UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Sciences

RESEARCH THESIS

Title: **The challenges experienced by staff in managing substance-induced psychotic patients in the emergency department of a district hospital in the Western Cape**

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DECLARATION

I hereby declare that the dissertation, THE CHALLENGES EXPERIENCED BY STAFF IN MANAGING SUBSTANCE-INDUCED PSYCHOTIC PATIENTS IN THE EMERGENCY DEPARTMENT OF A DISTRICT HOSPITAL IN THE WESTERN CAPE, is my own work and that all resources that were used or referred to by me during the research study, are indicated by means of a complete reference and acknowledgement.

Signature: _____ Date: _____

Mrs V.Y. WILLIAMS

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ABSTRACT

Staff members of a district hospital experience various challenges in managing psychotic patients in the emergency department. Psychosis can result from the use of illicit drugs. Persons presenting in a psychotic state due to use of illicit substances are common at emergency departments of district hospitals. In terms of the South African legislation, mental health services are accessible at general district hospitals with the 72-hour observation period being mandatory. Emergency departments are the first area where behaviourally disturbed and psychotic persons are assessed and managed in terms of the Mental Health Care Act of South Africa (Act No. 17 of 2002). Emergency staff members render a 24-hour service to all public users requiring emergency services, and should have the skills, training and resources necessary to manage any public user presenting for emergency services. A large proportion of the patients presenting with psychosis at the hospital where the study was done, were reported as using illicit substances. This study sought to discover and understand: **What are the challenges experienced by staff members in managing substance-induced psychotic patients in the emergency department of a district hospital?**

In an attempt to answer the research question, the **aim** of this study was **to explore and describe the challenges experienced by emergency department staff members in managing substance-induced psychotic patients in a district hospital** in the Western Cape**.** An explorative and descriptive research design was used, grounded in the qualitative research approach. Ten **s**taff members managing or assisting with managing substance-induced psychotic patients in the emergency department were purposefully sampled. This sample comprised doctors, nurses, and other support staff members, such as security guards, porters and general workers. An interview schedule guided the face-to-face semi-structured interviews as the method of data collection. The digitally recorded data from these interviews were transcribed verbatim, and analysed into six themes as well as sub-themes. Data were analysed according to Tesch, as cited in Creswell (2009). Measures to ensure trustworthiness were adhered to, such as neutrality, consistency, truth value, and applicability.

Ethical considerations were closely followed, such as obtaining permission from the Senate Higher Degrees of the University of the Western Cape and the Provincial Health Ethics Committee, participants' gave voluntary written consent to partake in the study, aware of the right to withdraw at any time, and of their anonymity and confidentiality being maintained through the use of pseudo names. The findings of the study were that the emergency department was inappropriate for the managing of acutely psychotic or behaviourally disturbed patients such as these, particularly if these staff members were not adequately trained, and where there were staff shortages. Though there was recognition of these patients' rights to obtain medical care, fear and resentment accompanied by stress on the part of staff presented throughout the themes. The study yielded recommendations such as the need for training and debriefing of staff members and support by hospital management, as well as services such as groupwork and supportive services to patients and family. Recommendations were also made for a review of staffing, infrastructure, facilities and legislation. These recommendations are considered important to assist in the planning, and implementation of healthcare services to mental healthcare users, with specific reference to substance-induced psychotic patients.

KEYWORDS

Challenges, Staff members, Substance-induced psychosis, Emergency department, District hospital

THE CHALLENGES EXPERIENCED BY STAFF IN MANAGING SUBSTANCE-INDUCED PSYCHOTIC PATIENTS IN THE EMERGENCY DEPARTMENT OF A DISTRICT HOSPITAL IN THE WESTERN CAPE

TABLE OF CONTENT **PAGE**

DECLARATION **i**

ACKNOWLEDGEMENTS **ii**

ABSTRACT **iii**

CHAPTER 1: INTRODUCTION AND ORIENTATION TO THE STUDY **1**

1.1 INTRODUCTION **1**

1.2 BACKGROUND INFORMATION AND LITERATURE STUDY **2**

1.2.1 Common drugs of abuse and treatment **2**

1.3 SUBSTANCE-INDUCED PSYCHOSIS AND ATTENDING TO SUBSTANCE RELATED PROBLEMS AT HOSPITALS **6**

1.3.1 The setting at a district hospital **8**

1.3.2 The management of patients in terms of the Mental Health Care Act of South Africa (Act No. 17 of 2002) **8**

1.3.3 Evaluation of implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) **11**

1.4 PROBLEM FORMULATION **12**

1.5 RESEARCH QUESTION **13**

1.6 AIM AND OBJECTIVES **13**

1.6.1 Aim **13**

1.6.2 Objectives **13**

1.7 RESEARCH APPROACH **13**

1.8 RESEARCH DESIGN **14**

1.9 RESEARCH METHODS **14**

1.9.1 Population and sampling **14**

1.9.2 Data collection **15**

1.9.3 Data analysis **15**

1.10 TRUSTWORTHINESS 16
1.11 ETHICAL CONSIDERATIONS 17
1.12 SUMMARY 18

CHAPTER 2: A REVIEW OF CORE CONCEPTS AND THEORETICAL PERSPECTIVES RELATED TO MANAGING SUBSTANCE-INDUCED PSYCHOSIS 19
2.1 INTRODUCTION 19
2.2 A REVIEW OF COMMONLY USED SUBSTANCES AND THE POTENTIAL OF PSYCHOTIC EFFECTS 20
2.2.1 Statistics of illicit drug users **21**
2.2.2 Classification of drugs of abuse and their effects **21**
2.2.3 The effects of substance abuse on the family **26**
2.3 PSYCHOSIS AND SUBSTANCE ABUSE 27
2.4 CHALLENGES EXPERIENCED IN MANAGING SUBSTANCE-RELATED HEALTHCARE PROBLEMS 30
2.5 THE EFFECTS OF VIOLENCE, FEAR AND STIGMA IN MANAGING SUBSTANCE ABUSE AND SUBSTANCE-INDUCED PSYCHOTIC PATIENTS 32
2.6 THE THEORY THAT FRAMES THE STUDY – ATTRIBUTION THEORY 33
2.7 THE ROLE OF THE SOCIAL WORKER IN THE EMERGENCY DEPARTMENT OF A HOSPITAL 35
2.8 SUMMARY 35

CHAPTER 3: RESEARCH METHODOLOGY 37
3.1 INTRODUCTION 37
3.2 THE RESEARCH QUESTION AND AIM OF THE STUDY 37
3.3 THE RESEARCH OBJECTIVES 38
3.4 THE RESEARCH APPROACH 38
3.5 THE RESEARCH DESIGN 39

3.6 RESEARCH METHODOLOGY 40
3.6.1 The research setting **40**
3.6.2 Population and sampling **41**
3.6.3 Preparation for data collection **44**
3.6.4 Setting up the interviews **45**
3.6.5 The pilot study **46**
3.6.6 Data collection **46**
3.6.7 Conducting the interviews **47**
3.6.7.1 The interview protocol **47**
3.6.7.2 The interview questions **50**
3.6.8 Data analysis **51**
3.7 LIMITATIONS AND STRENGTHS OF THE STUDY 52
3.7.1 Limitations and strengths of the in-depth interviews **52**
3.7.2 Limitations in overview of the study **53**
3.8 SUMMARY 54

CHAPTER 4: RESEARCH FINDINGS 55
4.1 INTRODUCTION 55
4.2 DEMOGRAPHIC DETAILS 55
4.2.1 Gender **56**
4.2.2 Age **57**
4.2.3 Home language **57**
4.2.4 Years of experience **57**
4.2.5 Current position **57**
4.3 FINDINGS PERTAINING TO THE CHALLENGES THAT STAFF EXPERIENCED IN MANAGING SUBSTANCE-INDUCED PSYCHOTIC PATIENTS IN THE EMERGENCY DEPARTMENT OF A DISTRICT HOSPITAL 57
4.3.1 **Research setting 59**
4.3.1 Theme 1: Staff members have different understandings of substance-induced psychosis 59

4.3.1 **Subtheme 1.1:** Medical staff members' understanding of substance-induced psychosis **60**

4.3.1 **Sub-theme 1.2:** Non-medical staff members' understanding of substance-induced psychosis **65**

4.3.2 Theme 2: Substance-induced psychotic patients' unique presentations compared to other emergency patients in the emergency department 68

4.3.2 **Subtheme 2.1:** Substance-induced psychotic patients present with dangerous and aggressive behaviour **69**

4.3.2 **Subtheme 2.2:** Substance-induced psychotic patients present with unpredictable behaviour **71**

4.3.2 **Subtheme 2.3:** Substance-induced psychotic patients exhibit sexually inappropriate behaviour. **72**

4.3.3 Theme 3: Management of substance-induced psychotic patients disrupts other emergency services 73

4.3.3 **Subtheme 3.1:** Other patients and staff members require protection from substance-induced psychotic patients **76**

4.3.3 **Subtheme 3.2:** There is limited staff for protection and managing of substance-induced psychotic patients **77**

4.3.3 **Subtheme 3.3:** Facilities for managing substance-induced psychotic patients are inappropriate and/or unavailable **78**

4.3.3 **Subtheme 3.4:** Staff members experience challenges with regard to teamwork **83**

4.3.3 Subtheme 3.5: The defensiveness or lack of supportiveness of family has an influence on services **86**

4.3.3 **Subtheme 3.6:** Untrained staff members are a challenge in dealing with substance-induced psychotic patients **88**

4.3.4 Theme 4: Staff members experience personal challenges in dealing with substance-induced psychotic patients 93

4.3.4 **Subtheme 4.1:** Medical staff members experience resentment **93**

4.3.4 **Subtheme 4.2:** Medical staff members experience fear in the work place **100**

4.3.4 **Subtheme 4.3:** Non-medical staff members' fear of the substance-induced psychotic patients **105**

4.3.4 **Subtheme 4.4:** Non-medical staff members find it stressful to control substance-induced psychotic patients **107**

4.3.4 **Subtheme 4.5:** Some staff members have more tolerance towards substance-induced psychotic patients **109**

4.3.5 Theme 5: Staff members acknowledge dignity for all patients 112

4.3.6 Theme 6: Staff members made special recommendations to the hospital management for assistance with managing substance-induced psychotic patients 114

4.3.6 **Subtheme 6.1:** Staff members recommend a separate facility for referring substance-induced psychotic patients **115**

4.3.6 **Subtheme 6.2:** Staff members recommend that substance-induced psychotic patients be separated from other emergency patients **115**

4.3.6 **Subtheme 6.3:** Staff members recommend improved resources and facilities at the emergency department **116**

4.3.6 **Subtheme 6.4:** Staff members recommend training of staff to work with aggressive and substance-induced psychotic patients **119**

4.3.6 **Subtheme 6.5:** Staff members are of the opinion that the management of the hospital is oblivious of their recommendations **120**

4.4 SUMMARY 121

CHAPTER 5:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 124

5.1 INTRODUCTION 124

5.2 SUMMARIES OF CHAPTERS 1 TO 4 124

5.3 CONCLUSIONS REGARDING THE FINDINGS OF THE RESEARCH 126

5.3.1 **Theme 1:** Staff members have different understandings of substance-induced psychosis **126**

5.3.2 **Theme 2:** Substance-induced psychotic patients' unique presentations compared to other emergency patients in

the emergency department **127**

5.3.3 **Theme 3:** Management of substance-induced psychotic patients disrupts other emergency services **128**

5.3.4 **Theme 4:** Staff members experience personal challenges in dealing with substance-induced psychotic patients **131**

5.3.5 **Theme 5:** Staff members acknowledge dignity for all patients **133**

5.3.6 **Theme 6**: Staff members made special recommendations to the hospital management for assistance with managing substance-induced psychotic patients **134**

5.4 THE ASSUMPTIONS THAT THE RESEARCHER HELD 135

5.5 THE RELEVANCE OF THE ATTRIBUTION THEORY AS CONCEPTUAL FRAMEWORK TO THIS STUDY 135

5.6 RECOMMENDATIONS 136

5.6.1 Recommendations pertaining to the research process **136**

5.6.2 Recommendations pertaining to the research findings **136**

5.6.2.1 Hospital management **136**

5.6.2.2 Training **137**

5.6.2.3 Government and non-government departments/resources **137**

5.6.2.4 The role of the social worker **138**

5.6.2.5 The Mental Health Care Act of South Africa (Act No. 17 of 2002) **139**

5.6.3 Recommendations for future research **140**

5.7 CONCLUSION 141

LIST OF REFERENCES 142

LIST OF APPENDIXES

APPENDIX A – INFORMATION SHEET **156**

APPENDIX B – CONSENT FORM **158**

APPENDIX C – PERMISSION LETTER BY THE PROVINCIAL DEPARTMENT OF HEALTH ETHICS COMMITTEE TO CONDUCT THE STUDY **159**

CHAPTER 1
INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Attending to psychosis caused by the abuse of substances is not uncommon in the emergency department of district hospitals, internationally and nationally. Substance abuse has a deep influence on every facet of the lives of individuals, families, the community, public health and social services, educational and justice services (Weich, in Baumann, 2007:290).

Abuse is defined as **"**the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances" (Prevention of and Treatment for Substance Abuse Act of South Africa. Act No. 70 of 2008). Substance abuse is seen by some people as immoral, or as a disease which has been caused by other problems. Substances may be used to cope with stress, to aid being accepted, and to allow people to feel normal. Abuse of substances is a behavioural disorder learnt in a social context (Hanson, in Heller & Gitterman, 2011:450). There is an interplay of factors, socio-cultural or unique to the individual, which contributes to substance use and abuse (Ruiz, Strain & Langrod, 2007:3).

"Substances" are understood as "chemical, psychoactive substances that are prone to be abused, including tobacco, alcohol, over-the-counter drugs, prescription drugs and substances defined in the Drugs and Drug Trafficking Act of South Africa (Act No. 140 of 1992), or prescribed by the Minister after consultation with the Medicines Control Council established by section 2 of the Medicine and Related Substance Control Act of South Africa (Act No. 101 of 1965), and 'drugs' in the context of this Act have a similar meaning" (Prevention and Treatment for Substance Abuse Act of South Africa. Act No. 70 of 2008). The Drugs and Drug Trafficking Act of South Africa (Act No. 140 of 1992) defines "drug" as "any dependence-producing substance, any dangerous dependence-producing substance or any undesirable dependence-producing substance."

Regulations in the Mental Health Care Act of South Africa (Act No. 17 of 2002) make provision for persons requiring mental health care to be attended to at a general hospital, observed for 72 hours, and then either discharged home or referred to a psychiatric facility. Ramlall, Chipps & Mars (2010) questions the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) at district hospitals where the lack of adequate staffing, training and infrastructural incapacity is a matter of concern. Gacki-Smith, Juarez, Boyett, Homeyer, Robinson & Maclean (2009) and Sorsdahl, Stein & Myers (2012) identify the existence of violence towards staff members working in an emergency department as well as stigma and attitudes that staff members have towards substance abuse and those with substance-induced disorders. These dynamics are discussed in this study as a result of staff members' resonating resentment and fear in managing or assisting in managing substance-induced psychotic patients in the emergency department.

The researcher is a social worker at the district hospital where the study was done, and had observed the agitation, aggression and physical restraining of psychiatric/behaviourally disturbed patients. The researcher was also aware of medical staff members who had been assaulted while treating substance-induced psychotic patients. This led to the researcher being cautious when entering the emergency department, where all patients requiring psychiatric evaluations can normally be identified in a hospital gown of a specific colour. Awareness of own reaction and management of these cases, as well as interest in the experiences of doctors, nurses and support staff who render 24-hour service in the emergency department and who are required to deal with any trauma or emergency situation, prompted the researcher to conduct the study.

1.2 BACKGROUND INFORMATION AND LITERATURE STUDY

1.2.1 Common drugs of abuse and treatment

There are three comprehensive groupings of drugs: central nervous system stimulants (for example methamphetamine, cocaine, and ecstasy); central nervous system depressants (for example alcohol, mandrax, and heroin); and hallucinogens, for example cannabis/dagga and LSD ("Stimulants", 2007). There are several common substances of abuse: cannabinoids (e.g. marijuana); depressants (e.g. alcohol, mandrax and barbiturates);

dissociative anesthetics (e.g. valiums); and hallucinogens (e.g. LSD). There are opioids (e.g. heroin, codeine and morphine) and stimulants (e.g. amphetamine, methamphetamine, cocaine and nicotine). Other composites are, for example, inhalants (Abadinsky, 2008:10). More clarification is given in Chapter 2 (2.2.2) under the classification of drugs of abuse and their effects.

"Motivation" is a keyword in seeking help to combat substance abuse. Reasons why substance abusers drop out of rehabilitation programmes can be classified according to whether treatment is in- or out-patient, where the resource is situated, and the specific substance of abuse. Dropping out is normally higher in individuals attending out-patient rehabilitation programmes as they have a higher chance of being persuaded not to finish programmes (Parry, Plüddemann & Myers, as cited in Ramlagan, Peltzer & Matseke, 2010:45). Societies assign negative meaning and association to the words "substance misuse", "substance abuse" and "addiction". Saying and defining these words differ across different professions and universally. Preference of professionals in medicine and psychiatry is for dependence and addiction to include functional and psychological need for a drug. Diagnosing substance abuse remains reliant on diagnostic criteria (Hafford-Letchfield & Nelson, as cited in Nelson, 2012:15).

According to the World Drug Report (2012) a probable 20% of problematic substance abusers in 2010 were treated for dependence on drugs. In Asia, Europe, Africa, North America and Oceania, opioids are the main drug of abuse, and the reason for requiring treatment, with heroin being the main one in the first two countries given. In South America, only 1% of drug users account for negligible opioids treatment demands. Though considered the least harmful of the illegal drugs, cannabis is the most used illegal substance globally. It is a main drug for which treatment is required in Africa, North America, and Oceania, and adds to demand for treatment in South America. It is a second key drug adding to the demand for treatment in Europe. Nearly half of the reasons for requiring treatment for an illicit drug use in the Americas are due to cocaine usage while in Asia, Eastern Europe, South-Eastern Europe and Oceania the treatment need for cocaine combined, are less than 1%. In Asia the second most frequent illicit drug which demands treatment is amphetamine-type stimulants (mainly methamphetamine). In

Oceania, Western and Central Europe and North America the treatment demand for the latter illicit drug is lower (World Drug Report, 2012:15-16).

The South African Community Epidemiology Network on Drug Abuse (SACENDU) was established in 1996 with specific objectives pertaining to alcohol and drug abuse in South Africa. SACENDU's monitoring of 9,109 patients seen at treatment admissions across 60 centres from January to June 2010, revealed that 3,134 patients were treated at the 23 specialist treatment centres/programmes in the Western Cape, with the most common substances of abuse accounting in combination for 92% of the admissions, being methamphetamine, alcohol, cannabis, and heroin (Plüddemann, Parry, Dada, Bhana, Bachoo, Fourie, Perreira, Nel, Mncwabe, Gerber & Freytag, 2010). Dada, Plüddemann, Parry, Bhana, Vawda & Fourie (2012) give findings in SACENDU's update of June 2012, regarding alcohol and drug trends. SACENDU monitors the alcohol and drug use trends every six months, at alcohol and drug treatment centres.

Findings in Table 2 (page 5) represent data for the latter half of 2011 from 59 centres where 8,291 patients were admitted for treatment or involved in programmes. Findings in all the nine provinces show that alcohol continued to be the primary substance abused except in the Western Cape and Northern Region (Mpumalanga and Limpopo). Cannabis was the main substance of abuse that was reported by most patients younger than 20 at all of the centres with the exception of KwaZulu Natal. Cocaine-linked admissions had decreased at the centres, with admission for heroin having increased in the Western Cape and in Gauteng, KwaZulu Natal and Northern Region. Methamphetamine was still the most frequent substance of abuse in the Western Cape with half of the patients admitted to the treatment being younger than 25 years of age. Though methamphetamine admissions came down for other areas, there was a constant increase since the last six months of 2009 in Port Elizabeth. The use of multi-substances across sites continues to be high, and also the abuse of over-the-counter and prescription medication, as well as inhalants and solvents abuse being on the rise (Dada *et al*., 2012).

Table 2 below reflects centres' findings for the second half of 2011 for major substances of abuse for all patients under 20 admitted for treatment or involved in programmes in the provinces in South Africa. Johannesburg and Pretoria are combined as Gauteng (GT); Mpumalanga and Limpopo are combined as Northern Region (NR); Northern Cape and Northwest are combined as Central Region (CR) (Dada *et al*., 2012).

Table 2: Main drug of abuse (%) for patients under 20 years of age

	Age	WC	KZN	EC	GA	NR	CR
Centres		23	6	5	14	6	5
Patients		2733	610	721	2786	892	549
Alcohol	All	24	67	40	36	27	59
	<20	5	47	11	9	14	12
Cannabis	All	15	16	16	28	36	21
	<20	58	39	49	62	47	67
Methaq. (Mandrax	All	2	3	5	2	<1	2
	<20	3	4	7	2	1	3
Cocaine	All	2	5	4	6	4	6
	<20	1	0	1	2	1	3
Heroin	All	17	6	3	13	22	2
	<20	7	8	0	12	17	1
Methamphetamine	All	39	1	18	1	2	2
	<20	25	1	29	1	5	0

(SACENDU, 2012)

In the World Drug Report (2012) it is stated that, though the range of the international use of illegal substances has stayed steady in the past five years up to and including 2010, 10% to 13% of the drug users remain problem users who are dependent on drugs and/or present with drug use disorders. Cannabis remains the most widely used substance internationally and the main drug causing treatment demand in Africa, with opioids also accounting for a large amount of demand for treatment. Globally the second most commonly used drugs are methamphetamine, amphetamine and ecstasy (amphetamine type stimulants). The variation trend with use of drugs has changed in numerous countries, with different substances being used in combination or after each other. The

extent of illegal substance use has remained stable. Though a worldwide estimation in 2010 of between 153 million and 300 million individuals aged 15 to 64 using an illegal substance the year before, the probable 15.5 million to 38.6 million of problem drug users, inclusive of those dependent on drugs or having substance use disorders, continues to be alarming (World Drug Report, 2012:1-7).

1.3 SUBSTANCE-INDUCED PSYCHOSIS AND ATTENDING TO SUBSTANCE RELATED PROBLEMS AT HOSPITALS

Substance-induced psychosis is a reaction to noxious substances rather than a major psychiatric illness. Indecision may occur in defining substance-induced psychosis, and urgent psychiatric attention may be necessitated. Substance-induced psychosis generally is the "time-limited psychotic state produced by acute or chronic drug effects" (Waller & Rumball, 2004:283). The primary features of substance-induced psychosis are the presence of psychotic symptoms (hallucinations, delusions) caused by a psycho-active substance such as methamphetamine, cannabis and alcohol. A person should be taken to hospital when they become psychotic or violent, where there are auditory and visual hallucinations, or paranoia ("Stimulants", 2007).

Weich (in Baumann, 2007) states that alcohol-induced psychiatric problems include cognitive disorders and psychotic disorders depicted by hallucinations, mood, anxiety and delusional disorders. Methaqualone/mandrax, usually smoked with cannabis, may result in aggression in some individuals as the effects start to work out of the system. Withdrawal symptoms include anxiety and restless behaviour. Opioid intoxication is associated with relief from anxiety. Anxiety, acute hopelessness and irritability are amongst the withdrawal symptoms. Central nervous system stimulant intoxication results in complications such as panic, violence and paranoia. Withdrawal symptoms include psychiatric complications such as delirium, anxiety and psychosis. Cannabis withdrawal symptoms include aggression, restlessness, and insomnia, anxiety and muscle tremors. Psychiatric effects include anxiety, acute psychosis, and withdrawal syndrome. Existing mental health conditions are worsened or place the individual at risk of a mental health illness, for example schizophrenia. The use of other hallucinogens such as ecstasy and

LSD also brings about mood changes, anxiety and hallucinations, and behaviour can be unpredictable (Weich, in Baumann, 2007:302–317).

