think these measures would be helpful in your work setting?

			Not at all
very	moderate	little	

Security measures				
Improve surroundings				
Restrict public access				

OPINIONS ON WORKPLACE VIOLENCE

20 In your opinion, what are the three most important contributing factors to violence in your work setting?

21 In your opinion, what are the three most important measures that would reduce violence in your work setting?