According to Malonie & Friedman (2005), alcohol abuse is the highest community health problem in Britain, and 99% of emergency staff members have fallen prey to verbal and physical abuse by patients who have misused alcohol. Professionals in emergency departments indicate their inability to manage alcohol abuse owing to the lack of resources, staff members and training. Findings in a study in Ireland show that there are staff members who are optimistic towards the illicit substance abusers, but are of the opinion that persons who present at the hospital owing to substance abuse should be cared for elsewhere (MClaughlin, McKenna, Leslie, Moore & Robinson, 2006).

Research results between 2002 and 2004 have indicated that there are a significant number of persons in South Africa with mental disorders for which they have not been treated. The results also showed that there should be more resources distributed to mental health services in order for needs to be met. It was found that participants frequented the general medical division for mental health conditions rather than the mental health division. Persons accessing services for mental health for substance use disorders numbered the highest in the Western Cape Province (Seedat, Williams, Herman, Moomal, Williams, Jackson, Myer, & Stein, 2009).

Conclusions and findings from a national population-based 2008 survey of illicit drug use in South Africa revealed that there was an escalation in cannabis and other illegal substances from 2005 to 2008. This study concluded that there should be action at various different levels on national and provincial levels, and that treatment should be provided by properly trained professionals. Other conclusions were that more studies were needed to evaluate the effects of illegal drug use, that the more severe substance-use disorders need specialist care, and that primary care service providers should be better equipped to diagnose and manage illegal drug disorders (Peltzer & Ramlagan, 2010).

1.3.1 The setting at a district hospital

Unpublished statistics indicate that there were a total of 2,623 psychiatric/psychotic admissions from August 2009 to June 2011 at the district hospital in the Cape Flats, Western Cape, where the present study was done. (Although the hospital where the study took place granted permission for it, hospital management agreed with the recommendation by Senate Higher Degrees of the University of the Western Cape that anonymity should extend to the name of the hospital). Ninety percent of the patients were reportedly admitted owing to substance abuse while 70% of these patients abused methamphetamine and/or dagga (Psychiatric Medical Registrar, 2011, pers com).[1] Unpublished headcount statistics gathered by the researcher for January 2012 to December 2012 at the hospital where the study was done, indicated that between 92 and 150 patients per month with psychiatric/behaviourally disturbed symptoms were admitted. For the first eight months of 2012 there was a monthly average of 104 of these types of patients. Eighty to ninety percent of the psychotic patients remained owing to use of illicit substances and not owing to a primary mental health illness (Professional Nurse, 2013, pers com).[2] A psychiatric unit to which male substance-induced psychotic patients are referred by the hospital where the researcher conducted this study reflected that a large percentage of patients diagnosed with substance-induced psychoses for the period January 2012 to December 2012 had a dual diagnosis of schizophrenia. Cannabis and methamphetamine also featured prominently among the main drugs of abuse for this period.

1.3.2 The management of patients in terms of the Mental Health Care Act of South Africa (Act No. 17 of 2002)

Prior to the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002), most behaviourally disturbed individuals, including substance-induced psychosis, were assessed at the community health centres.

[1]In order to protect the confidentiality of the hospital where the study was conducted identifying particulars of the psychiatric medical registrar was not disclosed.
[2]In order to protect the confidentiality of the hospital where the study was conducted identifying particulars of the professional nurse was not disclosed.

The referral procedure was as follows:
Behaviourally disturbed individuals were taken to the community health centres or clinic, by police (either accompanied by a family member or unaccompanied). At the clinic or community health centre a medical assessment was done, including necessary tests to exclude treatable medical conditions that might cause disturbed behaviour.

- Once the medical condition/s was excluded as a cause for the disturbed behaviour, the individual was referred to a psychiatric hospital. The district hospital was usually by-passed, but sometimes the behaviourally disturbed individual was taken directly to the district hospital where the above was also carried out (Clinical Manager, 2012, pers com).[3]

The Mental Health Care Act of South Africa (Act No. 17 of 2002) states that all behaviourally disturbed individuals are to be given a 72-hour observation period in a district hospital before referral to a psychiatric hospital. In order to comply with the prescript of this Act, the following procedure was carried out at the hospital where the social worker works.

- A three bed low-secure area, situated in the emergency area was created for the 72-hour observation period.
- A psychiatric team comprising a doctor, a nurse, and security personnel, was formed to look after behaviourally disturbed patients.

In view of the fact that more behaviourally disturbed men than women were admitted at the hospital, the low-secure area was nearly always occupied by men, as the different genders may not be mixed. The abuse of drugs escalated however, and the influx of behaviourally disturbed patients increased rapidly from between 10 to 30 individuals per day. An internal provincial guideline was consulted, which stipulated that where patients were discharged within three months from a psychiatric hospital that they are not allowed

[3]In order to protect the confidentiality of the hospital where the study was conducted identifying particulars of the clinical manager was not disclosed.

72 hour observation at the district hospital but were to be referred back to the psychiatric hospital (Clinical manager, 2012, pers com).

The workload of staff members was affected in the emergency department of the hospital where the researcher works, and staff members experienced a considerable degree of insecurity. Staff members felt that their safety from physical assault could not be guaranteed, and female staff members were concerned about sexual harassment or inappropriate sexual approaches from psychiatric patients. Staff members threatened not to be present at work while the emergency centre was overrun by behaviourally disturbed patients and the three beds were inadequate. Keeping the female patients in the holding area became problematic owing to the rise in numbers and the length of stay, which infringed on their comfort, dignity and sustenance. Four female beds were created at a step-down ward at another district hospital. In addition the male patients were moved from the overnight ward to a side ward where eight patients could be accommodated. Given the high numbers of behaviourally disturbed patients, a discharge lounge with twelve lazyboy chairs was converted into a holding area for behaviourally disturbed patients (Clinical Manager, 2012, pers com).

Decisions were later taken that all women be excluded from the 72-hour observation at the hospital, and after investigating and exclusion of any organic cause or psychiatric illness, they were (and still are) referred to a psychiatric hospital, preferably within 24 hours. The average number of behaviourally disturbed patients (male and female) who were admitted per day ranged from 17 to 34. In view of the fact that the 72 hour observation period was not supposed to be done at the hospital where the study was done, a decision were taken that male patients should be transferred to a 15 bed unit at another psychiatric unit of a district hospital. The average length of stay for male patients waiting admission to a psychiatric hospital can escalate to 16 days (Clinical Manager, 2012, pers com). The aforementioned decisions were taken to address the inability of the district hospital where the researcher works to cope with the increased number of substance-induced psychotic patients.

At present, most of the substance-induced psychotic patients at the hospital where the study took place are sedated and physically restrained if they become aggressive. The psychiatric nurse contacts the significant others for information on the patient, which is obtained either telephonically or via a hospital appointment. The patient is observed under the 72-hour observation requirement according to legislation (The Mental Health Care Act of South Africa. Act No. 17 of 2002) with the psychiatric nurse monitoring the patient's condition. The patient is assessed by the psychiatric medical officer, and if a bed is available, is transferred to an overnight ward in the hospital. If the condition stabilises the patient is discharged and not observed for 72 hours. A community organization dealing with substance abuse (mainly SANCA) is telephonically contacted by the psychiatric nurse or social worker, and if the patient is motivated to enter a treatment programme, he or she is referred. However, the majority of substance-induced patients are not motivated. Acutely psychotic patients are transferred to a psychiatric hospital (Professional Nurse, 2013, pers com).

1.3.3 Evaluation of implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002)

Conclusions from research done on the impact of the Mental Health Care Act of South Africa (Act No. 17 of 2002) at regional and district hospitals in KwaZulu Natal, South Africa, yielded that the said Act had made it easier to obtain services for those in need of mental health care, but that there were remarkable limitations in the "infrastructure, staffing, training and administrative requirements" (Ramlall *et al.*, 2010). Burns (2008) offered solutions to manage the requirements of the Mental Health Care Act of South Africa (Act No. 17 of 2002) at district hospitals that were in practice not ready for implementation. These suggestions translated into designated in- and out-patient facilities in terms of management of the facility, an adequate number of staff members who are trained in managing patients with mental disorders, and also regular training and capacity building in terms of the different mental health illnesses. Burns (2008) further proposed that there should be collaborative efforts in the form of forums and outreaches by mental health care practitioners to train and develop staff members at district and regional hospitals.

1.4 PROBLEM FORMULATION

The emergency department of the hospital where the study took place attends to an increasing number of psychiatric/psychotic admissions, reportedly due to substance abuse. Literature reviewed by the researcher on the subject of substance abuse and psychosis was in-depth and clear about the different substances of abuse, and the intoxicating and withdrawal symptoms, as well as the effects. Thus, insight was given into the substance-induced psychotic patients who are managed by medical and non-medical staff who render a 24-hour service. Emergency staff members manage patients amidst a host of challenges, such as staff shortages, lack of knowledge, lack of infrastructure, and abusive and/or violent patients. The majority of studies reviewed by the researcher support the fact that staff members in emergency departments have negative views about substance abusers and substance-induced psychosis, as well as a lack of knowledge about how to deal with these patients, a lack of skills and training, and also staff shortages. There appears to be insufficient information on the specific challenges amidst the various challenges that staff members experience who attend to substance-induced psychotic, and how they negotiate the challenges experienced.

This study explored and described the challenges experienced by staff members in the emergency unit, which is often the first point of contact for patients and their families. The researcher gained an understanding of what and how these challenges experienced by staff members, affect their attitude towards their management of this category of patient. The researcher chose the attribution theory as a conceptual framework since the study sought to understand the daily challenges experienced in relation to substance-induced psychotic admissions, and how these challenges might influence staff attitudes in exercising patient care.

The relevance of this study to social work is that substance-induced psychosis in this research study advertently links to abuse of illicit substances, a current social problem where social work service delivery is common practice. The topic of research is a neglected concern and the nature of this study yielded insights and knowledge from a qualitative research perspective. It aids new considerations towards the staff members who manage or assist in the management of these patients and towards improving social

work practice to the stabilized substance-induced psychotic patients and families. Furthermore, this study could advance changes in the interest of the holistic management of substance abusers and those presenting with psychosis, in collaborative partnerships with relevant government, non-government and community stakeholders.

1.5 RESEARCH QUESTION

What are the challenges experienced by staff members in managing substance-induced psychotic patients in the emergency department of a district hospital?

1.6 AIM AND OBJECTIVES

1.6.1 Aim

- To explore and describe the challenges experienced by emergency department staff members in managing substance-induced psychotic patients in a district hospital.

1.6.2 Objectives

- To explore and describe emergency department staff members' understanding of substance abuse.
- To explore and describe staff members' perceptions of the difference between substance-induced psychotic patients and other patients in the emergency department.
- To explore and describe what it is like for emergency staff members to deal with substance-induced psychotic patients in an emergency department.

1.7 RESEARCH APPROACH

The researcher used a qualitative research approach which provided an in-depth description and understanding of the participants' challenges in managing substance-induced psychotic patients. This approach was used in order to answer the research question (Babbie & Mouton, 2001:270; Kumar, as cited in De Vos, Strydom, Fouché & Delport, 2011:65).

1.8 RESEARCH DESIGN

Creswell (2009:3) indicates that a research design is an approach which is specifically chosen for its applicability for use in the problem or issue to be researched. This choice is guided by the assumptions, the researcher's knowledge and experience, and to whom the research is geared. Strategies, methods, data analysis and data interpretation, aid the choice of which design would be best for a specific study. An explorative and descriptive research design was used since the "what" question in explorative research provided an understanding of occurrences, persons and situations (Mouton, as cited in De Vos *et al*., 2011:95).

Explorative research was deemed the best design since there was little information on the matter, and it would familiarise the researcher with the situation in order to understand the problem (De Vos *et al*., 2011:95). The research design was also explorative of what the challenges are of the emergency staff members who manage substance-induced psychotic individuals in the emergency hospital of a district hospital, and attempted to understand the actions of the participants in relation to their own opinions, as well as past and present circumstances (Babbie & Mouton, 2001:72, 272 – 273). The "how" question was central to this descriptive research which endeavoured to give a detailed depiction of the situation, public setting and connections (Kreuger & Neuman and Rubin & Babbie, as cited in De Vos *et al*., 2011:96).

1.9 RESEARCH METHODS

1.9.1 Population and sampling

The emergency department's staff members of the hospital where the study took place were the study population. Inclusion criteria denoted the aspects that the researcher took into consideration when selecting the sample (Halloway & Wheeler, 2010:340). Only the staff members who managed or assisted in managing substance-induced psychotic patients in the emergency department of the hospital constituted the sample. They were considered the best population from whom to gain the information to answer the research question. Out of a total number of 32 staff, 10 staff members (male and female) were purposefully sampled from day and night staff workrosters of the emergency department of the hospital.

Participants had to be able to speak and understand English (Halloway & Wheeler, 2010:144). The researcher did not plan to use a translator since it would have been time-consuming to translate the questions and communication techniques used as part of the interviewing process. The essence of what a participant was conveying could also be lost with inaccurate translating (Morse & Field, 1995:103). Ethical considerations were of paramount importance to the researcher not to cause harm to the participants, as well as anonymity and confidentiality (Babbie, 2010:65 – 67) which could be contravened by a translator. Apart from all the aforementioned, the researcher was of the opinion that sampling of participants might have been more difficult, or the participants might have felt threatened during the interview, and thus the data obtained would not have been as rich if there was a translator.

1.9.2 Data collection

Qualitative researchers gather data through observations, interviews, documents and audio-visual tools. A characteristic of qualitative research is the vital importance of the researcher in gathering data. The interviews were carried out in an office in the natural setting of the hospital, which was convenient since the participants worked at the hospital (Corr *et al*., Creswell, 2009:175 - 178; Boeije, 2010:35). The researcher explained the interview procedure and process to participants and obtained their permission for the use of audio recording. Individual, face-to-face semi-structured interviews were used as the data collection method. The participants did most of the talking, but the researcher guided the interview by using interview and communication techniques (De Vos *et al*., 2011:343-344). The language use was important, and caution was exercised not to put the participants under pressure (Babbie & Mouton, 2001:288 – 289). As far as possible, the researcher took field notes throughout the interview. Preparation was done timeously with regard to the venue and a check whether audio equipment was in working order.

1.9.3 Data analysis

Through scrutiny of information gathered from the participants, the researcher built an analysis of the bigger sense of the data (Creswell, 2009:183). Eight steps were used in the data analysis process, in which firstly all transcripts were perused to gain an understanding in the entirety, and thoughts were noted. Secondly, the researcher selected a transcript and

perused it for its meaning. Ideas were written on the transcript. Thirdly, the same was done for the other interviews. Themes that were alike were listed and arranged in groups. In a fourth step the researcher went back to the data, using the groupings. Themes were shortened into codes in the appropriate parts of the text. Fifthly, the themes were categorised using the most suitable explanatory words, and grouped together to reduce the number of categories. As a sixth step codes were assigned using alphabet letters, once the researcher had finalised abbreviations for the categories. Seventh, the information for each category was arranged and a preliminary analysis done, and as the eighth step recoding would have been done, but it was not necessary (Tesch, as cited in Creswell, 2009:186). An independent coder was used to enhance trustworthiness of the study.

1.10 TRUSTWORTHINESS

Characteristics of truth value, applicability, consistency and neutrality were used to assess trustworthiness. The researcher applied truth value by spending sufficient time with each participant during an interview, and findings only from information obtained from the staff member's perspective were given. This aided the credibility of the study. Since the researcher's findings only reflected information obtained from participants, the aspect of neutrality was applied. The intention was to give an accurate account and inferences of the challenges which should be recognisable to others with the same challenges. Applicability was achieved by providing enough rich data for comparisons to be made with the findings of existing studies carried out or of future studies. The researcher was consistent by taking into consideration the uniqueness of the participants in the emergency setting and their interpretation of the challenges. The researcher's focus was on the individuality of the descriptions, and not on seeking matching recurrences of problems (Guba, Field & Morse, as cited in Krefting, 1991:215-216).

The researcher, who was also a staff member of the district hospital where the study was done, used reflexivity to counter overly identifying with participants, by keeping a reflective journal to assess the impact of her views, ideas and background on research developments. The researcher noted her concerns, opinions, feelings, ideas and questions throughout the research procedure to assist in identifying prejudices or existing assumptions, and to bring about changes in data assessments and methods (Krefting,

Good, Herrara, Good & Hooper, as cited in Krefting, 1991:218). In data-verification the researcher used the suggestions proposed by Creswell (2009), carrying out a variety of actions. To guarantee trustworthiness, the data transcribed was checked for possible mistakes made when transcribing the interviews. The researcher also cross-checked and compared the interview information to the codes. An independent coder was asked to go over the transcripts and codes the researcher had assigned, and to participate in reaching consensus on themes and subthemes.

To ensure further trustworthiness the researcher included rich data in the findings outlined in Chapter 4, using longer quotations from the participants and the researcher's discussions, to give the reader an experience of what the participants shared in the interview. Sound trustworthiness for the themes was created by giving the different perceptions of the participants and information from different sources in the findings. The study was checked throughout by the supervisor to add to the trustworthiness of the participants' stories. An external editor was used to scrutinise the written report of the study and to add to the corroboration of the study as a whole (Creswell, 2009:190-192).

1.11 ETHICAL CONSIDERATIONS

Permission to conduct the research was obtained from the Senate Higher Degrees of the University of the Western Cape and the Provincial Health Ethics Committee. Participants agreed to participate voluntarily, and their work routine was not interrupted. Their right to withdraw from the study at any time was made clear to them (Babbie, 2010: 64). Research intention was explained and outlined in a written consent form, thus providing a choice to be part of the study or to withdraw. The importance and relevance of the study were explained. Any participant identified as being emotionally at risk was excluded from the study (Patton, as cited in De Vos *et al*., 2011:117). The participants were protected by not publicly disclosing their identity, thereby retaining anonymity and confidentiality (De Vos *et al*., 2011 and Babbie, as cited in De Vos *et al*., 2011:120).

Pseudo names were provided to protect the participants' identity. Information that might harm the participants' employment or embarrass them, was not disclosed (Babbie, 2010:65 - 67). They were not misled as to the purpose of the study, the research

questions, or the researcher herself. Any involuntary deception that may have occurred would have been discussed afterwards with the participants in a debriefing interview, but it was not necessary (De Vos *et al*., 2011:119). Information was validated with the participants to ensure that interpretations were correct (Creswell, 2009:91). A psychologist had volunteered her services for debriefing to participants as suggested by De Vos, *et al.*, (2011:120).

1.12 SUMMARY

Chapter 1 sets the tone of the research study in which the research plan was sketched, providing a background to the study. The research methodology provided the population and sampling procedure, the process followed in terms of data collection and data analysis. The researcher is of the opinion that a qualitative approach to the study allowed her to explore, describe and answer the research question from which the aim and objectives flowed. It enabled her to understand the participants' challenges in relation to substance-induced psychotic admissions, and how these problems might influence their exercising patient care. The researcher explored the "what" and "how" in the challenges experienced, thus daily causal circumstances provided an understanding of the challenges which, according to the attribution theory, allow "control" over the event in the future. Ethical considerations were discussed and self-reflexivity and trustworthiness were explained. Further chapters will discuss all the aforementioned in more detail.

Chapter 2 will provide a review of literature pertinent to the research topic.

CHAPTER 2
A REVIEW OF CORE CONCEPTS AND THEORETICAL PERSPECTIVES RELATED TO MANAGING SUBSTANCE-INDUCED PSYCHOSIS

2.1 INTRODUCTION

Chapter 1 provided the research plan of the study. The researcher gave the background to the choice of the study topic, giving a short description of the emergency department setting, the problem of substance abuse and substance-induced psychosis as well as the extent of the problem. These were linked to the setting of the district hospital where the study took place, with reference to studies of staff challenges and attitudes in working with substance abusers and patients who present with psychosis.

Reference and discussion were given of the attribution theory which the researcher felt would give an understanding into how challenges in managing the substance-induced psychotic patient or assisting with managing might impact on the provision of patient care. Fritz Heider (1944, 1958) found in his early studies of attributions that rational thinking is used daily to understand grounds for people's behaviour. Heider maintains that irrespective of scientific validity for interpretation about causes of behaviour, actions of people are based on their beliefs (Delamater & Myers, 2011). Delamater & Myers (2011) in addition state that attributing behaviour to internal reasons in the individual or to external factors in the environment forms the major evaluations or conclusions that observers derive. The present study seeks to explore and understand the daily challenges experienced in relation to substance-induced psychotic admissions in an emergency department at a district hospital and how these challenges may influence staff attitudes in exercising patient care.

The researcher's choice of the attribution theory was felt to be supportive of the study based on her own observations as social worker at the hospital where the study took place, as well as assumptions that a substance-induced psychotic patient's right to emergency healthcare is inalienable, and that care for the carer (emergency department staff members) is continuous. The choice of attribution theory permitted what Anfara Jr & Mertz (2006) mention in their introductory comments on what a theory is, that to journey

into another person's mind and to see reality from that person's standpoint, is to comprehend theory. Theory is to get a sense of amazement at what seemed to be there all the time but what one had not noticed before. In order to grasp the theorist's concepts there needs to be a mindshift in one's own perceptions (Anfara Jr & Mertz, 2006).

Chapter 1 provided a description of substance abuse, a classification of drugs and the extent of illicit drug use. The psychotic effects on the drug abuser were presented, and the procedures with substance-induced patients at an emergency department at a district hospital were also addressed. A more detailed discussion of psychosis and the different types of psychosis was given, with further elaboration on substance-induced psychosis. The researcher's choice of the attribution theory was given in the above paragraph, and further literature is given in this chapter on the attribution theory, citing studies of relevance. Literature is cited on challenges experienced in managing substance related healthcare problems as well as alluding to literature on the effects of violence, fear and stigma in managing substance abuse and substance-induced psychotic patients in emergency departments. Further pertinent literature and studies extend the discussion of the attribution theory and its relationship to staff members who manage substance-induced psychotic patients. The researcher's role as social worker at the hospital where the study was conducted is also discussed.

2.2 A REVIEW OF COMMONLY USED SUBSTANCES AND THE POTENTIAL OF PSYCHOTIC EFFECTS

All socio-economic groups are susceptible to using substances. There is the possibility of abuse and dependence with all psycho-active substances, whether illicit substances which are not legally recognised, for example dagga or heroin, or substances accepted as legal, for example medicines that contain codeine or prescription medication. In layman's terms psycho-active substances are called drugs and can alter an individual's behaviour, wakefulness, mood, thought trend, and the way things are perceived (Wilson and De Miranda, in Robertson, Allwood & Gagiano, 2001:196). The online Farlex Medical Dictionary defines substance abuse as the wrongful use of any substance and particularly substances that affect perception, alertness and changes in consciousness (The Farlex Medical Dictionary, n.d.). The National Institute of Drug Abuse of the United States

Department of Health Services outlines commonly abused drugs in their March 2011 chart. These are cigarettes and cigars as well as snuff, beer and wine, marijuana, hashish, heroin, opium, cocaine, amphetamine and methamphetamine. Others are ecstasy, which is one of the "club drugs", methylenedioxymethamphetamine (MDMA), lysergic acid diethylamide (LSD) and psilocybin, also known as magic mushrooms.

2.2.1 Statistics of illicit drug users

The World Drug Report (2012) outlines the 2010 per annum occurrence of illegal drug users at a worldwide level, as set out in Table 1 below.

Table 1 Worldwide 2010 statistics of illicit drug users

	Occurrence (Percentage)		Total (Thousands)	
	Low	High	Low	High
Cannabis	2.6	5.0	119 420	224 490
Opioids	0.6	0.8	26 380	36 120
Opiates	0.3	0.5	12 980	20 990
Cocaine	0.3	0.4	13 200	19 510
Amphetamine-type stimulants	0.3	1.2	14 340	52 540
Ecstasy	0.2	0.6	10 480	28 120
Any illicit drug	3.4	6.6	153 000	300 000

Source: World Drug Report (2012)

2.2.2 Classification of drugs of abuse and their effects

Weich (in Baumann, 2007:291 – 292) indicates that a suitable method of classifying drugs with the potential of abuse is by regarding the effects and sensations they have on the individual. There are broadly three groupings of drugs of abuse, namely central nervous system stimulants, classified as 'uppers' with examples being cocaine, amphetamine and crystal methamphetamine, khat and ecstasy. Other stimulants are appetite suppressants, caffeine and nicotine. Examples of central nervous system depressants, classified as 'downers', are alcohol, opioids such as heroin and opium, mandrax and inhalants. Other examples are morphine, codeine and sedative-hypnotics such as benzodiazepines. Hallucinogens or psychedelics are the third group of drugs of abuse and examples are

cannabis (also known as dagga or marijuana), lysergic acid diethylamide (LSD), and magic mushrooms (psilocybin). Another example is ketamine, a dissociative anesthetic. There are substances that are stimulants (dagga) and depressants (ecstasy) that have hallucinogenic effects as well.

a. Central nervous system stimulants ('uppers')

- **Cocaine**

According to the South African Alcohol & Drug Abuse Research Group (2008) cocaine hydrochloride (HCL) and crack cocaine are the two compound types of cocaine. Cocaine is snorted or injected and crack cocaine is smoked or inhaled. When administered in high dosages it may bring about violent and unpredictable behaviour, the individual may become paranoid or dizzy and the pupils may dilate. Withdrawal symptoms may be anxiety, becoming irritable and paranoid. Undesirable mental state effects of cocaine can be psychosis, diminished attention and memory retention as well as compromising of the social, work and psychological environment.

- **Crystal methamphetamine ('Tik')**

Amphetamines are administered by smoking, snorting, intravenous (injecting) and oral ingestion. Crystal methamphetamine is a crystallised form of methamphetamine and is highly addictive (Weich, in Baumann, 2007:313). This stimulant intoxication effects can be physiological, as well as medical and mental health risks. Users can present with violent behaviour or become aggressive, or have an increased chance of convulsions with continued usage. Serious and long-lasting mental state effects are paranoia, psychosis, panic syndromes, confusion, compromised memory and concentration, delusions and insomnia (Plüddemann, Myers & Parry, 2007).

- **Catha Edulis (Khat)**

Khat is a stimulant and an amphetamine. It is the street name for Catha Edulis. The latter is an evergreen plant and the leaves at the top of the plant are chewed or infused in tea and orally ingested. The effects are similar to crystal methamphetamine and cocaine ("Stimulants", 2007:30). The National Institute of Drug Abuse, US Department of Health

(2011) in the information on Khat indicates that ingestion brings about heightened arousal and wakefulness which begins to wane after an hour-and-a-half to three hours, or longer. Mental health conditions cannot be proven as resulting from khat use, but there is a likelihood of aggravating symptoms in individuals who have a psychiatric illness.

- **Methylenedioxymethamphetamine (Ecstasy)**

Ecstasy is known as a designer drug and also referred to as 'stimulant-hallucinogens' since it has both effects. The short lived effects are alike to that of amphetamines for example, restlessness, becoming anxious, suppressed appetite and forgetfulness (Ruiz *et al*., 2007: 85, 116). Weich (in Baumann, 2007) explains that ecstasy normally comes in tablet form but can also be in powder or liquid form and is usually orally ingested. It takes effect after about 90 minutes and the length of the effect can last for up to four hours. The effects after the peak, ('high') has been reached lasts for up to six hours with the individual finding it difficult to go to sleep and is out of touch with reality. These can worsen as the drug wears off, ('crash') with feeling sleepy, expended, and depressed and worsening in mood (Weich, in Baumann, 2007:317).

b. Central nervous system depressants ('downers')

- **Alcohol**

Weich (in Baumann, 2007) explains that the intoxicating effects of alcohol are talkativeness, losing one's reserve, and diminished inhibitions. Emotions and behaviour change and fluctuate, and the person can become volatile as well as aggressive. In larger dosages it triggers suppression of the central nervous system resulting in speech being affected/slurred, there are psychomotor impairments, and with very high intake there is a risk of breathing problems, lapsing into a coma and even death (Weich, in Baumann, 2007:303). Alcoholics will experience withdrawal symptoms of queasiness, perspiring, memory loss, cravings and quivering. There is a risk of seizures from a sudden stop of alcohol. Delirium tremens (alcohol withdrawal syndrome) is a possibly lethal difficulty of alcohol withdrawal. It is detectable by altered awareness, severe anxiety, becoming restless and unusually active, as well as being delusional and hallucinating (Weich, in Baumann, 2007:303).

- **Heroin**

Heroin is an example of a semi-synthetic opioid as mixtures, harvested from natural sources such as plants for example, are used as preparatory ingredients. The words "narcotics" and "opiate" are commonly used, instead of opioid (Preda, 2012). Heroin can be orally administered, snorted, taken directly into the vein or muscle, or the vapours be inhaled. Heroin can be smoked with dagga or mixed with cocaine. The street name of heroin is "unga". Addiction can occur after only a very short time period. Some of the effects of heroin are speech becoming slurred, an incongruent thought pattern and confusion (Corr *et al.*, "Depressants", 2007:47 and Weich, in Baumann, 2007:309, 310). Of the opioids used in South Africa, heroin is the major opioid abused and is mostly smoked. Depression is one of the mental health conditions that result from usage, as well as lingering anhedonia and personality disorders (Weich, Perkel, van Zyl, Rataemane & Naidoo, 2008). Anhedonia is the inability to feel happiness with pleasurable experiences (Brynie, 2009). Setbacks or relapse are not uncommon in opioid addiction as it is a chronic condition. When heroin is used with other substances it can cause psychosis (Weich *et al.*, 2008).

- **Methaqualone (Mandrax)**

The trade names for methaqualone include quaaludes and mandrax, with various street names, but it is commonly known as "buttons". Mandrax is usually compounded, mixed with cannabis and smoked from a broken bottle neck called "white pipe". With intoxication there may be feelings of being relaxed and exhilarated. The user may also feel sleepy, concentration and movement may be affected and speech may be slurred. Users might lapse into unconsciousness. The intoxicating effects can last for a number of hours and as the effects wane, there may be symptoms of aggression ("Depressants", 2007: 49 and Weich, in Baumann, 2007:308). The abuse of mandrax is still problematic in South Africa, certain regions of Africa, and in India. Mandrax increases libido but is dangerous and addictive. Withdrawal symptoms can be intense. Withdrawal includes becoming manic, paranoid, heaving, fits and uncontrollable bodily shaking/spasms and even demise (Goldberg, 2010:194).

- **Inhalants**

Inhalants and solvents are usually used by minors and particularly those living on the street. Examples are glue, paint thinners or stripper, nail varnish and chemicals for cleaning the oven. All of these are fairly easy to obtain. They are inexpensive and not illegal and thus there is no problem in getting them. The early intoxicating experience is pleasurable, feeling exhilarated and losing inhibitions. The more unpleasant results are headaches, feeling bilious, lightheaded, being disorientated, and speech becoming slurred. There is inability to make sound judgments, forgetfulness, unsteadiness in bodily movement and becoming aggressive. Intoxication can render the user delusional and hallucinating which can endanger the user's life (Weich, in Baumann, 2007:311-312).

c. Hallucinogens

- **Cannabis**

Cannabis is commonly known as dagga or marijuana with street names of ganja, weed, pot and boom. Cannabis is the product of upper leaves and stems of the hemp plant that are cut, dried and rolled into cigarettes or joints. The semi-solid/dried substance that oozes from beneath and tops of the plant, is hashish. Methaqualone (mandrax) is usually crushed and smoked with cannabis in South Africa. Though cannabinoids are usually smoked, they can be swallowed or brewed in tea or form an ingredient in food. In comparison with other hallucinogens, cannabis has a greater sedating effect. The manner and frequency of use can vary from experimenting to heavy daily use (Robertson *et al.*, 2001:206; Weich, in Baumann, 2007:315 and "Depressants", 2007:51). Users become intoxicated soon after using cannabis with pleasurable feelings, feeling drowsy, lethargic and having a sense of calmness, but there can be inconsistent displays of aggression. The user might become paranoid and bodily movement may become affected. The attention span, ability to do ordinary tasks and memory being affected are effects of long-term use. Withdrawal symptoms are similar to alcohol, for example restlessness, forgetfulness, agitation, aggression, involuntary muscle movement and bodily quivers. The mental health effects include withdrawal syndromes, worsening of existing mental health conditions, uneasiness, psychosis, diminishing in area of concentration and memory, learning, attention, as well as motivation, and there may be chance of risk of a mental

health condition, in particular, schizophrenia. It might become necessary to have hospital admission when individuals become delirious (Weich, in Baumann, 2007:316 and Robertson *et al*., 2001:206 - 207).

- **Lysergic acid diethylamide (LSD)**

LSD is the most familiar of the hallucinogens. It is obtained from the rye grains' fungi and is processed in laboratories. It comes in liquefied, pill and powder form. In liquid form it can be injected into blotting paper, and LSD is released when put under the tongue ("Hallucinogens", 2007:54 and Weich, in Baumann, 2007:317). The effects of LSD are not the same for all users. There can be problems with coordination, making informed decisions, being anxious or delusional, or illusions and actions can be irregular. There is no withdrawal disorder, but there can be unpleasant experiences known as a "bad trip". There is evidence that LSD use corresponds with the start of depression and there could be thoughts of suicide (Ruiz & Strain, 2011:271 – 272 and Weich, in Baumann, 2007:317).

- **Psilocybin (Magic mushrooms)**

Ingestion of "magic mushrooms", a type of fungi, causes hallucinations with initial effects of euphoria in less than a few hours of use. This can last up to six hours. The impression formed in the senses can evoke another sense impression in the individual, called synesthesia, for example what is seen creates a sound impression. Some individuals have a bad experience, "bad trip" and effects are worsened in individuals with existing psychiatric conditions. Others develop tolerance (Rooney, 2010:36). It contains psilocybin that causes psycho-active effects for example panic attacks, paranoia, hallucinations, anxiousness, agitation, euphoria, flashbacks, and bad trip. If there is cessation of the substance, the effects are heightened with eating, bodily cramps and pains, tiredness, presenting with aggressive behaviour, or becoming depressed ("Hallucinogens", 2007).

2.2.3 The effects of substance abuse on the family

A study by Schäfer (2011) indicated that substance abusing individuals felt that they were unable to develop functional relationships with their immediate or extended family. The

abuse of substances affects all areas of the substance abuser's life, amongst others, family life, health of the abuser and financial circumstances. The Center for Substance Abuse Treatment (2004) in United States indicates in their treatment and improvement protocol that substance abusers can find themselves excluded from family, who may experience resentment, guilt, embarrassment, fear, anxiety, or concern. Family might also be in denial or might take to ignoring the substance abuser or severing ties. The concept of family suggests lifelong emotional connection that individuals have, and though family may find themselves in different countries across the globe, the emotional connection remains. Concern should be for both the substance abuser and the family members who have an important part to play in the treatment programme of the abuser. Attending to the family unit as a whole is important. Gifford (2011) echoes the importance of family in the life of a substance abuser, in particular in motivation to treatment. The effects of anger and detachment are repeated, pointing out that family and significant others who mean well can get ensnared in the cycle of aiding the substance abusing individual, and a relationship of mutual need. Family members who ignore the abuse of substances and go about their daily life routine pretending there is no problem, inadvertently make the problem worse for the substance abuser.

2.3 PSYCHOSIS AND SUBSTANCE ABUSE

The term psychosis is a common one and not well defined. It is widely used to mean the range of severe psychiatric disorders leading to disturbance in behaviour and diminished functioning. A central element of psychosis is that of deficient insight. Psychosis is an atypical mental state. There might often be symptoms of delusions and hallucinations but these are not always present. There are a number of mental health conditions that are connected with psychosis. Amongst these is schizophrenia where there is disorder perceptively, cognitively and behaviourally. It is a restrictive condition affecting the person's ability to perform as an individual. A difference needs to be drawn between intoxication; psycho-active substance-induced psychotic disorders and psychiatric disorders caused by psychoactive substances. Psychosis can be symptomatic of causative substances, especially amphetamine-connected substances, including methamphetamine (TIK) and cannabis (dagga). There have been supportive results that cannabis usage is

connected with a poor effect in schizophrenia and exacerbates the condition in those inclined to the illness (Baumann, 2007:457-467).

In delusional disorder there are strong false beliefs of grandiosity, control, persecution and suggestion (Karjiker, in Baumann, 2007:718). In dementia, there could be psychiatric problems arising from alcohol abuse, such as alcohol-induced dementia or alcohol-induced psychotic disorders (alcohol hallucinosis or alcohol delusional disorder). Dementia is deterioration of the persona, memory and intelligence, affecting all spheres of the person's life (Potocnik, in Baumann, 2007:494 - 495). Persons who suffer bipolar disorder experience episodes of abnormally low or high mood fluctuations and display signs of psychosis. Substance abusers who present at a hospital with psychosis and requiring admission might well be a first presentation of bipolar disorder, which could be diagnosed from information from escorts who know the person regarding the mood prior to use of either stimulants or sedatives. Bipolar disorder is known as manic depression as well (Horn, in Baumann, 2007:446 - 447).

Other types of psychosis are, major depressive disorder, where there might be elements of psychosis in severe cases, with the person hallucinating and being delusional. A substance that is familiar and extensively abused is alcohol. Abuse thereof is sufficient to result in a mental health condition like depression (Joska, in Baumann, 2007:430, 434). A common medical condition or substance use (intoxication or withdrawal) can result in delirium, which is an interruption of awareness, diminished reasoning, perception and thought pattern due to scattered failure of the brain to function normally. The basic principle is to identify and treat the underlying cause (Baumann & Lewis, in Baumann, 2007:483 – 488).

Freudenreich (2008:29, 30) explains that psychosis can result from numerous substances – legal, illegal, over-the-counter and herbal – and the absence of delirium. There are a variety of aspects that must be taken into consideration when doing an assessment for conclusion of substance-induced psychosis, such as how long the person has been using substances, what are the signs and symptoms displayed, and what are the urine test results. There are substances that result with certainty into psychosis with one usage only, for

example lysergic acid diethylamide (LSD) or phencyclidine (PCP), while other substances, like dagga, cause psychosis in a small number of persons, with psychosis resulting in persons who use the substances after a long time, for example cocaine. Alcohol is a major substance which, when in withdrawal, can bring about psychosis and so too sedative hypnotics. Opiate use, in exception, results in psychosis (Freudenreich, 2008).

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV, 1994), with reference to substance-induced disorders (e.g. substance withdrawal, substance intoxication and substance-induced psychotic disorder) makes a differentiation between substance intoxication and substance withdrawal. Substance intoxication is a changeable substance-specific condition which occurs with the intake of substances. The degree of intoxication differs from person to person depending on the substance and amount used as well as how long it is used, the effects of the substance on the individual, and when the last dosage of the substance was taken. Changes that occur can be psychological and behavioural. This includes interference in the ability to concentrate, thought pattern, alertness, decision making, bodily movement and actions, and relations. Substance withdrawal occurs when previous heavy or continued substance intake is lessened or stopped, resulting in enough medical concern or diminished effectiveness in social, behavioural, work, psychological or other areas. In both instances of intoxication and withdrawal, the benchmarks for diagnosis are that it is not symptomatic of a medical condition or due to another mental health condition (DSM-IV, 1994:183-185).

The criteria for diagnosis of substance-induced psychotic disorders are a challenge, and there remains a lack of research which thoroughly scrutinises the weight of the DSM-IV diagnostic measures for all substances. There is a scarcity of data, results, best intervention and management for substance-associated psychotic episodes (Mathias, Lubman & Hides, 2008:385).

Noticeable hallucinations or where the individual is delusional, are distinctive to substance-induced disorders, and are attributed to the direct response of the body to a substance of abuse, medicine, or contact with harmful poisons. Substances of abuse have

been linked with volatile behaviour. Certain individuals may also respond with violence due to intake of drugs that have been prescribed (e.g. benzodiazepines), owing particularly to the sedating effects. When individuals present at an emergency department with instabilities in their mental state, it might be due specifically to alcohol intoxication or withdrawal, or from another substance of abuse. Severe instabilities in behaviour related to alcohol and/or drug abuse are not an uncommon problem in the emergency department of the hospital (Wilson and De Miranda, in Robertson *et al.*, 2001:199, 277, 381).

2.4 CHALLENGES EXPERIENCED IN MANAGING SUBSTANCE-RELATED HEALTHCARE PROBLEMS

Results of several hospital studies in the United Kingdom have shown problems arising from lack of regulations in respective healthcare roles. These studies emphasises the lack of knowledge and skills by staff members to assist and to treat substance-induced psychotic patients. Personal acquaintance with people who use drugs affects how the staff members treat these patients (Currie & Crouch, 2008; Clutterbuck, Tobin, Orford, Copello, Preece, Birchwood, Day, Graham, Griffith & McGovern, 2009).

The results of a study in England revealed that psychiatric nursing staff's attitudes and judgements were based on personal experiences, especially with regard to individuals with dual diagnosis (schizophrenia and substance abuse). Interestingly enough, they were less critical about those substance abusers who were known to them. The need for further staff development programmes was identified, as well as opportunities to address the experiences, challenges and views of staff (Ralley, Allott, Hare & Wittkowski, 2009). In addition, a study in Ireland has shown that there are also challenges in clinical experiences of many health and social care professionals who have ingrained negative opinions about illegal drug users (MClaughlin *et al*., 2006).

On the contrary, findings at United States of America (USA) hospitals showed that emergency clinicians rendered quality care, irrespective of negative attitudes. It appears that substance abusers received better care than non-substance abusers (Segal & Dittrich, 2001). Results by Schanzer, First, Boanerges Dominguez, Hasin & Caton (2006) about emergency departments in Upper Manhattan revealed that the management of substance-

induced psychosis patients depended on the diagnosis. The author concluded that improvement in the approaches of clinicians in emergency settings were important when identifying the problem instead of attributing psychotic features to a primary psychotic disorder, and identifying that it coexisted with substance use. Likewise Hussein & Villar-Luis (2004) of Brazil emphasised that refusal by healthcare workers and the public to acknowledge extreme substance abuse present a challenge with regard to early recognition of substance-induced psychotic patients, as well as effective care and health education. It was however stated that negative attitudes of health professionals were changing in Brazil.

Kelleher & Cotter (2009), in a study in Italy found that doctors and nurses showed knowledge and attitude about substance use and substance abusers and indicated a dire need for education and training in substance use. Knowledge was found to be general pertaining to alcohol and drug abuse but there was a lack of knowledge in other substances as well as action plans. Conclusions were that training, operational standards and policies were needed to aid managing patients who present at the emergency departments for abuse of substances. Similarly Van Boekel, Brouwers, van Weeghel & Gerretsen (2013) emphasised the stigma of substance use disorders, the effect on service delivery, and negative attitudes, and suggested staff development to advance the mindset towards individuals presenting with substance-induced disorders. The aforementioned authors asserted that staff members who deal with these patients should receive support and counselling which might bring about constructive outcomes for both staff members and the care provided to those patients presenting with substance-induced disorders.

In Northern India the common problems of poor levels of staff satisfaction in government and non-government facility were identified apart from the poor level of skills in managing substance-use problems (Phillips, 2007). A comparative study in Australia found that substance-induced psychotic patients experienced more severe mania and disturbed behaviour on admission than persons with a primary psychotic disorder (Dawe, Geppert, Occhipinti & Kingsweel, 2011). In addition, results of a study on the knowledge, beliefs and attitudes of healthcare professionals towards mentally ill persons in Delta State, Nigeria, showed that cultural beliefs determined their attitudes, and not their medical knowledge and medical expertise. Health workers in Delta State

government viewed individuals with substance-induced psychosis as being reckless and excessive (Ewhrudjakpor, 2009). Results of a study at a teaching hospital also in Nigeria were that healthcare workers feared working with patients who had a mental health condition, in a general hospital environment. They preferred that there be separation of the wards and the patients. Results also concluded that training programmes and more constructive exposure to psychiatric patients during patient management, would decrease the attitude of a psychiatric condition (Chikaodiri, 2009).

Apart from stigmatisation, findings in Ghana and Uganda emphasised the shortage of staff to deliver services to substance-induced psychotic patients and expressed the need to reform legislation in order to improve care, mental healthcare and to protect human rights (Ofori-Atta, Read & Lund, 2010). Apart from staff shortages, nurses at a psychiatric hospital in Gauteng, South Africa experienced daily challenges in managing patients who were aggressive and violent. Contributing factors pointed to the type of patient that was admitted; lack of support among the multi-disciplinary team members, and lack of orientation to deliver services to these patients. The challenges resulted in attitudes of indifference, absenteeism, frustration, fear and substance abuse (Bimenyimana, Poggenpoel, Myburgh & Van Niekerk, 2009).

2.5 THE EFFECTS OF VIOLENCE, FEAR AND STIGMA IN MANAGING SUBSTANCE ABUSE AND SUBSTANCE-INDUCED PSYCHOTIC PATIENTS

Apart from the challenges and attitudes described in the above paragraphs (2.4.1), a study in managing substance related healthcare problems, the USA on violence against nurses in the emergency department concluded that violence against nurses from patients and visitors was a common feature (Gacki-Smith *et al*., 2009). Likewise, results of a study at a health facility in Italy on the incidence of violence towards healthcare workers and its link with emotional and mental aspects of the staff members, were that risk of verbal and physical violence towards doctors, nurses in the emergency department, and health professionals rendering psychiatric services were higher than risk of violence towards other staff members (Magnavita & Heponiemi, 2012).

Sorsdahl *et al*., (2012) found in a South African public survey that the stigma attached to all classes of substances are high but cannot be generalised to the broader South African population. Drug addiction was categorised as the most stigmatised condition. Those with psychotic disorders are frequently seen as being a risk and danger, as well as unpredictable. Substance-induced disorders seem to evoke added stigmatised responses. Myers, Fakier & Louw (2009) found in their study in Cape Town amongst the marginalised persons that there was stigmatisation of persons who had a disorder induced through the use of substances. This in turn affected seeking help from services. The use of current services was hampered by the adverse opinions on the success of intervention and these views posed as obstacles. In addition how persons with a substance-induced disorder were portrayed by the media and the amenities providing the treatment, added to the obstacles.

2.6 THE THEORY THAT FRAMES THE STUDY – ATTRIBUTION THEORY

As indicated by Anfara Jr & Mertz (2006:189), a theory used by a researcher in the qualitative approach, has a significant role to play. The attribution theory was the framework which outlined and formed what the researcher was looking at and was inclusive of how the researcher thought of the study and how the research was conducted. The researcher's assumptions are given in the introductory comments of this chapter.

The classic work of Hewstone (1989:9-10) indicates that the attribution theory uses two groups of concepts for the explanation of behavioural outcomes. The one group exists internally in the individual (dispositional attribution) and the other considers the factors present in the environment (situational attributions). The author asserts that societal approaches to attributions have been ignored in the attribution approach. Social attributions may be influenced by social interactions or social influences; attribution is made involving a person; attributions are public in that, for example, the same experience may have diverse explanations for different individuals. Hewstone **(**1989:9-10) asserts that causal attribution should be psychological and social.

People are apt, according to the attribution theory, to attribute another person's conduct to internal personality and qualities but tend to attribute their own altered behaviour to outside influences. The attribution theory assists to shed light on how people see and evaluate the cause of behaviour and its effects. Internal, individual attributions assume that people's individual traits bring about their conduct or experiences. External or circumstance attributions assume that outside influences decide people's conduct or experiences. People are able to evade the basis that dreadful things occur entirely per chance and thus not within control when they attribute the root cause of the range of demeanours and events to particular influences. The causes of events and behaviour involve people's attribution viewpoints of the causes which are commonly founded on experience or what has been observed. These views serve as clarifying or for hypothesising why things occur or are going to occur in a definite manner. The incorrect view of a chain of events, in which the cause is wrongly assigned, constitutes misattribution. People's behaviour, their anticipations or hypothesis about experiences can be constructed by attributions and misattributions thus showing the important part the latter can have (Parrish, 2010; Weiner and Vourlekis, as cited in Parrish, 2010:124).

Problems linked to the abuse of substances and in particular addiction to drugs seems to be mostly stigmatised. Stigma can be comprehended as an attribute, conduct or a standing that in a social context can harm, shame or disgrace the person (Room, Rehm, Trotter, Paglia & Üstünas, as cited in Kelly, Dow & Westerhoff, 2010:806). The extent of stigma is frequently watered down if a reason for a substance associated problem is for example seen as not the person's fault or if the person is exonerated as helpless. This often brings about feeling of sorry and compassion for the person. Whereas if the person presenting with the substance-related problem is seen to be able to exercise control they are met with being at fault, irritation, resentment and little want of being of service (Hegarty & Golden, as cited in Kelly *et al.,* 2010:806).

The assumptions of the attribution theory of internal and external attribution as explained in the above paragraphs links to what literature (Tashakkori & Teddlie, 2010:106-107) indicates that difficult or motivating circumstances or job requirements can be

experienced as challenges. Each person's perception, version or interpretation may differ, which in some way supports their actions.

2.7 THE ROLE OF THE SOCIAL WORKER IN THE EMERGENCY DEPARTMENT OF A HOSPITAL

Social workers work in a variety of settings including in a hospital setting (Nelson, 2012:169). The role of the social worker in the emergency department is fast-paced. A variety of cases ranging from suicide assessments, evaluation of patient care, substance abuse, mental health problems, terminal patients, to living related matters are dealt with. The substance-induced psychotic patients cannot be attended to upon admission owing to their psychosis. Substance-induced psychotic patients can be referred to the social worker when they are no longer psychotic for substance abuse related problems as well as individual, family or social related problems. Family members are also referred to the social worker for the mentioned problems connected to the patient. A small team of social workers are delivering services not only in the emergency department but also in other wards in the hospital where the researcher is working. Various challenges impact on the rendering of social work services on any given day. The type and number of referrals can be challenging. Language barriers, staff shortages due to a variety of reasons, limited or no community resources or significant others to refer patients to, or unrealistic expectations from family, add to the challenges the social worker experiences (Van Pelt, 2010; Fusenig, 2012).

2.8 SUMMARY

Defining substance abuse, the different kinds of drugs, psychosis and its different types as well as providing global, national statistics of drugs of abuse, illicit drug users and their treatment provide insight into the extent and effects of substance abuse. An indication is that substance-induced psychosis is one type of psychosis that can result from substance abuse which often requires treatment in the emergency department of a district hospital where all other emergency cases are seen as well. The statistics of the hospital where the researcher is working and the brief information on the hospital where these patients are referred to for psychiatric treatment provide further insight of the prevalence of substance-induced psychoses. The relevant literature reviewed compares and contrasts with findings

of this study which will be discussed in detail in Chapter 4. Studies accessed provide comments on staff challenges in dealing with these patients and shed light on findings of participants of this study's challenges where fear and resentment as major emotional challenges were noted throughout the study. These challenges form part of the thematic discussions in the findings of this study.

It is also noted that there are not enough qualitative studies with specific reference to substance-induced psychosis and a study of this nature which includes non-medical staff will be useful. The attribution theory gave an idea of attributions that staff members make and how, based on the level and extent of the attributions, the substance-induced psychotic patients are managed or assisted in being managed. Indications are that the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) has had an effect on district hospitals. The importance of family in the life of the substance abuser as well as cognisance of their own need, were pointed out. The role of the social worker gives insight of the social worker role in dealing with the substance-induced psychotic patients. The qualitative methodology used to embark upon this research undertaking, proposed in Chapter 1, is described in Chapter 3.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 discussed literature reviewed on the topic namely, **the challenges experienced by staff in managing substance-induced psychotic patients in the emergency department of a district hospital**, which the researcher considered relevant to this study. Chapter 3 will explain the research methods and processes used in executing this qualitative study at the district hospital. The importance to the study of the research question is outlined. The aim as a guiding force to the research design is described, followed by the objectives which formed the steps taken in order to attain the aim. Further discussions centre on the research approach and research design which one should be able to duplicate in other research. The research methodology outlined describes the research setting, population and sampling, the preparation for the data collection, setting up the interviews, conducting the interviews, and the pilot interview. The discussion in the data analysis gives the steps followed in analysis of the information.

3.2 THE RESEARCH QUESTION AND AIM OF THE STUDY

A research question is a comprehensive question that requires exploration of the essential experience or idea in a study. The various perceptions of the participants, or what the study meant to them, will be presented (Creswell 2009:129). A qualitative research study starts with devising questions which will be answered in the collecting of data. The research question is general and abstract and differs from the questions in an interview guide. The findings of this study were obtained with the aid of interview questions in the interview guide. Interview questions should be comprehensible to those being interviewed, and phrased in easy, conversational language (Hennink, Hutter & Bailey, 2011:33–34). The research question was therefore central to what the researcher wanted to explore, and reverberates through findings from participants' interpretations and the meanings assigned, in Chapter 4.

The **aim of this study was to explore and describe the challenges of emergency department staff managing substance-induced psychotic patients.** The researcher regards this study as significant in providing a base of understanding and awareness of the challenges that the participants regularly experience.

3.3 THE RESEARCH OBJECTIVES

Objectives are the steps taken in order to reach the aim. Descriptive research results in thick description of the particular information of an issue or problem. Amongst the various reasons for using social research, the most frequent and helpful ones are for exploration and description (Babbie, 2010:92, 94; Fouché & De Vos, in De Vos *et al*., 2011:94, 96).

The **objectives of this study were:**

- **to explore and describe emergency department staff members' understanding of substance abuse;**
- **to explore and describe staff members' perception of the difference between substance-induced psychotic patients and other patients in the emergency department;**
- **to explore and describe what it is like for emergency staff members to deal with substance-induced psychotic patients in an emergency department.**

The challenges could only be described once they were experienced in order to give insight into what it was like to manage these patients. This descriptive study yielded rich data and explanations could be deduced from findings, making attributions for attitudes and emotions, discussed in Chapter 5, of the participants in this study.

3.4 THE RESEARCH APPROACH

Undertaking social research can be for reasons of investigating, giving an account of something, and for giving insight into a certain topic or phenomenon (Babbie, 2010:92). Creswell (2009:4) indicates that there are three research approaches, namely qualitative, quantitative and mixed methods. A qualitative research approach provides one with an

avenue to explore and gain understanding of the significance of a problem or issue from the perspective of a specific person or group. A qualitative research approach is non-numerical but through data analysis, can provide meaningful interpretation of the findings which may either compare or contrast with earlier information. A quantitative research approach involves gathering of data and statistics and therefore graphs or tables are used in data analysis and feedback. It uses statistics to compare, relate or describe variables or a combination of variables through the use of various strategies of enquiry (surveys, experiments, correlational, comparative). A mixed methods approach is a combination of qualitative and quantitative approaches (Creswell, 2009:4, 51, 133). Qualitative and quantitative research approaches are the two familiar approaches (Fouché & Delport, in De Vos *et al*., 2011:63).

Adopting a qualitative research approach and strategy of enquiry afforded the researcher the opportunity to explore and describe **the challenges of emergency department staff members managing substance-induced psychotic patients**. Understanding and insight were gained into participants' perspectives, values, attitudes, concerns, fears and behaviours. What was important, apart from the understanding, was the meaning of the data. Through specific steps followed for qualitative data analysis, the explorative and descriptive objectives were achieved (Creswell, 2009:4, 232; Babbie, 2010:92; Fouché & De Vos, in De Vos *et al.*, 2011:95 - 96).

3.5 THE RESEARCH DESIGN

By using a qualitative research approach the researcher used an exact direction for processes, provided in the research design. A research design creates a plan, and a distinctive feature of a good research design is that it provides a duplicable blueprint of a study that can be followed by another person. A qualitative research design provides an avenue for exploration and understanding to be gained into the situations or problems of others (Kumar, as cited in De Vos *et al*., 2011:110; Creswell, 2009:4). Understanding could be gained through the individual interviews that were held to explore the meaning of the challenges that participants described from attending to substance-induced psychotic patients. The data collection process involved semi-structured, individual interviews,

guided by questions in an interview schedule. The questions as set out in the interview guide are outlined in section 3.6.7.2 of this chapter.

Coupled with the explorative nature of this qualitative study was the purpose of describing the challenges that the staff members experienced. The interviews generated descriptive data in staff members' spoken words. Inferences could be drawn from what they said and from observations in the semi-structured interviews. Comparisons as well as contrasts could be made between existing literature and these findings. This constituted inductive reasoning which started from wanting to understand more about the challenges that staff members experienced with these patients in the emergency department of a district hospital. The researcher could arrive at some understanding and conclusions about the topic being investigated (Leedy & Ormrod, Kumar, McRoy, as cited by Fouché & Delport, in De Vos *et al.*, 2011:64, 65; Nicholls, 2009:531, 532).

Thus, following a qualitative approach with its specific research design allowed the researcher to gain understanding and insight into the understandings, attitudes and beliefs, apprehensions, fears, and desires of this group of hospital staff members who managed or assisted in managing substance-induced psychotic patients (Creswell, 2009:234). The qualitative research approach was therefore deemed the best approach to achieve the aim and the objectives of the study.

3.6 RESEARCH METHODOLOGY

3.6.1 The research setting

As quoted by Creswell (2009:175) and Boeije (2010:35), a characteristic of qualitative research is the opportunity to gather information in the natural setting of the participants, which allows for one-on-one communication and contact. The authors cited indicate that thought has to be given on the benefits and outcomes of doing research in such a setting. The choice about where to conduct the interviews was based on the convenience of the hospital where the participants worked and were accessible. The emergency department was chosen since it was the best suited location for interviewing the emergency staff, being less time-consuming and easily accessible.

The Farlex's Medical Dictionary (n.d.) describes the emergency department in a hospital as an area where emergency care is provided to individuals who have suffered severe trauma or sudden sickness. It is a triage area with all the necessary equipment and staffing to screen and classify patients to render the quickest service. It is also the main point of entry into the mental health system. Here individuals presenting with psychiatric features are managed by medical and non-medical staff to assess whether further psychiatric intervention is necessary. In summary from legislation in the Labour Relations Act of South Africa (Act No. 66 of 1995), section 213 (a) and (9), staff members may be seen as any person employed by another person to assist with the rendering of a service, and any other individual who also helps in other ways to aid with the service offered. Doctors, nurses and support staff render 24-hour service, and are required to be able to deal with any trauma or emergency situation (Griffin, 2010:62).

Psychotic patients arrive at the emergency department via ambulance, on their own, accompanied by family or significant others or strangers, or are brought in by the police, particularly if there is inappropriate behaviour or the individual is violent, agitated or disorganised. They are attended to, a psychiatric evaluation is arranged, and they are referred to a separate ward for psychotic admissions (Riba & Ravindranath, 2010:116-117). Psychosis greatly impairs the individual's sense of reality and thought patterns. The Mental Health Care Act of South Africa (Act No. 17 of 2002), regulation 4 (a) stipulates that care must be provided at primary, secondary and tertiary hospitals. The said Act stipulates in regulation 6 (1) (a) and (b) that any individual requiring mental health care services must be attended to within the scope of practice, or appropriately referred to health facilities that provide the required level of mental health care.

3.6.2 Population and sampling

The crux of qualitative research is to discover the individual and joint meaning that participants give to matters (Denzin & Lincoln, Silverman and Gubrium & Holstein, as cited in Nicholls, 2009:590). As pointed out by Geertz, and Halloway & Wheeler (as cited in Nicholls, 2009:590) a qualitative researcher searches for participants who will be able to provide in-depth and valuable information on the topic that is being researched.

Qualitative research frequently starts with a small sample of the population, and the researcher is not as detached from participants as in quantitative research. In qualitative research there is no hypothesis to be tested, and new problems can be explored by the researcher as they emerge from the participants in answer to the research question. Qualitative research is therefore flexible, and analysis is not aimed at quantification of findings, unlike quantitative research, which involves a larger population size and is rigid by comparison (Broom & Willis and Carpenter & Suto, as cited in Nicholls, 2009:590; Kumar, as cited by Fouché & Delport in De Vos *et al*., 2011:65). DePoy & Gitlin (2011: 161,169) and Rubin & Babbie (as cited in De Vos *et al*., 2011:392) view the population as the group of persons or components or both, with a set of shared features predetermined by the researcher.

The sample of individuals who take part in a study are a subsection of the population. Sampling is the process of selecting a sample from the population. The authors cited further indicate that purposive sampling is also referred to as "judgmental sampling" because it entails the intentional selection by the researcher of individuals or features on the grounds of predetermined criteria. Creswell (2009:178) and Coyne (as cited in Boeije, 2010:35) suggest that purposeful selection occurs when the sample from the study population described will assist the researcher in best understanding the research question and the problem. Thus the sample of 10 in this study was intentionally sampled from the emergency department staff population until data saturation occurred (Kumar, 2011:192). Bloor & Wood (2006:153) state that a sample is selected from the population which is typically representative of a unit of analysis. Steward (in Finlay & Ballinger 2006:41) concludes that the general intention in sampling is to access a sufficient number of participants to be able to represent the population in providing information applicable to the research question, goal and objectives of the study. Likewise Barker (as cited by Strydom in De Vos *et al.,* 2011:224) indicates that a sample is a smaller number of the total number of people representative of the bigger number (population) from which an understanding is to be gained. The unit of analysis in this study was the 32 emergency department staff members of the hospital from which the sample was drawn. The diversity of the emergency staff members, the resources that were available, the level of considered truthfulness, and the actual sample category, had an influence on the sample

size of ten participants (Grinnell & Williams, and Neuman as cited in De Vos *et al.*, 2011:225).

The sample of participants was selected from day and night rosters, with the assistance of the immediate supervisor or the unit manager in the emergency department. Verbal and written explanations of the study were given to the supervisor or the unit manager. The staff members identified were approached by the researcher and they were given a verbal and written explanation of the study (see Appendix A, page 157). They could peruse the written information in their own time. Staff members who consented verbally had to do so in writing as well on the day of the interview, with their immediate supervisor or manager signing as witness. Section 3.6.3 gives a further explanation on setting up the interviews.

The **criteria for inclusion** were such that only ten staff members managing or assisting in the managing of substance-induced psychotic patients in the emergency department were purposefully sampled:

- Participants needed to be able to **speak and understand English** since the researcher was not going to make use of a translator as interviews would have been longer and the essence of the participants' meaning could also get lost.
- The participants needed to **sign an informed consent form** before they took part in the research in recognition of protection of their rights as participants, including a guarantee of confidentiality (see Appendix B, page 159).
- Participants had to be **working at the hospital** where the study was done.
- **Only staff members in the emergency department managing or assisting in managing the substance–induced psychotic patients** were considered since that was the population that the researcher was interested in gaining information from (Babbie, 2010:199). Sampling of participants stopped when data saturation was reached (Halloway & Wheeler, 2010:144, 340; Monette, Sullivan & De Jong (as cited by Greeff in De Vos *et al.*, 2011:350) and Seidman (as cited by Greeff in De Vos *et al.*, 2011:350).

3.6.3 Preparation for data collection

The researcher followed the actions in preparation for data-collection through in-depth interviews as highlighted by Hennink *et al.*, (2011:120-123). In the following discussion the steps of Hennink *et al.*, (2011) are given in bold lettering with the researcher presenting the steps taken for data collection in the study:

- **There needs to be permission to do the research, and forming a link with the study population is important.** In this study the researcher informed the managers of the operational managers' team of the hospital that permission was granted by the Health Ethics committee and the executive hospital management to proceed with the study (see Appendix C, page 160). The study was explained to them, including how participants would be selected and approached. A schedule of the proposed appointments with participants was provided in order to obtain permission for the participants to attend the interview in a specific timeslot.

- **An appointment for the interview has to be made.** There was mutual agreement between the researcher and participants in arranging the date and time of the appointments. The participant's written consent to partake in the study was obtained on the actual day of the interview. Managers or supervisors were given a written explanation of the researcher and the study. The time for the interview was taken into consideration based on the availability of participant, the venue where the interviewing would take place and the estimated duration of the interview. More details with regards to the arrangement of interviews are provided in section 3.6.4, in this chapter.

- **A suitable location to conduct the interview has to be secured.** The researcher identified a suitable office in the out-patients' department for conducting the interviews, and obtained permission to use it for the duration of the study before she met with the respective managers. The office was selected for its situation in the hospital where disturbance and noise level were minimal,

and where generally there were no patient services or working staff after 16h00 on a week day, and no services on a weekend. One interview took place on a Saturday. The setting and time were thus suitable for interviewing.

- **Be prepared with writing material and recording equipment.** The office was prepared before interviews took place, regarding the seating, the setting up of the digital recorder and testing to make sure that it was in a working condition. There was one instance where the battery was flat near the end of the interview, but the researcher could write down the last part of the conversation. Writing material for the researcher was also placed in position beforehand.

3.6.4 Setting up the interviews

Supervisors or managers acted as gate keepers and identified participants from day and night working rosters, who were then approached by the researcher. The explanation of the study, digital recording, and the ethical considerations were explained, allowing them to volunteer to be part of the study. In instances where participants withdrew, others were recruited. In the case of a non-medical participant withdrawing twice, the participant recruited a colleague in his place and identified the new participant to the researcher. This participant met the selection criteria and the same procedure of explanation of the study was followed. Apart from verbal explanation of the study, the potential participants were given the information sheet to read in their own time. Participants and their supervisors were also informed where the interview would take place. The staff member responsible for locking up the interleading department door was informed. In addition, a notice was placed on this door to indicate that the researcher was busy with an interview, in order to avoid interruptions. The security manager was alerted about the times of the interviews for safety reasons, since the majority of interviews were done after 16h00, and one on a weekend. Two interviews were not done in the assigned office because of the participants' requests, but were done elsewhere in the hospital premises without disturbance and a minimum level of noise.

3.6.5 The pilot study

The pilot study was included in the plan as a trial run allowing the researcher to reflect and make adjustments, which proved helpful. An interview was conducted with a non-medical participant. The interview schedule, as research instrument, could therefore be reviewed and was refined afterwards in simpler understandable terms giving the same meaning. The pilot interview allowed the researcher to practise the interview techniques that were going to be used during the interviews and to determine the expected timeframe. In addition, the safety of the researcher and the participants could be assessed in the particular area where the interviews were to be conducted. The timing of taking notes and writing of reflective notes was also evaluated (Bloor & Wood, 2006:130 – 131; Oliver, 2010:97; Sampson, as cited in Marshall & Rossman, 2011:95). The pilot interview was followed by ten interviews until data saturation took place (Monette *et al.,* as cited by Greeff in De Vos *et al.,* 2011:350); Seidman, as cited by Greeff in De Vos *et al.*, 2011:350).

3.6.6 Data collection

Data were collected by means of individual interviews, guided by a semi-structured interview schedule (Boeije, 2010:62). As recommended by Creswell, (2009:175) the researcher was the main instrument for data collection in this qualitative study, and she had to do careful planning regarding the ethical considerations and reflexivity. Hennink *et al.,* (2011:70-75) stresses important aspects in data collection, such as providing adequate information to the participants about the study, the researcher and the processes; the fact that recording will be done; who has access to information that is transcribed and what happens after data collection. The prescribed ethical considerations as indicated in 1.10 of this study were followed. Staff members were referred to as "medical staff members" or "non-medical staff members" and in a few cases their job title were used in the data analysis. This was done when it became evident during the data analysis that medical and non-medical staff members attached different meanings to the challenges that staff experienced in managing the specific patients owing to their different roles. Giving them the opportunity to share the challenges they experienced was positively received while becoming conscious of their own feelings and thoughts. It also resulted in their considering and putting forward recommendations about the challenges they described.

Sensitive issues caused stress and disturbance to the participants and therefore debriefing by a psychologist as support to the participants was available. The opportunity was, however, not used by the participants. The researcher herself was involved in debriefing sessions with a psychologist for sensitive issues revealed in the interviews and for her own reflections (Hennink *et al*., 2011).

3.6.7 Conducting the interviews

3.6.7.1 The interview protocol

The researcher used an interview protocol incorporating some of the components as outlined by Creswell, (2009:183). A copy of the information sheet of the study was set out in the office where the interviews took place, which the participant could refer to while the researcher explained the study, reasons for conducting the research, the process including the digital recording, the ethics involved, what would happen with the transcripts, and who would have access to the transcripts. The researcher followed the same instruction for each interview so as to standardise all the interviews. A general question was used as an ice-breaker to the interview. Each participant had an identifying sheet containing their name and date of interview, on which the research question was also outlined. The researcher had writing material to note further questions, keywords and reflective notes. The interview started and ended with thanking the participant for partaking in the study (Creswell, 2009:183).

The interviews were done in English and were in-depth, with the researcher using interviewing techniques and communication skills (Greeff, in De Vos *et al.*, 2011:343 - 346) discussed in the next paragraph. These techniques and skills allowed for flexibility in order to create a relaxed, informal and trusting atmosphere. Though employed at the hospital where the research was done, the researcher still needed to build a rapport with the participants at the beginning of each interview to put them at ease. The seating arrangement assisted, in that the researcher was not seated behind the desk in the office where the interview was done. The desk would have been a barrier between the researcher and the participants. The connection could be observed throughout the interviews in the participants' non-verbal communication such as eye contact, body language, expression and tone of voice. The rich data that came from the interviews is

evidence of the rapport built since participants felt at ease in sharing information (Hennink *et al.*, 2011:123-128).

Collecting data through interviewing demands skill, and therefore the researcher relied on valuable guidance from literature on interviewing and communication skills as set out by Greeff (in De Vos *et al.*, 2011:343-346). Examples of these are that the participant should do most of the talking; words used must be understandable to the participant; silence in the interview should not make the researcher feel uneasy as pauses give time for the participant to think something through; a question can rather be written down to be explored instead of interrupting the participant; the effects of the interview on the participant are to be observed throughout, and follow the researcher's instinct. Examples of communication skills used were paraphrasing the staff member's information to increase the efficacy of what was said and showed that the researcher was paying attention; clarifying, in order to be clear on what the staff member had said; reflection, so that the staff member could add something significant they mentioned; reflective summary, by summing up what the staff member had said to assess if the researcher understood it, and to keep the information flowing; listening and probing, to get more information (Greeff, in De Vos *et al.*, 2011:345).

The researcher used the above interviewing and communication skills as the interview was the main method of collecting the information from the participants. The researcher needed to put the participant at ease, and therefore after briefing and thanking them for agreeing to take part in the study, a general question was asked which opened up the conversation. The researcher knew the questions in the interview schedule but remained attentive to what the participants said and allowed them to tell their story. She was not intent on following the sequence of the questions but on listening to what the participant was saying, in order to show interest and attentiveness. This allowed for the communication techniques of paraphrasing by relaying the participant's words in another way; by asking the participant to clarify something that was not clear to researcher; by using encouraging words to elicit more information, and by making comments to keep the conversation going and to get more information.

The researcher also made use of reflective summary, in which what the participant said was summarised to see if the researcher had understood what was said. This not only encouraged the participant to share more information, but was recognition that the researcher was listening to what was said. The researcher used probing by intentionally contradicting and by linking what the participant said to what the researcher wanted to find out, as well as by being complimentary sometimes to spur the participant to continue. Understanding was shown by allowing time for the participant to expand in more detail.

Intertwined in the communication techniques were the interviewing techniques, used in conjunction with one another. The researcher thus allowed the participant to do most of the talking while listening, and writing down keywords for further questioning at the right moment or to bring the participant back to what they had not finished speaking about. There were instances where the researcher had to speculate about certain issues in order to get a reluctant participant to open up. The researcher repeated key questions throughout the interview and also asked questions when she did not understand. Single questions were asked and the researcher followed her intuition thus allowing for more information to be forthcoming from the participants. Though the participants did most of the talking, the researcher needed to keep control when participants were digressing from the topic and needed to be drawn back in order to remain focused on the subject under discussion. Where there were pauses in the conversation, they allowed the researcher to reflect on what the participant had said and gave the opportunity for the participant to gather their thoughts.

The researcher was equally attentive to non-verbal communication by the participants. These gave an indication of the effect of the challenges or issues experienced by the staff members, with specific reference to fear, resentment, stress, and concern. It also guided the researcher in some instances to avoid sensitive questions. The researcher remained alert to information that participants gave after the digital recorder was switched off, and noted what participants shared in these instances for inclusion in the transcripts and data analysis. The duration of the interviews was between 45–60 minutes (Greeff, in De Vos *et al.*, 2011:345). The interview ended with the researcher thanking the participant again for participating, without promise of bringing about changes. Ethical considerations of

anonymity as well as confidentiality were repeated. The interview was guided by interview questions outlined below.

3.6.7.2 The interview questions

The interview schedule contained semi-structured questions that guided the interview. This did not restrict probing into emergent conversation from the participants (Bloor & Wood, 2006:104). The interview was not one-sided but was a shared conversation which gave participants a chance to share their perspective on the challenges they experienced. The questions that the researcher asked matched the topic of the research, in the way the researcher introduced it to the participants, and for which consent for participation had been given. The questions were framed in a way that was understandable to the participants (Boeije, 2010:62 - 63). Most of the talking was done by the participants. The researcher knew the questions and this made possible the natural, flowing manner in which the interview proceeded (Babbie, 2010:320). The following questions were set out in the interview guide:

- What is your understanding of substance-induced psychosis?
- **What is your understanding of being affected mentally by drugs or substances?**
- Tell me about your challenges in managing the substance-induced psychotic patients.
- **What makes it difficult to work with these patients?**
- **What makes it easy for you to work with these patients?**
- What is it like for you to deal with the substance-induced psychotic patients?
- **What is it like for you to deal with the patient or to be working in the area where these patients are?**
- How are substance-induced psychotic patients different from other patients you attend to?
- **How are these patients different from other patients you attend to?**
- How can the hospital assist you with the challenges around managing substance-induced psychotic patients?

- **How can the hospital assist you with the difficulties around your assisting in your duties to these patients?**

In order for interview questions to flow naturally in conversation style, the researcher needed to listen attentively to what the participants shared. Interviews were digitally recorded. Bloor & Wood (2006:160) point out the major advantage of recording for use of collecting information. The information offered by participants, as already stated, after the recorder was switched off, was also noted. It added to the richness of the data from which deductions could be made and assisted with prompts in subsequent interviews. In terminating the interview the researcher wanted to feel comfortable to leave the participant and thus repeated explanations given about the study and what will happen to the information gathered (Hennink *et al*., 2011:128-131).

The researcher found it distracting to make continuous notes during the interview, so keywords were made for probing questions she wished to ask on issues raised by the participant. The researcher wrote reflective notes immediately after the interviews but could not transcribe interviews immediately. The reflective notes and non-verbal communication were included in a column in the transcribing of interviews. When the researcher had reached data saturation, a decision was taken to discontinue with selecting more participants for the study. Kumar (2011:192), Monette *et al*., (as cited by Greeff in De Vos *et al.,* 2011:350), and Seidman (as cited by Greeff in De Vos *et al.,* 2011:350), explain saturation as occurring when the researcher begins to hear the same information from participants and no new information is forthcoming.

3.6.8 Data analysis

Boeije (2010:77) states there is a series of actions involved in data analysis. These actions are an interrelated process which involves using particular steps in dissecting information, and reconstructing data. In methodologically analysing the data, the researcher followed the eight step process of Tesch (as cited in Creswell, 2009:186) and proposed in Chapter 1:

Each transcript was read, including the reflective notes, to get perspective of the whole.

- An interesting transcript was selected which the researcher read thoroughly for its meaning, with the researcher making notes on the transcripts.
- This was then done with all the other transcripts. Themes and subthemes that were alike were listed and grouped.
- The data was perused again using the groupings. Themes were shortened into codes in the fitting part of the text.
- The most appropriate explanatory words were used to categorise the themes and were grouped together to reduce the number of categories.
- After finalising the abbreviations for the categories, alphabet letters were used for the codes.
- An initial analysis was done after information for each category was arranged.
- Recoding was done.

The above steps assisted with inductive reasoning in the qualitative data analysis process. (Schwandt as cited by Schurink, Fouché & De Vos, in De Vos *et al*., 2011:399).

3.7 LIMITATIONS AND STRENGTHS OF THE STUDY

Fouché & Delport (in De Vos *et al.*, 2011:111) state that the most carefully planned research studies are not without various probable limitations, and this study was no exception. As suggested by the authors, the researcher had tried to counter problems in the study over which the researcher had no control. The researcher would like to start by pointing out the strengths and limitations of doing in-depth interviews before expanding on the limitations of the study as a whole.

3.7.1 Limitations and strengths of the in-depth interviews

The limitations and strengths of conducting in-depth interviews in this study were compatible with what Hennink *et al.*, (2011:131) stated:

- The interviews were face-to-face and the strength was that the researcher could get first-hand data on the participants' challenges and emotions.

- The data obtained from participants required a lot of transcribing, but the strength was that it yielded information from the participants' stories of the challenges they experienced.
- Skills in applying interviewing and communication techniques were needed and could have been limitations but these were strengths since the researcher relied on her personal experience, together with guidance from academic requirements and literature, which resulted in in-depth information being gained.
- The researcher needed to be flexible in the interview questions in order to follow the flow of the participants' stories, which was considered as a strength since it helped in enhancing the participants' meanings in the context of the research problem.

In addition the researcher can add the following as strengths:

- The willingness and support from the hospital management, unit managers and supervisors for her to conduct the research, was an added strength.
- The fact that non-medical and medical staff members complemented each other with their experiences to provide better understanding of the challenges experienced was a further strength.

3.7.2 Limitations in overview of the study

The researcher attempted to purposefully select a sample to be as representative as possible of the population of the emergency department of the hospital where the study was done. The intention was to interview four nurses, but the nurses identified for the study could not partake due to time constraints. Further nursing personnel who were approached declined to partake. The following limitations can be deduced from the research process:

- Time constraint of the staff members and staff shortage due to absenteeism often affected the arranged date and time for interviewing. Service delivery to the patient receives priority and the researcher had to be flexible regarding the availability of the participants.

- Only the statistics of substance-induced psychosis of the hospital where the study was done and information from one other hospital are represented. Statistics from other hospitals on the incidence of substance-induced psychosis admissions at emergency departments were requested, but there was no response to make these available. The researcher can thus only speak of the incidence of substance-induced psychosis not abating at the hospital where the study was conducted and the one other district hospital who released statistics, and data was based on the information of the staff members interviewed.

3.8 SUMMARY

Choosing a qualitative research design enabled the researcher to answer the research question of the study. The qualitative approach allowed for exploration and description to be given of the challenges experienced in managing substance-induced psychotic patients. Staff members were purposefully selected from the emergency department since they could provide the best data on the topic selected. Information was collected by means of in-depth interviews done in a location on the hospital premises, guided by an interview schedule, and with the use of a digital recorder. Specific steps for data analysis were followed after interviews were transcribed. There were several emergent themes as well as subthemes. An independent coder aided accuracy and trustworthiness of findings and the information analysed. Ethical considerations were adhered to throughout the research study in that permission was obtained to execute the study, the participation in the study was voluntary, with written consent, and there was the right to withdraw at any time. Measures in data analysis were put in place with regard to confidentiality of data collected and anonymity of the staff members in order to protect them from any harm.

The findings of the study will be discussed in Chapter 4. The information that was analysed into themes and subthemes will be discussed in detail, with evidence provided for substantiation through direct quotations from the participants. Literature and reflection are used in an attempt to answer the research question of this study with the focus on the staff members' meaning of the challenges they experience in managing substance-induced psychotic patients in the emergency department of the hospital.

CHAPTER 4
RESEARCH FINDINGS

4.1 INTRODUCTION

The previous chapter outlined the methodology used in the study in order to derive findings from what was shared in the individual interviews with the participants. The participants were purposefully selected from day and night staff, with the assistance of their immediate supervisors or unit managers, who had been briefed about the study. Participants were approached by the researcher, and one pilot interview was done. In instances where participants withdrew, the researcher approached other staff members working in the emergency department during a particular shift.

Though an information sheet was given to each participant to peruse at leisure, the contents were verbally explained. Individual interviews were conducted at times convenient to the participants and the particular work demands. Consent forms were signed before the start of the interviews. An interview schedule containing open-ended questions, guided the interview. Data collection and analysis of the information were guided by the aim of the study, which was to explore and describe the challenges to emergency department staff managing substance-induced psychotic patients in a district hospital. By way of introduction the demographic details of the participants were outlined and discussed, followed by discussion of the themes and subthemes. Relevant findings from literature were compared with the findings of this study (Creswell, 2009:189). In both instances data was tabulated to provide information at a glance.

4.2 DEMOGRAPHIC DETAILS

Ten participants partook in the study and their demographic details are presented in the following table.

Table 1: Tabled demographic detail of participants

Participant	Gender	Age	Home language	Years of experience	Current position
1	F	37	isiXhosa	4	Security guard
2	M	43	isiXhosa	17	Registered nurse
3	F	26	English	3	Medical officer
4	F	33	English	9	Staff nurse
5	M	51	Afrikaans	12	Security guard
6	F	54	English	3	General worker/assistant
7	M	33	isiXhosa	8	Enrolled nursing assistant
8	F	28	English	5	Medical officer
9	F	48	isiXhosa	3	Porter
10	M	29	English	6	Medical registrar

4.2.1 Gender

Six of the participants were women and four were men, which is an indication of the fact that there were more female than male workers at the hospital where the study was conducted. There were more female general workers than male general workers, more men than women in positions as porters, and more male than female security guards. There were also more female nurses than male nurses in the emergency department where the study was done, and there were more female doctors than male doctors at the time of the study. Ncayiyana (2011) confirms that the numbers of female doctors in South Africa have increased, but they are still outnumbered by their male colleagues in leadership positions. Wildschut & Mqolozana (2008:14) outlined the following table which represents the South African nursing category statistics by gender in 2006.

Table 2: Gender distribution of nursing staff by occupational category, 2006

Nursing category	Female		Male		Total	
	Count	%	Count	%	Count	%
Professional	95336	94.1	5959	5.8	101295	100
Enrolled	36347	92.4	2958	7.5	39305	100
Auxiliaries	51402	91.2	4912	8.7	56314	100
Total	183085	92.9	13829	7.0	196914	100

Source: SANC (2007)

4.2.2 Age

Three of the participants were between the ages of 25 and 30, three between the ages of 30 and 40, one between 40 and 45, and one between 45 and 50. Two were in the age range 50 to 55.

4.2.3 Home language

Interviews were conducted in English. The ability to speak and understand English was one of the selection criteria. Four participants' home language was isiXhosa, with the ability to converse in English, and two were conversant with Afrikaans as well; five were predominantly English-speaking with one being bilingual in English and Afrikaans, and one participant's home language was Afrikaans with the ability to converse in English.

4.2.4 Years of experience

The working experience of medical participants such as emergency doctors and nursing staff ranged from 3 to 17 years. The experience of non-medical participants, such as security guards, porters and general workers, ranged from 3 to 12 years.

4.2.5 Current position

Of the ten participants who partook in the study, three were doctors, with one also being in a supervisory capacity as a registrar; three were nurses, with one in addition being in a supervisory position as a registered nurse; there were also two security guards, one porter and one general assistant. The participants who were selected usually worked in the emergency department and managed or assisted in services to the substance-induced psychotic patients.

4.3 FINDINGS PERTAINING TO THE CHALLENGES THAT STAFF EXPERIENCED IN MANAGING SUBSTANCE-INDUCED PSYCHOTIC PATIENTS IN THE EMERGENCY DEPARTMENT OF A DISTRICT HOSPITAL

The steps to data analysis as suggested by Tesch (as cited in Creswell, 2009:186) were followed. Data was independently coded and agreement was reached as to themes and subthemes. There were six emergent themes from the findings. Findings were then grouped into subthemes in order to articulate structure (see Table 3 below). The

researcher preferred to present longer quotes at selected places in the discussion to clearly reflect the in-depth experiences of the participants.

Table 3: Themes and subthemes

THEME	SUBTHEME
Theme 1: Staff members have different understandings of substance -induced psychosis	**Subtheme 1.1**: Medical staff members' understanding of substance-induced psychosis **Subtheme 1.2:** Non-medical staff members' understanding of substance- induced psychosis
Theme 2: Substance-induced psychotic patients' unique presentations compared to other emergency patients in the emergency department	**Subtheme 2.1:** Substance-induced psychotic patients present with dangerous and aggressive behaviour **Subtheme 2.2:** Substance-induced psychotic patients present with unpredictable behaviour **Subtheme 2.3:** Substance-induced psychotic patients exhibit sexually inappropriate behaviour
Theme 3: Management of substance-induced psychotic patients disrupts other emergency services	**Subtheme 3.1:** Other patients and staff members require protection from substance-induced psychotic patients **Subtheme 3.2:** There is limited staff for protection and managing of substance-induced psychotic patients **Subtheme 3.3:** Facilities for managing substance-induced-psychotic patients are inappropriate and/or unavailable **Subtheme 3.4:** Staff members experience challenges with regard to teamwork **Subtheme 3.5:** The defensiveness or lack of supportiveness of family has an influence on services **Subtheme 3.6:** Untrained staff members are a challenge in dealing with substance-induced psychotic patients
Theme 4: Staff members experience personal challenges in dealing with substance-induced psychotic patients	**Subtheme 4.1:** Medical staff members experience resentment **Subtheme 4.2:** Medical staff members experience fear in the work place **Subtheme 4.3:** Non-medical staff members' fear of substance-induced psychotic patients **Subtheme 4.4:** Non-medical staff members find it stressful to control substance-induced psychotic patients **Subtheme 4.5**: Some staff members have more tolerance for substance-induced psychotic patients
Theme 5: Staff members acknowledge dignity for all patients	
Theme 6: Staff members made special recommendations to the hospital management for assistance with managing substance-induced psychotic patients	**Subtheme 6.1:** Staff members recommend a separate facility for referring substance-induced psychotic patients **Subtheme 6.2:** Staff members recommend that substance-induced psychotic patient be separated from other emergency patients **Subtheme 6.3:** Staff members recommend improved facilities and resources at the emergency department **Subtheme 6.4:** Staff members recommend training of staff to work with aggressive and substance-induced psychotic patients **Subtheme 6.5:** Staff members are of the opinion that management is oblivious of their recommendations

Aspects of the research setting have been covered in the methodology Chapter 3, section 3.6.3 (preparation of data collection) and section 3.6.4 (setting up of the interviews), but a short explanation is provided again as a way of introduction to the findings.

4.3.1 Research setting

As described in the National Health Act of South Africa (Act No. 61 of 2003) regarding the policy of management of hospitals, the hospital where the study was conducted is classified as a medium sized district hospital. The package of care at the hospital is that of emergency and trauma services, in- and out-patient services, and some specialist care. As yet there are no obstetric and pediatric services.

A convenient time was arranged with the participants in order for their work not to be interrupted. Interviews were conducted in an office on the hospital premises in an area that was quiet and accessible, and contributed to the privacy of the interviews. The seating arrangements supported participation and communication since they were arranged for comfort, and the researcher was seated in a position without the barrier of a desk (Greeff, in De Vos *et al.*, 2011:350).

Theme 1 provides the setting on which other themes build, to provide an understanding of the challenges that staff members experience in managing substance-induced psychotic patients in the emergency department. The specific understandings of medical staff members are highlighted in subtheme 1.1 and non-medical staff members' perceptions are outlined in subtheme 1.2.

4.3.1 Theme 1: Staff members have different understandings of substance-induced psychosis

Findings show that medical staff members and non-medical staff members had different conceptualisations of substance-induced psychosis. The medical staff members presented a theoretical explanation of substance-induced psychosis as being a psychotic condition which can be diagnosed using specific medical criteria. The causal factors were academically clarified by extensions on specific physical symptoms of hallucinations, delusions and evidence of intoxication/withdrawal. Attention was drawn to the

behavioural symptoms, with substance-induced psychotic patients being described as restless, unpredictable and aggressive. Non-medical staff members, on the other hand, perceived a substance abuser presenting with psychosis as a psychiatric patient, and their focus was on the behavioural symptoms.

Psychosis can be symptomatic of a variety of mental health illnesses or it might be due to a different illness. Psychosis can also be caused by a variety of drugs whether over-the-counter, herbal, prescribed medication, or use of alcohol or illicit substances (Baumann, 2007; Freudenreich, 2008:29 and Nordqvist, 2012).

The specific understandings by medical and non-medical staff members of substance-induced psychosis are given in the following subthemes.

4.3.1 Subtheme 1.1: Medical staff members' understanding of substance-induced psychosis

One of the medical staff members who took part in the study gave his understanding of substance-induced psychosis as follows:

> *"It's basically a psychotic disorder which is precipitated by substance use or substance abuse…it would be a person who might or might not be predisposed to developing a psychotic disorder, then becomes psychotic with prolonged use of whatever substances they may be using either through chemical derangements in the brain or otherwise structural derangements, can be caused by certain of the drugs."*

Medical staff members' responses related to the cause of substance-induced psychosis specific to use of illicit drugs. Literature reviewed is supportive of substance-induced psychosis being caused by illicit drugs. Wilson and De Miranda (in Robertson *et al*., 2001:196) and Freudenreich (2008:29, 30), also point out that psychosis manifests with the use of other drugs as well. The responses from medical staff members are interpreted as their experience, based on their assessment of the psychotic patient who

presents at the emergency department. Later in the feedback on the findings, their awareness of misdiagnosing will be highlighted.

The following responses from medical participants correlate with what is being interpreted:

> *"Substance-induced psychoses are those patients that are using drugs. All forms of drugs like, TIK, mandrax, dagga."*

> *"It's still psychosis. It's still people, who are not in touch with reality because of the substance."*

> *"…those psych patients that are drug addicts. They come here, they are sick of drugs not because it just happened to them…this drug made them to be in our unit."*

> *"…causing them to behave inappropriately and psychotic enough for them to actually come in here and be admitted because they're a danger either to themselves, or their community or their family."*

Two of the participants who were medical staff members drew attention to patients presenting at the emergency department with a psychotic episode, being mainly due to illicit substance use. Seedat *et al*., (2009) support this notion and emphasised the high prevalence of persons gaining access to services due to substance-use disorders being the highest in the Western Cape Province. The following responses illustrate the interpretations made by the medical staff members:

> *"…the majority of patients that you see are genuine substance-induced psychosis, genuine mental health care users. It's a very small percentage that would end up having an actual medical problem which is causing their behaviour."*

> *"Sometimes there are three or four or five for the day. Sometimes even more..."*

Findings reveal that when these psychotic patients present at the emergency department **medical staff members have specific diagnostic criteria when concluding that psychosis is substance-induced.** The literature reviewed agrees with the findings of criteria applied in diagnosing substance-induced psychosis in Chapter 2, section 2.3 and emphasise the use of a variety of substances whether prescription, over-the-counter, or illegal. Various considerations have to be taken into account when doing an assessment to conclude substance-induced psychosis (Baumann, 2007:457 – 467; Horn, in Baumann, 2007: 446 – 447; Freudenreich, 2008:29, 30).

There is a lack of research which thoroughly scrutinises the weight of the DSM-IV diagnostic measures through the range of substances. Information, outcomes, suitable intervention and management for psychotic occurrences linked to substances, are lacking (Mathias *et al*., 2008:385). The following response indicates that diagnostic criteria are applied in a diagnosis of substance-induced psychosis:

> *"…we obviously have diagnostic criteria for diagnosing it so, hallucination and delusions, evidence of using the drugs within a month and then being unable to account for the problem by another psychotic disorder and if the patient is not delirious during that course of psychosis. So you need to just remember that diagnostic criteria when diagnosing the substance-induced psychosis."*

The person presenting with substance-induced psychosis could have delusions, hallucinate and have diminished perception (Nordqvist, 2012). Literature reviewed and outlined in Chapter 2, section 2.2.2 on the substances and their effects (Weich, in Baumann, 2007:303; "Depressants", 2007:35; "Hallucinogens", 2007; Plüddemann *et al.*, 2007; Goldberg, 2010:194; Alcohol and Drug Abuse Research Group, 2008; Rooney, 2010:36; Ruiz & Strain, 2011:271–272), supports their responses about symptoms, for instance in the following comments:

> *"…they have hallucinations, delusions due to the direct physiological effects of the substance that the patient has taken, or toxin exposure."*

"They start to become aggressive. They start to hear voices. They start to behave in a manner which they do not behave in normally. It's actually the drugs that cause them to become psychotic."

"…the patients are not in touch with reality."

Further aiding medical staff members' ability to diagnose substance-induced psychosis is that there is evidence of intoxication or withdrawal. Sussman & Ames (2008:19) state that the indicators of withdrawal are evident when there is too much activity in the nervous system resulting in changes in the physical and behavioural abilities of the person. It happens with sudden cessation of a substance particularly when the person is physically dependent, although withdrawal symptoms are not the same in all drugs. Weich (in Baumann, 2007:292) discusses the same effects of substance abuse with intoxication being the opposite of withdrawal, and it is reversible. Several authors such as Robertson *et al*., (2001:207); "Depressants" (2007:49); "Hallucinogens" (2007:54); Ruiz *et al*., (2007:85, 116); Weich (in Baumann 2007:313); "Stimulants" (2007); Alcohol and Drug Abuse Research Group (2008); Abadinsky (2008:107–108); Rooney (2010:36) and Preda (2012) confirm the evidence of intoxication and withdrawal as symptoms of the disorder. The following comment from one of the participants is regarded as conclusive in diagnosing that the psychosis is substance-induced:

"…you can actually differentiate it from primary psychotic states because of the evidence of intoxication of a substance or withdrawal of a substance."

The participants, not only medical staff members, alluded throughout the discussion to the aggression, restlessness and unpredictability of substance-induced psychotic patients. They drew attention to the challenges that the behavioural symptoms present and their effects on the staff members and the service, as well as the distinguishing characteristics from other patients. One of the participants summarised the behavioural symptoms of substance-induced psychotic patients as follows:

"The challenge when you are working with drug-induced psychosis is that one must always expect anything. The environment is unpredictable. There is a lot of violence and…one must always be alert…The person might be walking up and down, talking to himself and the next minute the person is holding a wea.., a chair trying to throw at one of the patients or staff member."

In view of the fact that substance-induced psychotic patients are often aggressive, aggression can be considered an action that can be exhibited towards an individual, self or the surroundings in a verbally, physically or symbolically strong manner. It might be appropriate in order to protect the self, or might be shown in an inappropriately aggressive or behaviourally destructive way. Agitation is explained as linked with inner unease or strain and generally there is non-purposeful extreme movement, for example, pacing up and down, being fidgety, and being unable to stay in one place (Shahrokh, Hales, Phillips & Yudofsky, 2011:8).

Aggression and agitation as described in the above literature lead to the findings of the following comments from medical staff members as further evidence of the behavioural symptoms of substance-induced psychotic patients and the feelings they evoke or how they affect their work:

"Very aggressive and scary. They're very agitated…. You always have to watch your back."

"Most of them are violent."

"They just interfere a lot with things….they'll bother you all the time and you can't carry on working."

The above findings reflected the medical staff members' understanding. The interpreted perceptions of non-medical staff members were simpler than those of the medical staff members with their focus on the abuse of substances and it being a mental health condition.

Nordqvist (2012) serves as an introduction to non-medical staff members' understanding, capturing the simplicity of their understanding of substance-induced psychosis.

4.3.1 Sub-theme 1.2: Non-medical staff members' understanding of substance-induced psychosis

Nordqvist (2012) states that the word "psychosis" is used in reference to unusual signs and symptoms in persons whose mind has been affected to the extent that their behavioural, cognitive and emotional state is altered. In essence they lose touch with reality. The non-medical staff members' understanding of substance-induced psychosis focused, however, on substance abuse and a "psychiatric condition".

The following comments reflect their understanding of substance-induced psychosis:

> *"The main thing when we call you a psych patient is according to your mind…It touches his mind."*

> *"When you use that substance it is like it damage your knowledge of thinking and you abuse yourself when using that…"*

> *"Psychs, the people who are using drugs."*

> *"…they are in a very bad state sometimes, because most of them don't know what they are doing really."*

Non-medical staff members' understanding of substance-induced psychosis is not far from what psychiatrists consider substance abuse to be. Pilgrim (2009:39) states that psychiatrists consider the abuse of substances to be a mental disorder on its own and to be a common reason for affecting health in various ways. Therefore it is not uncommon to encounter the problem in medicine.

Non-medical staff members' focus is on the **behavioural symptoms** of the substance-induced psychotic patients. According to Pilgrim (2009:41) a person who is a substance abuser adds to the possibility of posing a threat to himself and others. Persons with a mental health illness who abuse substances are a higher danger risk. Not all substance abusers are a risk, and so too, not all psychotic persons are dangerous. With regard to the following comments it is deduced that in the challenges participants encounter with the majority of substance-induced psychotic patients, non-medical staff members' understanding focuses more on behavioural symptoms. The non-medical staff members expressed themselves as follows:

> *"…their behaviour…like shouting at the doctor. Some is happy. Some is cross. Some talk a lot. Some walk around. Some run, wants to go out. Some want to take off their clothes. So that's the only behaviour of them and some is maybe emotional, cry a lot and some don't talk. Some just sit there."*

> *"… and then some of them they're very aggressive and then you have to deal with them."*

Non-medical staff members said:

> *"…That patient can smash your face, can give you scratches in your face. It happened already he can take a cigarette or throw it in your face, or a cup. You have to take note of that patient carefully…The affect is he can be much stronger than what we are because the drugs give him the power, and it is dangerous to be like that because you can hurt any person."*

> *"…if you see a patient is a drug addict, you see he's very restless it makes the security nervous sometimes...because that guy is moaning, or his nagging, or he's fighting…"*

> *"Always be aware, where they going. Be careful, because they can do lots of things running out and here and there."*

"Like for instance there are people that are coming not for drug abuse. Just with his illness, asthma. So that person is not like a person, using drugs. So the one who is using drugs, they're always so aggressive and don't feel with this people [other emergency patients]."

Medical and non-medical staff members agreed that substance-induced psychotic patients are "*psychs*" (non-medical term), though their conceptualisation differs, as does the opinion that the condition is triggered by substance abuse. They interpreted that these patients present as irrational because of drugs having "*damaged their thinking*". Behavioural irritability and aggression are strongly emphasised. Referring to them as "*psychs*" leads to the inference that participants who took part in the study labelled substance-induced psychotic patients as psychiatric patients, based on what others call them and to distinguish them from the rest of the patients. Pilgrim (2009:153) quotes Alexander & Link on studies done on labelling, as well as the effects, and point out that that the public's fear of aggression lessens with more contact with persons with a psychiatric diagnosis. Based on this and other studies, they draw their own modified labelling theory that a person receiving quality mental health care can profit, but whether or not the services are positive or negative, there is still the labelling, stigmatisation and rejection in the community.

The literature reviewed confirms that there is often the perception of danger and unpredictability when encountering a person with a psychotic disorder, and added stigmatisation if it is a substance-induced disorder (Sorsdahl *et al.*, 2012). Findings of the present study have revealed participants being in constant fear, which is contrary to Alexander & Link quoted by Pilgrim (2009). These authors indicate that the fear of aggression, danger and unpredictability lessen over a period of time as the staff member gets use to the patient's behaviour. The findings of the present study overall reflected that all participants were continuously conscious of aggression, and unpredictability, and that the substance-induced psychotic patient can be irrational, leading to participants' fear and being on their guard.

Theme 1, with its subthemes, focused on the understanding that staff members had of substance-induced psychosis, depicting the medical and non-medical staff members' specific understandings. Theme 2 will present the findings of the different challenges that the substance-induced psychotic patient presents to staff members, in relation to other patients in the emergency department.

4.3.2 Theme 2: Substance-induced psychotic patients' unique presentations compared to other emergency patients in the emergency department

The findings discussed in Theme 1 on participants' understanding of the psychosis showed that staff members are faced with challenges in attending to the substance-induced psychotic patients which are different from those of the other patients that present in the emergency department. Under Theme 2, findings are presented of these different challenges related to the specific presentations.

The participants who took part in this study stated that they were able to manage other patients in the hospital. In contrast, they stressed the aggressive nature of substance-induced psychotic patients and explained that substance-induced psychotic patients were agitated and unpredictable, causing staff to be alert, feeling unsafe and at risk. The participants also indicated that managing these patients interrupts other services in the emergency department, and there has to be continuous risk assessment to safeguard the other patients, staff and the psychotic patients themselves. When these patients were aggressive and violent, immediate medical intervention and restraint were required and it generally required more than one staff member to assist with restraining. Apart from the additional manpower required, participants also mentioned the inappropriateness of attending to these patients in the emergency department by staff members who lack the necessary training. Ambivalent viewpoints about teamwork were expressed as well as the challenges when patients are unaccompanied by family, and collateral support thus being lacking.

4.3.2 Subtheme 2.1: Substance-induced psychotic patients present with dangerous and aggressive behaviour

Patients who present with abnormal behaviour are not uncommon in the emergency department of a hospital (Cresswell III, Riccio & McCabe, in Glick, Berlin, Fishkind & Zeller, 2008:45). Therefore violent behaviour and aggression towards staff members in an emergency department are higher than in other departments, and the staff members in that area are more at risk of injury and violence than other staff members in the hospital. It might also happen that the doctor's assistance is viewed negatively and not seen as providing help. Aggression and violence are major problems and the substance-induced psychotic patients' aggressive, agitated and dangerous disposition in the emergency department was clearly emphasised by participants, for instance:

> *"…these people they can be very dangerous. They can murder or hurt, kill other people and they're known to steal as well."*

> *"They're often very aggressive, extremely abusive, verbally as well as physically and they present a danger to your colleagues and the other patients."*

> *"They're very agitated."*

> *"…touch everything... but they don't want to be touched…He's wild, his eyes are running up and down, looking everywhere and he doesn't like to sit in one place, relaxed."*

The effects of the aggressive nature of these patients were described in the following manner:

> *"It's not nice for the other patients [emergency patients] because they [substance-induced psychotic patients] are traumatizing them because of their noise and stealing because some of them steal the clothes of the other patients and then run away with their clothes."*

"…We must be close to the patient [substance-induced psychotic patients] so that he doesn't do anything wrong there...they just want to fight or they don't want to stay in the hospital…if they look something, they need it, they want. They force they want it."

The following comments further indicate how the aggressive behaviour of these patients affects staff members. Their reaction to the substance-induced psychotic patient and the manner in which it was expressed were also indicative of the fear of these patients felt by the participants:

"If someone is aggressive and comes in, the first thing you need to do is to get help. Never go alone and try and sort the patient out. Especially for a female, that's the last thing you want to do…personally I find it very scary sometimes to deal especially with the male patient that is very aggressive."

"…Anything can really happen so you must always keep an eye out on them."

"He can hurt himself. He can hurt the staff member, he can hurt the patient and it's definitely not a nice thing to go through…they can hurt you. They're just strong. If the doctor sedates them you'll see it takes four, five of us to get them down."

Studies reviewed (Gacki-Smith *et al*., 2009 and Magnavita & Heponiemi, 2012) are congruent with the aggression and violence experienced in the emergency department and especially towards those staff members who render mental health services. Apart from the challenges experienced with dangerous and aggressive behaviour, the participants also stressed that behaviour of these patients can be unpredictable. This matter will be discussed under the next subtheme.

4.3.2 Subtheme 2.2: Substance-induced psychotic patients present with unpredictable behaviour

Agitation, verbal abuse and an increase in anxiety amongst patients in the emergency department are often a warning to staff members that violence may erupt. Staff awareness of these warnings gives them a chance to react and intercede before a violent episode occurs. Substance abuse and psychosis are amongst the risk factors associated with violence (Simon, 2011). Participants indicated that they felt at risk owing to the patients' aggressive and unpredictable behaviour.

The following comments bear evidence of the fact that some of the patients' behaviour caused participants to feel unsafe in the emergency department:

> *"That people, they don't think normally…because that drugs they use are very, very dangerous. They just think and do. They don't think deeply. Maybe if I do this, this would happen."*

> *"They're not rational. You feel very unsafe, you don't know when this person [substance-induced psychotic patient] is going to lash out or do something to you. You always have to watch your back."*

> *"…you never know what they are going to do next and you never know when they going flair up."*

> *"…take something and hurt you."*

> *"So you must then be prepared for that unpredictability. That the next ten minutes the person was pacing up and down, not bothered by anything and now he is violent, physically violent. So now you must be prepared to restrain the person."*

> *"…the sedation work after a while and they are drug-induced you know, so it will take a while to them. They'll keep on maybe swearing…swear and swear and swear."*

"Always be aware. Be careful, because they can do lots of thing…"

The above quotations bear evidence of the fact that the participants felt their safety was compromised in the workplace and that they were afraid of the substance-induced psychotic patients. The fact that they had to be observant owing to the unpredictability of the patients' behaviour is an indication of their fear and anxiety in dealing with these patients. These findings are congruent with literature reviewed (Bimenyimana *et al*., 2009; Chikaodiri, 2009; Magnavita & Heponiemi, 2012; Sorsdahl *et al.*, 2012), on the effects on staff members of managing these patients.

Findings also pointed to the fact that staff members observed and experienced inappropriate sexual behaviour from substance-induced psychotic patients.

4.3.2 Subtheme 2.3: Substance-induced psychotic patients exhibit sexually inappropriate behaviour

The findings of this study revealed that substance-induced psychotic patients may display inappropriate sexual behaviour. The following comments from medical and non-medical staff members bear evidence of this behaviour among substance-induced psychotic patients in the emergency department:

"…they like to play with their private parts in trauma and while they are playing then there's lot of male patients and the male security…"

A staff member said that the patient was:

"…showing me his private parts…"

Another staff member indicated:

"...female colleagues being touched inappropriately [by substance-induced psychotic patients]…"

Theme 2 discussed the behaviour displayed by substance-induced psychotic patients in the emergency department and that it indeed differs from that of other patients (Cresswell III, Riccio & McCabe, in Glick *et al*., 2008:45 and Simon, 2011). In Theme 3 the effects of the aggressive and agitated substance-induced psychotic patient on the services rendered are discussed as well as the interruption of services to other emergencies.

4.3.3 Theme 3: Management of substance-induced psychotic patients disrupts other emergency services

As discussed in the previous two themes, several participants emphasised that they had to deal with the aggressive and agitated substance-induced psychotic patients **immediately** as they posed a risk to themselves, to other patients and staff members. "*Immediate response*" meant leaving what they had been busy with, even other medical patients, to attend to the substance-induced psychotic patient and therefore interrupted emergency services. Zeller (2010) concludes that the large numbers of patients presenting at a hospital who require urgent psychiatric services are on the increase. Owing to this need for emergency psychiatric intervention, medical doctors in the trauma department have to exercise emergency psychiatry. The same holds for the type of patient presenting at the emergency department, from which the participants for this study were sourced. In addition, the substance-induced psychotic patient's agitation and physical strength requires more than one staff member to assist if the patient has to be restrained and sedated. A patient who has been sedated is put on a bed which, in the view of the majority of the participants, could be occupied by another emergency case. The following responses indicate that the substance-induced psychotic patients who present at the emergency department of the hospital require more attention than other patients, and other emergency services are therefore interrupted:

> *"You always monitor him. They take you off the other patients, even the ones [other emergency patients] who need help and can't speak for himself. They always distract you, want to fight all the time and needs attention all the time."*

"…You are busy with other emergencies then you have to put everything down, go straight to them to get them sedated…so that they don't affect everyone else, like the other patients in the unit."

"…often you have to leave the really ill patient to see to this psych patient."

"...because you have a potentially dangerous person on your hands."

Apart from the fact that substance-induced psychotic patients interrupt services in the emergency department, **immediate medical attention and often restraint with risk assessment are required throughout**. Findings point to the fact that there is immediate medical intervention with the assistance from other medical and non-medical staff to restrain the patient in order to contain the situation. Rapid intervening, restraint and sedation to defuse danger are an infringement on other patients as well as staff members in the emergency department.

Immediate intervention is shown in what was imparted:

"Making sure that I'm able to contain the patient in such a manner that it's safe for the patient and for the other patients around them and also dealing with that patient in as fast a time as possible."

"If however it's an aggressive patient then it's a different story, we need to go and see to that patient immediately and sedate him. We have to make the environment safe for doctors and nurses, security [staff members]…"

"We've got a standard approach to psych patients. See them coming in. Ok they're aggressive, we sedate them. We do the bloods, examine them, and find collateral to get them sorted out as soon as possible."

"Some of them will be violent with other patients and yourself so we quickly call security. We quickly tell doctor…because we know they're psychs therefore we are

quick…and that they are given sedation, then they'll put him on a bed and retrain them."

The same participant drew attention to the restraining and sedating of the aggressive substance-induced psychotic patient in the presence of other patients in the emergency department:

"…most of them become so violent that there must be maybe four securities that hold them on the floor…sometimes it's not nice to the other patients that are in the unit if the patient got sedated."

What participants shared is congruent with literature, where it is indicated that in cases of violent and disruptive behaviour, the first response of staff members at the hospital is to restrain and sedate the patient under duress. At the same time these measures to secure the patient have disadvantages in that a sedated patient cannot partake in the management. Restraint and sedation are therefore forcibly done (Zeller, 2010:39). Restraint is not at once physical but begins with verbally engaging the patient. Physical restraint is used as a last safety measure but can also be the first choice when there is great agitation and potential aggression (Gallego, Pérez. Aquilino, Angulo & Estarlich, 2009:123, 124).

In view of the immediate attention that is required for protection and having to be alert throughout managing the substance-induced psychotic patients, responses reveal that there has to be constant evaluation with regard to threat and safety. The participants emphasised the need for continuous risk assessment in the following comments:

"You must be prepared to be quick in getting the medication in order to sedate the person, and you must be constantly doing risk assessments."

"They will carry weapons at times because they want to protect themselves… So one must also be able to check that they don't come in with weapons or even when they have visitors, constantly check there is no liquor carried in – including the substances."

"All I want to say is, they have to be watched because they are dangerous for me."

In addition to emergency services being interrupted, the participants also indicated that they had to protect themselves as staff members as well as other patients, creating continuous risk assessments.

4.3.3 Subtheme 3.1: Other patients and staff members require protection from substance-induced psychotic patients

The findings of this study reflect that other patients and staff members need to be protected from the substance-induced psychotic patient, therefore acting swiftly to secure the safety of everybody else in the emergency department is vital. Immediate reaction is produced in the interest of the psychotic patient as well.

The following comments reflect the sentiments of the majority of the participants:

"One must be alert that anything can happen at any time. One must always know getting injured is one of the things that one must always try to prevent. Not only getting injured yourself and other staff members in the unit, but you must also safeguard the other patients that are around this person as well as the equipment."

"…if a substance-induced psych patient comes in, you can't just leave the patient. I can't run away, stand behind something. The patient will attack other patients. The patient will hurt himself or the patient will break the things in the unit."

"They are a danger for themselves and a danger for the other patients [in the unit], and for the people that is working here and even for the doctors here."

Attending to mental health patients in a hospital is mandated by the Mental Health Care Act of South Africa (Act No. 17 of 2002). The subject of emergency psychiatry becoming an important subspecialty in all emergency settings in the United States is congruent with the needs at the hospital where this study was conducted (Zeller, 2010:35). Reinhardt (in Glick *et al.*, 2008:26) specifies the calming ability of use of "self" is very important,

specifically in an emergency psychiatric department, in making correct assessments and in contrast to a medical emergency department where the focus is on physical investigation and intervention. Based on what participants said, the use of self is not specific to emergency psychiatric departments but is also true for the emergency department at the hospital. Responses of participants reflect that they have to contend with the behaviourally disturbed substance-induced psychotic patient as a health care user.

In addition the participants alluded to the fact that there are not always enough human resources to assist and to manage substance-induced psychotic patients in the emergency department of the hospital.

4.3.3 Subtheme 3.2: There is limited staff for protection and managing of substance-induced psychotic patients

The shortage of staff, as well as having to deal with a substance-induced psychotic patient against this backdrop and the effect on the rendering of services in the hospital is confirmed as a challenge (Ramlall *et al*., 2010; Burns, 2008). Participants mentioned that restraining and sedating requires more than one person to execute it successfully. Even participants who are security staff members feel unsafe and would prefer more security personnel to assist them with this task in the emergency department of the hospital. Gallego *et al.*, (2009) points out that in the case of physical restraint the team should be at least five people who have training, and restraint should be managed according to a plan to minimise unnecessary danger. Most of the participants found the limited staff members in the emergency department a challenge, and the fact that more staff members are required to deal with one substance-induced psychotic patient added to their frustrations.

> *"It's like one person, takes up the doctor, a sister and three to help and stand by with the drugs, and sometimes up to four securities for one patient. In that time you could deal with different patients."*

> *"…you need at least another five people to hold the person down and getting those people is a problem and then getting the drug from the nurses [to sedate the substance-induced psychotic patient]."*

"…maybe two, three more security guys on the site. I mean in trauma [emergency unit] you feel better with another security with you."

The World Health Report (2006:12) indicated that there were 57 countries with a critical shortage of health workers, and of these countries the sub-Saharan area had 36. A figure of an additional 2.4 million professionals worldwide was given to reach the target number of health workers. However, as pointed out in the report, these figures were only for the three types of health workers that the report dealt with, namely doctors, nurses and midwives. South Africa, in the information provided in the World Health Report (2006), was given amongst the countries without a critical shortage of health workers. Often attention is focused on doctors and nurses in the category of health workers. However as termed in the World Health Report (2006:4) there is also the, "invisible backbone" in health systems which is the health management and the support staff (World Health Report, 2006).

A study at eight public hospitals in South Africa has emphasised the challenges of staff shortages and postulated that some professionals take on tasks and duties that are rendered by a particular category of staff. Though the participants or professionals in the present study were nurses and doctors, it was pointed out that staff shortages affect not only these categories but support staff as well, such as the porters, drivers, messengers, cleaners, and so on. Shortage of support staff, whose services are generally regarded as of lesser importance, undercuts and hampers the efficient running of hospitals (Von Holdt & Murphy, in Buhlungu, Daniel, Southall & Lutchman, 2007:331).

Although the participants in this study are in agreement with the abovementioned literature findings, they also emphasised the inappropriateness and/or unavailability of facilities for substance-induced psychotic patients.

4.3.7 Subtheme 3.3: Facilities for managing substance-induced psychotic patients are inappropriate and/or unavailable

The responses from the participants indicated that the substance-induced psychotic patients should not be attended to in the same facility or be mixed with other patients

requiring emergency care, because untrained staff experience fear working with them owing to their often aggressive, agitated and unpredictable nature. The participants stressed that these patients pose a potential threat to themselves, to staff members and also others around them. Emergency services are therefore interrupted in dealing with substance-induced psychotic patients who require additional assistance from a short-staffed department. The participants would prefer that substance-induced psychotic patients not be treated where other patients requiring emergency care, are treated. The participants expressed themselves as follows:

"... They overloading trauma [emergency unit]. An emergency unit is not for psych patients and they're not even supposed to be here."

"...where there are sick people. They're all mixed-up there."

"...the ones who are sick with drugs, mental, they mustn't be put with patients who are ill, of asthma, diabetics because these people they don't need stress like that."

"...you sitting with three...six psychotic patients and you've got eighteen in the emergency unit."

The following comments from participants address the challenge of the number of days substance-induced psychotic patients are housed in the emergency department, exacerbating the problem of overcrowding:

"They stay in trauma for even two days."

"...after...two days then they take the patient to another ward."

"*There isn't any place for them anywhere else...they don't deserve to be sitting on chairs for days, six, seven, eight days on end."*

Overcrowding in emergency departments is a worldwide problem. It is a requisite for emergency departments to render a 24-hour service with proper and sufficient resources. Crowding infringes on quality care and the safety of patients, and should not be viewed as a mere work problem (Flores, 2011:63; Jayaprakash, O'Sullivan, Bey, Ahmed & Lotfipour, 2009:233). There are numerous causes for overcrowding in emergency departments. In Europe emergency departments experience a dire shortage of hospital beds where patients requiring admission to wards depend on the availability of vacant beds, nursing staff and supporting services (for example laboratory). Waiting on laboratory results can cause crowding, and so can waiting on radiology imaging results. There is also a lack of resources in the community to refer these patients to. Crowding occurs with walk-in patients not referred from by a medical doctor or healthcare facility. Other reasons for overcrowding in emergency departments in Europe are medical staff (doctors) who are inexperienced, inadequate triaging (screening) of patients, shortages of nurses and doctors, the admission of older persons who stay longer and the inadequate after-hour services by general practitioners, all of which result in more patients coming to the emergency department (Jayaprakash *et al*., 2009:234 – 237).

Ovens (2010) has drawn attention to the overcrowding in emergency departments in Ontario, Canada, to the extent that government in 2006 ordered an investigative report. Overcrowding led to high levels of stress and low staff morale among doctors and nurses, leading to staffing problems. Ambulances also had to be redirected elsewhere. The main features of the overcrowding problem in Ontario were the generally sick patients who needed in-patient care when there were no free beds in the wards. It was concluded that solutions to the problem were out of the scope of the different hospitals, but needed a reaction from the healthcare system.

In the United States, the escalation in the number of mental health conditions and substance-abuse problems arriving and staying in the emergency department has increased difficulties in emergency departments (Nicks & Manthey, 2012). The emergency department in the present study encounters the same problems outlined in literature, and was evident in what participants said. As indicated, their viewpoints were that mental health users should not be in the same unit as other emergency care patients. The focus in

the literature cited was mainly on the problems of nurses and doctors, while in the current study those of non-medical staff were also considered, with fear and stress running across all the participants. There is no clear-cut or fixed definition of crowding. Both Flores (2011) and Jayaprakash *et al*., (2009) refer to the definition in the American College of Emergency Physicians, which is that crowding is a situation where the existing resources are inadequate to cater for what is needed for the emergency services, and exceeds available resources. Jayaprakash *et al*., (2009), Ovens (2010) and Flores (2011) suggest that crowding should be universally addressed, and be designed to suit a particular country and region, if there is collaboration and accord.

In addition Flores (2011) and Jayaprakash *et al*., (2009), confirm that the need is too great to be catered for by the existing resources, the inadequacy in facilities and a **lack of physical space to attend to these patients**. Some of the participants who took part in this study further indicated that the need for safe and secure rooms where the medical staff can conduct an interview or examine the substance-induced psychotic patient is critical, and expressed themselves as follows:

> *"…there is no actual interview room to sit and talk with the patient. A room that's safe where the desk is placed in such a way where you can sit near the exit and the patient can sit inside the room."*

> *"…At the moment we've got an examination room with a bed but we see the other patients there and then it's always full."*

These findings, reflected in comments from participants and discussions in subtheme 3.3, guided the researcher to three essential areas that are vital for service excellence in hospital settings, namely the relationships between people, the hospital environment, and the practical care (Potter, Morgan & Thomson, as cited in Jenkins, Calabria, Edelheim, Hodges, Markwell, Walo, Weeks & Witsel, 2011:1). The hospital environment, which includes the layout and room plans, affects the thoughts, emotions and functioning of patients, staff and others (Jenkins *et al.*, 2011:5). Jenkins *et al.*, (2011) who undertook a study of four hospitals in South Wales on the quality of emergency departments,

confirmed medical staff members' need for safe and secure rooms for consultation and examination purposes, as well as the limitations in the current stressful settings.

Ramlall *et al.*, (2010) and Burns, (2008) point to one of the challenges in the South African context in the implementation of the Mental Health Care Act of South Africa (Act No. 17of 2002) at district hospitals, which also speaks of the inadequacies of the infrastructure. The National Core Standards for Health Establishments of South Africa (2011:10, 42) are structured into seven areas, namely patient rights, safety, clinical governance and care, clinical support services, public health, leadership and corporate governance, operational management, facilities and infrastructure. The last four areas are stressed as being of vital importance in rendering the central services. All seven areas have certain standards and criteria that need to be met. With regard to facilities and infrastructure, there should be regular checks to see that the facility is fit for the use intended, and that the layout of the facility is planned and tailored to the needs of the patients and services to them. In this area of the core standards, safety and security in the environment are further described in this document, as paramount for all.

The lack of examination rooms and consulting rooms for patients is seen by the researcher to be a safety and security risk. Another risk mentioned by one of the participants was that there was **no emergency communication equipment for staff members,** and that there needs to be persuasion for communication equipment to facilitate quick response to adverse patient situations. This is reflected in the following comment by one of the participants:

> *"…a challenge that I'm facing to convince them that we need a two-way radio when we are working with these people. The other challenge that I'm facing is, the panic button…"*

Staff members in an emergency department need to get assistance as quickly as possible to ensure safety, and therefore teamwork is of the utmost importance. The participants expressed ambivalence with regard to teamwork with some agreeing that they work

together as a team, while others were of the opinion that there are challenges in their teams.

4.3.3 Subtheme 3.4: Staff members experience challenges with regard to teamwork

Findings from participants revealed that there are challenges with regard to teamwork, especially when immediate attention is required by more than one staff member to assist in attending to a substance-induced psychotic patient. Some narratives from the participants reflected good team work while others commented on the limitations in this regard. The following participants indicated that there is good teamwork in the emergency department:

> *"I think everybody helps. It's not only me and the security [staff member]. We call quickly and Sister will come…and the doctors. Anybody will be involved but I'm scared. I am staying so far away because I get frightened…but at least you do call for help. Manpower will hold and restrain."*

> *" (security staff members) if they are there I think it's good teamwork, if…all are at their proper posts where the one can call the other one but if it's not, that's the only time when things do go wrong..."*

> *"The nurses must also help you because you're a team…We must work together but the nurses or doctors they're not all the same."*

On the other hand there were also participants who experienced ambivalence about teamwork. Medical staff in particular felt that security staff members could be more vigilant in their response to substance-induced psychotic patients, and highlighted their challenges in this regard as follows:

> *"…the security just to be more alert. To keep an eye open instead of us having physically to go them and ask them for help cause what if something happen."*

"Usually we've got security guards and porters to help you contain the patient. My personal preference is the porters around because usually they're more experienced than the security guards. With the security guard, they're often not trained to deal with psychotic patients. Sometimes the security reacts badly…and wants to retaliate."

"…you never know when they are going to snap and the security is not always very alert. The security can be very slack and they take a long time to respond."

"…it took the security as least 20 minutes to come forward and do something. One comes and then 10 minutes later another one comes and they don't want to keep the patient down on their own. They want the rest of the security to come. When they get there eventually, it also happens that no-one brought the restraints, and it was a psych patient."

"…the slowness of the staff in responding to the violent patient…"

A study in the United Kingdom on the working and learning experiences of porters draws attention to porters in general being awarded inconspicuous importance in status, but that their duties and responsibilities as porters are integral to efficient services in a hospital. This contrasted with the opinion of one participant regarding the high esteem of a porter's role in assisting in managing substance-induced psychotic patients. Further comparison showed overlaps in duties and limited opportunities to express their views (Fuller, Laurie & Unwin, 2011). The aspect of responsibility overlap was expanded upon in the Subtheme 3.4 on the opinion of teamwork, and Subtheme 6.5 discusses the opinion of staff members that hospital management is oblivious of their challenges and views. Contrary to the positives with regard to porters in this study and the study in the UK, a 7-month porter operation study at a general hospital in Canada was seeking to improve the efficiency of the services provided by the hospital porters (Odegaard, Chen, Quee & Puterman, 2007).

The fact that participants alluded to the porters being more accustomed to handling substance-induced psychotic patients may be because they are more used to handling patients, whereas security guards are not sensitised to recognise symptoms and lack training, resulting in fear.

In contrast with the abovementioned findings some of the non-medical participants commented that there is teamwork. The security guard participants felt that medical staff should respond immediately to the substance-induced patients especially when they are aggressive, agitated or violent. The following comments are evidence of the finding of ambivalence in teamwork and the expectation of immediate response from non-medical participants' perspective:

> *"The people that come in with the substance abuse in the hospital they do get help. There are lots of doctors and nurses that attend to them. The assistance is always there [if] the nurses are not there, we help, I help."*

Another staff member emphasised the teamwork, saying:

> *"…we work with the nurses and doctors and help each other. We won't say, 'Nurse it's your job or we are not trained', that won't work for us. Nothing will bring us apart. The securities are also part of our team… We are pulling together. We must be there for each other at the hospital but sometimes some people won't understand how we are working and think that we are fighting, but we'll never fight. We are busy with a job that time."*

A staff member expressed the expectation of immediate response:

> *"…the doctors see them but the doctors take a while to see them. I would like that the doctors first to see that patient because they are giving us a hard time while they are waiting for the doctor to see them."*

What another staff member expressed also indicated the difficulty and expectation:

> *"…the security must just calm him down but it can be too much for you. If the patients get treatment now - now by the doctor and nurse, it makes it better for security because the patient is not going to be up and down or moaning or groaning."*

The same participant added:

> *"If they [doctor and nurse] are quick and help the patient immediately, the security got no problem in the trauma…if I talk about support. I would like all to be like that. Immediately give the patient help. If the nurses and the doctor are working together with the security."*

In conclusion, it appears that the medical staff members and the non-medical staff members who took part in this study have different expectations of each other. Teamwork in essence denotes several persons who are interdependent, working for an organisation and working together in order to get a job done. With the exception of one participant there were no comments of lack of teamwork in their own group of medical or non-medical colleagues. They are viewed by others and by themselves, as a group. The input from medical staff members can be seen as multi-disciplinary since they fulfil different professional roles. Non-medical staff members linked to this team, can be seen as inter-disciplinary since they have a different category of training but assist together with service to the psychotic patients (Shea & Guzzo, Overetveit & Opie, as cited in Onyett, 2003:2-3). Findings also indicated that not having the support of family or family being on the defence, has an influence on services delivery in the emergency department. This matter will be outlined and substantiated in the following sub-theme.

4.3.3 Subtheme 3.5: The defensiveness or lack of supportiveness of family has an influence on services

According to the participants, substance-induced psychotic patients are normally brought to the hospital by the police. The absence of family members to give support to these

patients makes intervention difficult as no background history is available to assist medical staff in their management and diagnosis of the patient. One of the medical staff members mentioned that some of the reasons why parents and/or family members are not supportive to the substance-induced psychotic patients are that they often become defensive about their children's use of substances, while others are in denial. Some substance-induced psychotic patients are rejected by their families, and cultural beliefs in witchcraft may also play a role.

Substances can cause harm to people's lives and health in a number of ways (Nelson, 2012:45). Literature reviewed in Chapter 2, section 2.2.3 (Gifford, 2011; Schäfer, 2011) describes the effects on all areas of the substance abuser's personal and family life, and though the importance of family in the abuser's life is stressed, shame, resentment and detachment towards the substance abuser or detachment from the problem are often shown by family members. The following comments substantiate the echoes from medical staff members in the present study:

> *"…in most cases it's parents who don't know what their kids [substance-induced psychotic patients] are doing. The parent will say, 'My child is not even smoking cigarettes' while the patient will disclose that, 'Actually I'm using drugs."*

The same participant said:

> *"…these patients are not the ones that families prefer. They don't like them and in many cases even when they're discharged, they don't want to come and fetch them."*

Other participants echoed the same viewpoint with emphasis placed on the responsible role families can play:

> *"A lot of times I see that this family of the drug users they just get fed-up. They leave them alone, they don't want anything more to do with them and a cycle will follow where the drug users will come in with substance-induced psychotic disorders."*

"The parents must accompany their children [substance-induced psychotic patient] because it's for other people's safety in the hospital. The family also has to take responsibility for those things because in the hospital they endanger other people's lives."

Gifford, (2011) & Schäfer, (2011) are in agreement with the abovementioned sentiments and emphasise the importance of family to the substance-abusing individual, adding that isolation of the substance abuser from family may be due to feeling ashamed, guilty and anxious, or being in denial. In addition, Hegarty & Golden (as cited in Kelly *et al.*, 2010:806) and Delamater & Myers (2011), emphasise the applicability of external attribution in that the family externalise the cause of individuals presenting with a substance-related problem. An added challenge to deficient family support and family being protective of the patient presenting with substance-induced psychosis, is therefore the problem of untrained staff members.

4.3.3 Subtheme 3.6: Untrained staff members are a challenge in dealing with substance-induced psychotic patients

Some participants pointed to the fact that they lacked adequate training in managing the substance-induced psychotic patients. The lack of training led to feeling incompetent and reluctant to deal with such patients. The comments that follow are evidence of participants' feelings of incompetence and resistance:

"We're not trained to deal with them. Not even the doctors are trained to deal with them."

"...we teach ourselves. Nobody else teaches us. They just expect me to approach and deal with this patient and although you don't know anything about psychs, they just expect you because you're in the emergency unit."

"...truly we're not trained to look after the psych patients. I only know there are two sisters that are trained."

"…nobody taught me but I was just told if a patient comes, a psychotic patient, take off the clothes, do the obs, put on ID band. So obviously when he acts weird, like real violent I call security, to restrain and you call doctor."

Other staff members said:

"…if you know how and you are trained you can deal with them but not everybody got the training that is working here. Some people will get a fright. They don't want to work in that area."

"In med school you don't really get trained. They don't formally teach you how to hold down the patients or how to give sedatives. It's spoken about but you only really see it when you start working."

"I don't think it really prepares you for dealing with the acutely psychotic patients that you get in an emergency unit. So, probably inadequate, I think, but then again, like with a lot of medicines, you sort-of learn on the job."

Another staff member indicated:

"I don't think we have security staff that is really trained to deal with this specifically."

The following comment reiterated participants' lack of training and dislike of working with these patients:

"I don't like working with psych patients. I was never trained. I don't like it but I do because I'm supposed to do."

The challenge of untrained staff corresponds with national and international literature. Findings in these studies indicate that staff members providing services to mental health users need training in managing substance-abuse disorders in order to expand their

perception and attitude (Ramlall *et al.*, 2010; Bock, 2011 and Gateshill, Kucharsha-Pietura & Wattis, 2011). A comment in a survey on attitudes of physician registrars and junior consultants in the emergency department in Western Cape, Gauteng, Limpopo, and KwaZulu Natal, is that emergency department staff members frequently come into contact with substance-related disorders. Yet, as one of the results showed, emergency physicians and junior consultants' prescribed teachings in studies on drug abuse and dependence are limited or altogether lacking. The survey concluded that emergency department doctors consider substance abuse and dependence as a disease that can be treated, and favoured short-term intervention (Kalebka, Bruijns & van Hoving, 2012).

The findings of the present study agree with insufficient or non-existent training in substance abuse and dependence for medical staff members, as well as non-existent for non-medical staff members. A research survey at four psychiatric hospitals in South Africa with regard to managing aggression and violence revealed that nurses without training in psychiatry found it hard to calm patients, and they do not have insight. The trained nurses were more perceptive as to the effects of negotiating and communicating with the aggressive patient and dealing with the violent patient (Bock, 2011). Not much time is spent training student doctors in their curriculum or internship, and this can result in discomfort in medically okaying a patient presenting as psychiatrically or behaviourally disturbed (Cresswell III *et al*., in Glick *et al.*, 2008:45).

The findings of the present study showed that the need for training relates to non-medical staff members as well. It was clear in their responses that they lacked training specific to managing (negotiating, communicating, care and restraint) of the aggressive or agitated patient. The following comments by non-medical staff members substantiated their lack of training:

> *"It's a course by yourself. It is not a special course you do to handle the psych patient. A psych patient you must handle, how he is."*

"We work and learn, as we go…day by day. So we learn, I must be calm with this one… If the person is aggressive, I mustn't panic. Just you…, your experience in working with them now."

"…training how to deal with the patients there in trauma…would help a lot."

Training in completion of forms from referring resources, was seen as a need as well. **The lack of properly completed referral documents of substance-induced psychotic patients is a challenge for medical staff members.** Ill-completed forms for the admission of the substance-induced psychotic patient or the lack thereof, were mentioned as costing them time in seeing that the required paperwork was completed by having to re-do it.

The participants who took part in this study were of the opinion that:

"…if we can have the time for regular in-service training. We're getting forms from the dayhospitals and many people or medical doctors are not aware of the forms that patients must take when they come to us and we have to spend time filling in the forms."

"…the forms that's sent from the referral sites. If someone can do a course or something to teach the doctors at these sites how to fill the forms in properly, it would save us so much time. They make a lot of mistakes and we have to fill that whole form in again. It's two form fives, so we need two different doctors, two doctors' time that you using up."

"…sometimes they walk in without forms and we have to divert them back if the patient is not too aggressive. Otherwise if they are too aggressive we just certify them here and see them here."

The findings as discussed in Theme 3 reflected the effects on service of patients' aggression and agitation. It became evident that staff members managing substance-induced psychotic patients experienced emotional challenges, such as resentment, especially among medical staff members. Fear was experienced by both medical and non-medical staff members, though the emphasis on what was feared differed between the two staff categories. Stress was also experienced and was more notable in comments of non-medical staff members. Non-medical staff members' opinion of medical staff members not prioritising the substance-induced psychotic patient reflected this as a stressful experience for them. Tolerance was, however, felt by some of the staff members.

Information about fear and stress in staff members was based on personal communication with the clinical manager about the background of managing psychotic patients of the hospital where the study was conducted, as discussed in Chapter 1. Statistically there are significantly more substance-induced psychotic patients than those with a primary mental health condition. What was imparted was similar to the findings of this study regarding fear and stress in managing these patients. Literature reviewed in Chapter 2 on the fear of dealing with patients presenting with a mental health condition at the emergency department and the higher risk of violence in the emergency department (Chikaodiri, 2009; Gacki-Smith *et al.*, 2009; Magnavita & Heponiemi, 2012) is also congruent with the findings of the present study.

Arik, Anat & Arie (2012) in their study on the emergency departments at three large public hospitals found that the level of fear determines the manner and the degree of anger that is expressed. The participants were doctors, nurses and receptionists, but the focus was mainly on nurses. In their study the responses to fear ranged from disregard to complying with what the patient wanted, or enlisting the help of security straight away. The level of fear and reaction to psychotic patients in staff members from findings in the present study was more intense, with all staff being on the alert and quick to react. Resentment of the substance-induced psychotic patient was also clear in the staff members' responses, but justified. These findings of emotional challenges are discussed in Theme 4.

4.3.4 Theme 4: Staff members experience personal challenges in dealing with substance-induced psychotic patients

Happiness, grief, fear, revulsion, fury, disapproval, interest and surprise are eight emotions, across cultures that affect facial expression in a similar way (Ekman as cited in Louw & Edwards, 1997:432). Resentment and fear could be sensed in all participants in the present study, with fear being more intense in the medical participants. The findings from this study pointed specifically to the fact that all the staff members who had to deal with substance-induced psychotic patients in the hospital were often challenged by resentment and fear, a theme that appeared throughout the study. These emotions could also be detected in their tone of voice and facial expression. Five subthemes emerged concerning personal challenges, and the reader will be guided in each subtheme by referring to "medical staff members", "non-medical staff members" or "staff members" (meaning all the participants), as indications of who is being referred to in the findings.

4.3.4 Subtheme 4.1: Medical staff members experience resentment

Medical staff members felt resentment in dealing with the patients since they viewed substance-induced psychosis as self-induced, and furthermore that these patients demanded priority attention, often being helped before other patients also in need of critical medical intervention. The staff members also resented substance-induced psychotic patients' aggressive behaviour as well as their recurrent readmission.

Medical staff members resent substance-induced psychosis as they regard it **as a self-induced condition demanding priority emergency attention**. Most medical participants viewed psychosis to be due to substance abuse that is self-induced, self-harm and self-inflicted, and said that these patients should not be attended to in a general hospital emergency department. Owing to the aggressive disposition of the patients when presenting at the emergency department or when they were violent, immediate attention had to be given, which participants resented. The findings from this study revealed resentment, dislike and frustration from staff members, which were audible in their tone of voice as well. The following participants articulated their challenges in this regard as follows:

"…most of the people don't like to work with the drug-induced psychotic patients. For instance, some people, even doctors and colleagues say these are the people who are like self-harmers. They say it's self-induced, so it's a waste of time. It's like looking to a car and saying this is beyond repairs."

Another medical staff member said:

"It takes a lot of our time. We've got sick patients, who want help, laying in the ward and here comes a person that's using substances. So I'll think this is a waste of my time because there are so many other people here that actually want help but you can't say no."

Apart from resentment and regarding substance-induced psychotic patients as a waste of time, some of the participants emphasised their ambivalence with regard to the needs of a medical patient versus substance-induced psychotic patients.

"The really ill patient needs your help but you leave that patient to attend to somebody, whom I mean, he actually caused it himself."

"You actually leave your work aside to see to these patients. They take up at least say 15, to 30 minutes of your time, where that time could be spent on quality care to another patient. You have to leave that patient to see to this patient, which is also not right."

One of the medical participants said:

"…it's frustrating, irritating, annoying, because it's time-consuming…you have patients with heart attacks, sitting on the chairs instead of being in a bed because you've got a sedated psych patient there."

Another medical staff member felt:

"…to me, they are not sick. They are different from the sick patient because sick patients you do, maybe you feed them, they are fragile. They are not fragile."

Further resentment was audible in the following comments by medical participants:

"They don't have a real medical problem…You'd rather see someone that's got something really wrong, that you know you can help, than someone that's going to keep on abusing substances. That's how I feel."

"If they are not aggressive, alert and more or less stable, not fighting with anyone, we put them in a book but because there are so many patients that are a lot sicker, we generally tend to see the other patients before them."

There are a variety of viewpoints on self-harm which are debatable, but as expressed by the participants in their responses, lean towards the literature on self-harm. Pilgrim (2009: 36) specifies that self-harm, narrowly defined in medical view and though there could also be daily fixation, inclines to mean that it is injury to self with no threat to life, and not accidental. The author's statement that perhaps a strain exists between traditional medical protectiveness and preservation, in which the patient is treated caringly as the victim of a disease, and the cultural type of reproach of the substance-induced psychotic patient, because of the resilient moral dialogue on substance use and abuse, matches participants' views (Pilgrim, 2009:41).

Apart from resenting substance-induced psychosis as self-harm, **medical staff members resent the aggressive behaviour of substance-induced psychotic patients**. The findings of this study showed that medical staff members were afraid of the substance-induced psychotic patients, and their aggressive behaviour was resented because staff had been verbally and physically assaulted. The resentment was also due to the unsafe environment created in the trauma unit of this hospital when a patient became aggressive, especially with other patients and staff in the area. Literature mentioned that the common challenge of violence and aggression exhibited towards emergency staff members by patients who were behaviourally disturbed (Cresswell III, *et al*., in Glick *et al*., 2008:45)

led to the resentment and fear of the aggressive behaviour that staff members had towards these patients. The following comments substantiate the challenges of medical staff members which resounded with resentment and fear of the aggressive behaviour of the patients:

> *"…they are always escorted by policemen, not sedated, shouting, screaming, and causing a racket in the unit. I don't look forward to it and I don't like getting involved with the psychs…because they come in there very psychotic usually."*

> *"…they are physically aggressive and verbally abusive…and I do not want to work with them."*

> *"… you might be busy with a medical patient, maybe busy with a MI patient, now you have to leave that patient…to attend to that, run around because that patient is violent."*

> *"So it's not nice because when you come back tomorrow they're still there."*

What these medical staff members said depicted staff members being assaulted and fearful. They verbalised their experiences as follows:

> *"...I've been attacked by psychiatric patients lots of times and I'm just always so scared of them…"*

> *"I've seen team mates getting abused on a number of occasions. My female colleagues being touched inappropriately or physically assaulted. I myself was physically assaulted a number of times."*

Parrish (2010), Hegarty & Golden (as cited in Kelly *et al.*, 2010:806), Weiner and Vourlekis (as cited in Parrish, 2010:124) explain that according to the attributions theory individuals tend to attribute changes in their own behaviour to external influences. This study found that attributions made by staff members of substance-induced psychotic

patients were audible and visible resentment, fear and stress that they experienced in managing these patients.

A medical staff member indicated that his resentment was more towards the system of having to see to this type of patient in a general hospital where staff members were untrained and in a facility that was not suitable for attending to these patients. The viewpoint shared was that they should be attended to in a facility where staff members were trained. The medical participant also explained that mistakes could happen in managing these patients within the prescribed demands, which the researcher deduced as the prescribed legislation, that the substance-induced psychotic patients be triaged and managed through the district hospital's emergency department. The resentment was not directed towards the patient. Findings of a study abroad where staff members would prefer that substance-induced psychotic patients be seen to elsewhere, were not dissimilar to these viewpoints of the medical participant. In another comparative study that was reviewed, findings reflected these patients as being more manic and behaviourally disturbed than other patients with a main psychotic disorder (MClaughlin *et al.,* 2006; Dawe *et al*., 2011). This is congruent with descriptions by staff members of the substance-induced psychotic patients.

Studies in Africa and South Africa speak specifically of the legislative system in the Mental Health Care Act (Act No. 17 of 2002) with regulations for attending to these patients in hospitals which do not have the capacity in resources, training or infrastructure to manage mental healthcare patients. An appeal was made for legislation pertaining to the mental health care user to be reformed. Stigmatisation particularly of psychosis due to use of illicit substances, was indicated with fear experienced by staff in working with mental health patients (Myers *et al*., 2009; Ofori-Atta *et al*., 2010; Ramlall *et al*., 2010; Sorsdahl *et al*., 2012). These authors also depict stigma, resentment and a call for evaluation of systems, matching what was stated by the medical participant.

These words led to the analysis inferred:

"…my resentment is not towards them but rather the system. I think your psychotic, or mental health care user, should be taken to a facility with number one, trained staff whether it's the doctors, the nurses, the porters or security, all of them need to be trained in handling these patients…often you go home and you reflect, 'Why did I feel that way?' and it's like I said, it's almost a prediction that you have. You're unhappy with the state of affairs. You're unhappy with the system so project it onto the patients instead."

The same participant continued:

"…all my frustration stems from that I know we're not dealing with a situation that is even close to ideal in managing these patients. I can see how easily mistakes happen, where things can go wrong and at the end of the day it's not the system that get blamed, it's not the management, it's nobody else but the doctor on the ground or the nurse who didn't check or the security guard who pushed too hard."

Apart from the resentment of substance-induced psychosis as being self-inflicted, and resentment of their aggressive behaviour as well as the resentment expressed towards the system, **medical staff members dislike the repeat admissions of the substance-induced psychotic patients**. The emergency department at the hospital is confronted with "*revolving door*" patients. Medical participants expressed resentment of the same patients who had been discharged who returned continuously, and the frustration as well as disillusionment of the same intervention. They ended up wondering if there were some other ways of dealing with the patients through other interventions. These included motivation for rehabilitation and entering into discussion with management. Findings also indicated that amidst the resentment, there was tolerance of the fact that a service had to be rendered, but not at the expense of other patients. These quotes are substantiating evidence of analyses made:

"…with the revolving door. They're discharged when the person is right and then three months even nine months, or a year down the line then you see the same

person, then again in a year. Then you see the person is still using drugs…you mostly seeing the same people going out, coming in, going out, coming in and you feel you say the same thing, sing the same song."

"They…go back out into the communities, use again and come back…Same problem."

Medical staff members emphasised the following:

"I think they need more rehab because it's substance-induced and they keep on presenting the same behaviour. They come while there are some other patients that are sick and need your help."

"…to convince them to go to a rehab because they think drugs is not a problem to them. They can stop any time they want, but they keep on using. They keep on coming."

What these medical participants said supported the finding that they were tolerant amidst their resentment:

"I would like the management…and us to sit down and find a solution of dealing with the revolving door patients. The concern is, if it's purely drug abuse…is there no other way of dealing with this? Is there no other way or platform to insist that people go for rehab?"

"…sometimes it's very frustrating because you see them doing the same thing over and over and you wonder what are you actually doing for them but we have to do what we have to do…So you are making a difference even though it's very frustrating."

The above comments pointed to the resentment experienced by medical staff members of recurrent admissions and aggressive behaviour as well as resentment towards substance-

induced psychosis as being self-inflicted. Apart from the resentment, medical staff members experienced fear in the work place. Literature reviewed in Chapter 2, section 2.5 stated that violence was more prevalent towards staff members working in the emergency department and in particular rendering psychiatric services (Gacki-Smith *et al.*, 2009; Magnavita & Heponiemi, 2012). The authors also referred to staff members' fear of working with patients with a mental health condition. Substance abuse, the substance abuser and patients presenting with a substance-induced disorder were therefore stigmatised. Patients presenting with a psychotic disorder were often viewed as being dangerous, unpredictable and posing a risk (Myers *et al*., 2009; Chikaodiri, 2009; Sorsdahl *et al*., 2012 and Van Boekel *et al*., 2013). The following subtheme outlines the emotional challenge in terms of fear and what is feared with regard to the substance-induced psychotic patient, with substantiation and comparisons from the literature.

4.3.4 Subtheme 4.2: Medical staff members experience fear in the work place

A common reaction amongst participants was fear that could be triggered by an existent or apparent threat. Substance abusers and persons diagnosed with anti-social personality disorder are two wide-ranging diagnostic clusters with a considerable amount of violence. Persons who have an existing mental health condition and who abuse substances (dual-diagnosis) are significantly more dangerous (Pilgrim, 2009:28, 39). Findings show that staff members' encounters with substance-induced psychotic patients often contained aggression, agitation and assault, either from having been assaulted or being witness to assault on colleagues, or threatened. This has led to fear in the workplace specifically pertaining to aggressive attacks and injuries.

Medical staff members fear aggressive attacks and injuries which are reflected in the following quotations:

> *"You're scared. Security is scared. Everybody is scared but you have to see this patient before the person hurts himself or hurts somebody else…Most of us are terrified of the psych patients. You don't know when he's going to take something and hurt you…it's terrifying when they do come in."*

"I'm not comfortable around them. If they swear to the mother, what more can they do to you? One threatened to beat me around…you never know when they can grab you. I fear that they might touch me because they did touch the nurse…He was beaten by a psych so I don't want that to happen to me because I don't think I will be able to cope with that."

"I can't even hold the patient down myself, so I feel almost incompetent when the psychs come in. I try and avoid it. I often try to find another doctor to see to it…. They do say things in an aggressive manner because they are violent and they have a potential for violence. I can't help it I get scared."

In an introductory statement by the World Medical Association's 63rd general assembly in Bangkok, Thailand, October 2012, it was stated that violence by patients and significant others against staff in healthcare, affects the victim and the healthcare system. Violence can be verbal or physical, with threats and psychological ferociousness commonly occurring more than physical altercation. Recommendations put forward for National Medical Associations are, amongst others, that there should be strategic plans devised pertaining to dealing with violence and staff should be trained to deal with it. Where incidents of violence occur they should be documented for statistical and study purposes, to develop intervention approaches. Those staff members who have experienced violence should get an adequate supportive care package, and the cases should be investigated. Respective governments should therefore aptly provide funds to attend to violence in the healthcare setting (World Medical Association, 2012).

Apart from fearing aggressive attacks and injuries, **medical staff members fear misdiagnosing of the substance-induced psychotic patient**. As in all psychiatric emergencies, the priority is to rule out organic cause requiring a specific treatment (Gallego *et al*., 2009:122). In the medical practitioner's assessment of a psychotic and agitated patient, findings have revealed the importance of making as accurate a diagnosis as possible, since the precipitating condition could be something other than substance abuse. Findings show that medical participants fear misdiagnosing a patient as substance-

induced psychosis. In the responses of the present study, there was also acknowledgement that mistakes in diagnosis have happened before.

The following quotations bear evidence of the abovementioned literature findings:

> *"Often I have cases which turn out after a couple of hours down the line, that this patient has meningitis rather than a psychotic patient. So, you always have that fear in the back of your mind that you are mismanaging the patient and that it might be something else, rather than just a substance-induced psychosis."*

> *"Sometimes it could be something else and then you think its drugs. We have to obs [do observations on] the patient because sometimes they could have a UTI, an infection…"*

> *"Not everyone that just comes in you can say because you're intoxicated, that you've got it."*

Doctors dealing with psychiatric patients in the emergency department often view this category of patient as being difficult, time-consuming and frustrating, seeing that there are other patients for emergency medical or surgical interventions to attend to in a space not suitable for a psychiatric emergency. It is important to do a thorough medical assessment before making decisions that a patient needs to be referred for psychiatric intervention either as an in- or out-patient, as it can happen that the dual presence of a medical condition can go undetected especially if the psychiatric emergency case is behaviourally disturbed (Cresswell III *et al.*, in Glick, *et al.*, 2008:45). This literature is congruent with the findings reviewed in Chapter 2 where it is stated that psychosis can result from the use of various substances, while medical conditions can also set off psychosis. Thus a variety of aspects should be taken into account when doing an assessment, but the basic principle is to isolate the root cause and to treat it accordingly (Baumann & Lewis, in Baumann, 2007; Freudenreich, 2008).

Findings that were divulged by **medical participants show that there is continuous self-control, fear and stress in the emergency department**. Reinhardt (in Glick *et al.*, 2008:26) concludes that the use of self in therapy is of the utmost importance in psychiatric emergency departments, in comparison to an ordinary hospital emergency department where crucial skills needed are related to somatic investigation and life care expertise. It is therefore also important that staff members in the emergency department must be able to manage themselves when dealing with the substance-psychotic patient in a general district hospital emergency department.

The following comments illustrate the above concept:

> *"…that's why I say, 'Take it like it comes.' You have to approach the patient in such a manner that the patient can become calm and relaxed. If the patient is swearing, I can't swear back at the patient. I've got to be humble and try and calm the patient down by talking to the patient and therefore take it like it comes. If he's rude, I can't be rude also."*

> *"…the challenge that I'm facing, me as a person, is the challenge of always being calm when you're working with these people."*

> *"…you try and look past it and you try and deal with it in a calm and rational manner, but I think for most part we succeed, I succeed. Well, you definitely have to consciously think about keeping your cool with these patients especially the way they present."*

> *"…there are those ones who are co-operative with you but you never know about tomorrow. I count how many hours are turn around. I think some of my colleagues are not even comfortable around them."*

In the following comments the constant fear and stress as well as self-control became obvious as well as the issue of lack of insight and training.

"I'm not interested. I don't like psychs… Maybe if they can train me more about them to gain insight maybe I will stop the fear…dealing with those kinds of patients I can't trust them, to my opinion. I'm frightened of them and I don't know what they are thinking…it's nice to me if they come with the police because at least they can assist me…I will always ask them, 'Is he violent' because I am scared and not comfortable around them."

In addition, further experiences shared with the researcher were:

"I'm always scared when I see those patients. I feel fear for myself and the other patients…you just want to sort them out but it's our time because actually you must do all of that, you didn't yet see the patient. You're just trying to sedate them. It puts you behind because you must still see all the other patients. It's just, I think, a bit stressful."

"I always feel very threatened and it's not that I'm imagining it because they are actually threatening…they are always walking around the unit and you are always afraid because you feel if you can look now, they are right behind your shoulder. They can do anything. I think it impacts on my ability to work properly there."

"So you must be alert always, extra eye for them. You've got your own workload but also to them that is our work now but we are not trained to look after them."

Subthemes 4.1 and 4.2 illustrated medical staff members' resentment and fear of substance-induced psychotic patients in an emergency department. In subtheme 4.3 the non-medical staff members' emotional challenges of fear are presented and substantiated with quotations. In addition, findings in subtheme 4.4 reveal non-medical staff members' experience of stress in controlling the substance-induced psychotic patients and their fear of the unpredictable behaviour of these patients, plus their opinion that these patients should be prioritised by the medical staff members.

4.3.4 Subtheme 4.3: Non-medical staff members' fear of the substance-induced psychotic patients

Findings show that aggressive patients arouse retaliation from non-medical staff members, and in particular security personnel. This is thought to be due to the lack of training, as mentioned by nearly all participants in their approach to substance-induced psychotic patients as well as safety procedures. The fact that the aggressive patient provokes retaliation in non-medical staff is concluded from the following comments:

> *"...we are there to look after the patients, to be protective of them, but if the patient came in there in trauma, we have to treat them like normal people but some of us don't treat the patients like that. Like to kick him and we get to be angry. We don't have to do that. If you are going to raise your voice it's going to get him upset and maybe end up hitting you and that's another problem, we don't have a right to hit the patient back."*

> *"...some of us take that patient like it's a mad patient, while he's not mad but he's been drug abuse, so now some of us hit the patient."*

> *"...some of the securities are like that sometime. They don't care about the patient and then there's the security that's always on the ball."*

Security guards are employed at hospitals to provide security and protection to the patients, staff, and visitors. In managing agitated and aggressive patients, safety precautions are imperative since violence can erupt. The security personnel should be the first safety persons to react if a patient needs to be restrained physically (Gallego *et al*., 2009:123). Findings reveal that the reactions of some of the guards are retaliation in some and invisibility in others. However a deeper meaning is construed from their responses, which relate to lack of training and fear of the aggression displayed by the patient, with fear of injury.

In addition to fear, **anger** could be sensed from non-medical participants in the following quotations:

"It make…,'I don't feel for this job anymore now', because that guy is moaning, or he's nagging, or he's fighting and that make us also nervous…security cover himself too, because he don't want to get hurt."

"…you know they're fighting with the patient (security) or the patient is fighting with them."

"He tore my jersey and I was very, very angry that day when that happened to me."

"Sometimes you getting upset, really upset. You forgetting you come to work the way they tearing you apart…"

"Like the patients they are really ill, like asthma, sugars, because they are so aggressive towards people like that…they're also making us scared."

"…the main thing making securities sometimes scared is the patient who wants to fight the security."

Non-medical staff members also **expressed fearing the unpredictable behaviour** of the substance-induced psychotic patient. An agitated patient should not be mistaken for a violent patient, but the margins between the two might be difficult to differentiate. A violent patient essentially requires security guards' intervention since it is a matter of safety and normalising the situation. As described in Theme 1, agitated behaviour is linked to unpredictability (Gallego *et al.*, 2009:121 - 123) of the substance-induced psychotic patient, and therefore it is a major challenge for non-medical participants to manage them.

The following comments bear evidence of non-medical staff members' challenges with regard to substance-induced psychotic behaviour:

"You must always be careful of the patient who comes in at trauma… specially the drug patient, he doesn't want to be admitted and then people or the police bring them in. It happened many times with the security that they got hurt. The security must be careful, he must be wake up. He can't just stand there and then the patient come and give him a smack."

"…or they spit at you… catch you off guard…Sometimes he'll bite on you."

"Always be aware, where they going. Be careful, because they can do lots of things running out and here and there…. and it's quite dangerous they walk around and do not know what they think. Your eyes cannot be on them 24 hours because you've got to work here and there and there."

"You must be alert. I'm very alert when such patients came in, that people who use drugs."

Non-medical staff members do not only fear the unpredictable behaviour of the substance-induced psychotic patients but also find controlling of these patients very stressful. Chikaodiri, (2009); Magnavita & Heponiemi, (2012); Sorsdahl *et al*., (2012) agree that substance-induced psychotic patients are stigmatised as being unpredictable and dangerous, often become violent and therefore evoke fear and stress among staff members who render psychiatric services in the emergency department.

4.3.4 Subtheme 4.4: Non-medical staff members find it stressful to control substance-induced psychotic patients

Stress in the non-medical participants is caused by self-control in trying to defuse an aggressive encounter and to maintain control over their emotions in the wake of being injured and dishevelled. Stress is caused by the number of substance-induced patients coming to the hospital and they have to manage the patient since it is part of their job requirement. Stress is the feeling that is experienced when things get too much. It is an emotional response to circumstances and events that threaten us and challenge our coping

abilities (Sdorow & Rickabaugh, as cited in Grieve, van Deventer & Mojapelo-Batka, 2005:334).

One of the non-medical staff members described his sentiments with regard to stress deduction:

> *"…if the person is aggressive I mustn't panic. I must just be calm. Then he'll also be calm with me. If I become aggressive… everything will go uncontrollable… you have to be patient with them and experience the pressure…he doesn't give you any breathing moments, so you must be calm. Although he's tearing you apart, your clothes, losing your buttons of the shirts or watches, spectacles, things like that. You must try to be calm. That is some of the difficulties we're getting with this people in the hospital and some of us, getting punched at but you must be there. Sometimes we don't want to be here."*

This participant did not elaborate on his fear but he looked anxious and stressed, and it was audible in his tone of voice.

Other stress in controlling the substance-induced psychotic patients is caused by resentment and a perception that the patient's condition is self-inflicted. At the same time the self-search of how to counter the abuse of drugs can cause stress; it emanated from the following participant's response:

> *"I don't know how, but I wish I can help them to stop using that. They make themselves psychs by taking drugs that make them mentally ill while they are not a psych patient. They do not learn from school and the posters that are everywhere about the danger of using drugs but they keep on doing it. So they end up here and we call them psychs patients, while they are not psychs."*

In addition to finding it stressful to control the substance-induced psychotic patients, the **opinion of non-medical staff members is that these patients do not receive priority by medical staff members**. The majority of non-medical participants expressed that medical

staff should attend to the substance-induced psychotic patients immediately but it became obvious that they feared potential uncontrollable situations.

> *"…the doctors see them but the doctors take a while to see them. Maybe that patient is there for two days, and they're getting aggressive, they're getting tired because nobody helps them and they are demanding to be treated. They need, they demand to be helped because that substance they use, it's causing them that."*

> *"I would like that the doctors, whoever who's there, to first see that patient because they are giving us a hard time when the doctor don't see them."*

> *"It is good when the staff is listening to you when you're talking because you are a long time in this business and there are nurses who are young. They don't know the right story sometimes or they didn't even see, oh, this is a psych or what."*

In addition, the findings of the study pointed to the fact that some staff members displayed tolerance towards the substance-induced psychotic patients.

4.3.4 Subtheme 4.5: Some staff members have more tolerance for substance-induced psychotic patients

The researcher concluded that some staff members perceived themselves as better equipped to manage the substance-induced psychotic patients, although it caused stress, frustration and burnout. One of the medical participants reflected that his ability to manage substance-induced psychotic patients was due to training and expertise gained over many years of working with mental health patients and dealing with those who were aggressive. He expressed himself as follows:

> *"I'm now 17 years in nursing, and spend most of it in psych… I feel comfortable working with them…I got skills now to deal with them…called the management of aggressive people through care and restraint procedures where you learn the skill of managing the person because you don't just go and grab... It's not only the*

teaching about grabbing but also how to calm the person down. You talk the person down, then grab after…"

"…you must also know that when you are working with these patients you are going to be burnout, you are going to be drained. Why, because it's like a family to you. You mostly see the same people going out, coming in. So my challenge is that, 'I mustn't give up. I haven't failed because this is the third or fourth time that John is coming'. My experience with people who are using drugs, is that there will come a time in that person's life when that person changes. Maybe something will happen to the person."

The participant continued:

"So the challenge to me is always to say, 'Maybe this is time for this person to change.' When the right time comes and the right time can even be when you are no longer working in that institution. You left…not to look back and say I wasn't good enough. No, the challenge is to tell yourself to keep focusing on the dream."

Most staff members do not have experience and training in working with substance-induced psychotic patients and the behaviourally disturbed. The lack of training was discussed in Subtheme 3.7 and it was seen by the researcher as playing a major role in the fear, resentment, and stress described, and could be detected in their reflection about the management style and their reaction to these patients. Although Chikaodiri, (2009) asserts that frequent positive contact by healthcare staff members with patients who are managed for a mental healthcare condition will lessen negative attitudes towards these patients, the findings of the present study were to the contrary. The staff members of this study do have frequent contact with substance-induced psychotic patients but their attitude and emotional challenges with heightened stress do not improve. Grieve *et al*., (2005:325) point out that continued stress over a period of time results in burnout and can render a person emotionally depleted, with feelings of worthlessness, incompetence, detachment, and cynicism about ambition, work and the future. Burnout in a hospital while carrying out a duty to patients should therefore not be taken lightly. Ustundag (2012) indicates that

burnout syndrome develops over years in emergency department staff, and affects all staff members as well the patients who are attended to. In retrospect by all the participants, stress was not restricted to one participant but was evident in all the participants as they relayed their stories of the challenges that they experienced.

However, the following comments describe the attitude of a non-medical participant who responded with tolerance because her training in a course on how to work with sick persons and how to handle and care for difficult patients as well as being a mother herself, put her in the strong position of being able to cope with assisting in managing the substance-induced psychotic patients.

> *"I had the training. I got the experience, and training makes me stronger so I can understand their behaviour…"*

The researcher made a further inference of tolerance from the participant being a mother and her training, from the following comment made by the same participant:

> *"I can cope with people that are substance abusers, I can cope mentally, because I learn and I'm a mother myself…the person I am myself…I know how to deal with people like that, so for me it's not a problem."*

Findings revealed that managing or assisting in managing the substance-induced psychotic patients was emotionally challenging for staff members. Literature on attitudes by health professionals (Van Boekel *et al*., 2013) shows findings of stigmatisation of substance-induced disorders which gave rise to negative attitudes and in turn affected service delivery. In addition to emotional challenges, findings in another study (Bimenyimana *et al.*, 2009) were also congruent with findings of the present study such as lack of concern, shortage of staff, frustration and fear. Amidst emotional challenges, most of the staff members who took part in this study did not deny the patient's right to be attended to. However, the right to healthcare was not depicted by participants as their choice at the emergency department, but as a duty carried out to substance-induced psychotic patients in accordance with prescribed rights. These are discussed in the following theme.

4.3.5 Theme 5: Staff members acknowledge dignity for all patients

Undoubtedly, findings reflected that participants respected the patient's right to be treated with prescribed dignity. According to the Office of the United Nations High Commissioner for Human Rights (Fact Sheet No. 31, 2008) assuring good health remains the responsibility of a patient, but that there are factors beyond control that affect attaining and maintaining good health.

The acknowledgement of patients' prescribed rights was evident in the following quotations, which were voiced by all participants:

> *"We've got sick patients, who need help. I'll think now this is a waste of my time because there are so many other people here that actually need help but you can't say no, it's also a person with rights and maybe that person can actually stop using substances and make a difference to other people."*

> *"I actually try and treat the patients as you would any other patient."*

> *"The substance abuser and the normal person, what they must get, they must get…treat at the same level. According to the constitutional right…you have a right to medication, a right to health, healthcare."*

> *"…the psych patients are being housed in the emergency unit for days on end and it's completely unfair on them and the rest of the patients. I mean, they're also patients and don't deserve to be sitting on chairs for six, seven, eight days on end and deserve a bed like any other in-patient. They're fundamentally different from the rest of the patients in the unit. There is a big distinction between mental illness and physical illness but both should be given preference, deserving treatment but in an appropriate setting."*

> *"I don't think it's an ideal place for the acutely psychotic patient to end up in. They end up being sedated quite regularly and lack proper monitoring, and so it's a danger to them as well. So we try to put our personal feelings away and act*

professionally and objectively. I try to be aware of it with all my patients, whether it's pneumonia or a substance-induced psychosis, asking yourself how you would like to be treated or one of your own family members, and try and treat your patient accordingly."

"…talk [to the substance-induced psychotic patient] like we are all his family. The patient needs assistance and needs his life back. So we try to bring that life back. It is very painful when you look at him and his parent. You realize that it is not right but we are dealing with that and you must accept that. It is a human being who needs help."

"Everyone else knows you're psychotic, but you're a psych and you do not realize it. It's not nice for them also. If I was psychotic, sitting in a brown nightie, I don't want anyone to see, to watch me."

"Nevertheless the patient is what now, or his black or his white…for any patient you must have a smile on your face and treat them well."

"…We must bear in mind they are still people and they still need to be treated with dignity, according to human rights and lastly they are vulnerable…at that time when they are psychotic. Therefore we need to protect them at all times."

Although staff members described their emotional challenges and how the services are affected by the patients' aggression and agitation, as well as how the different challenges of the substance-induced psychotic differs from those of other emergency patients, there is still recognition of the patients' rights.

The Universal Declaration of Human Rights and human rights as established in the Constitution of South Africa (Act No. 108 of 1996), with the Bill of Rights forming the basis of democracy, seeks to conserve and assert the democratic ideals of dignity, self-worth, equality and freedom. It upholds anti-discrimination, is rooted in respect of these ideals and applies to all people, though there are confines in certain circumstances.

Human rights are interrelated and cannot be seen in isolation of each other since violation of one within the total cluster affects the others. However, there is some infringing on one another's rights, and human rights do not always strengthen each other (Constitution of South Africa. Act No. 108 of 1996; Taket, 2012:9-17).

As findings of the present study have revealed, there is intrusion on the rights of other patients and staff, and the substance-induced psychotic patient's rights are also compromised. In South Africa the rights of the patient and the responsibilities of the public user are standards decreed by the Department of Health in the National Patients' Rights Charter (2007), which should be upheld. This charter outlines that a patient has a right to healthcare, and both patient and health provider have a right to a healthy and safe environment. The patient also has the responsibility to respect the rights of other patients and health providers as well as taking care of their own health.

In this study there was acknowledgement by participants of prescribed rights and the sharing of challenges experienced by staff members. Participants also made some suggestions about how the management of the hospital might assist in the managing of the substance-induced psychotic patients. Findings pertaining to their possible solutions are given in the final theme 6 and substantiated by participants' comments.

4.3.6 Theme 6: Staff members made special recommendations to the hospital management for assistance with managing substance-induced psychotic patients

Participants projected a variety of resolves from hospital management, in favour of recognition of prescribed dignity of the substance-induced psychotic patient as mental health user. Through the recommendations presented they acknowledge that the rights of the other patients, the visitors as well as their own, in the emergency department, will be protected. A study with 63 patients other than the acute behaviourally disturbed patients, and 9 visitors of a single emergency department of a general hospital in Australia, came to the conclusion that most participants preferred these patients to be managed in another area. The authors concluded that the design of future emergency departments should include a separate room. Where these patients are seen in an existing emergency department, there should perhaps be some beds in a separate area in the department for the

said patients (Lim, Weiland, Gertdz & Dent, 2011). Although the participants were not emergency department staff, it does relate to the wishes of the participants in this study, namely to separate substance-induced psychotic patients from other patients.

4.3.6 Subtheme 6.1: Staff members recommend a separate facility for referring substance-induced psychotic patients

The findings from the present study highlighted the fact that substance-induced psychotic patients should be attended to in an emergency department of a psychiatric facility rather than at the emergency department of a general district hospital. The participants expressed their sentiments in this regard as follows:

> *"Why don't they [the psychs] just go straight to the psych hospitals?"*

> *"...have emergency centres at these psychiatric facilities. If there's a medical condition or surgical condition they can be sorted out and referred on for specific services."*

> *"...they should open another centre or unit where they can go to get detoxed or determine whether it's actually the drug that is causing them to become psychotic."*

> *"...if they can just change the system of the management. If they can have a proper place for them. I don't think it's right if they come straight to trauma and sit there."*

Apart from staff members' opinion of having a separate facility for referring the substance-induced patients there were recommendations that these patients should be separate from the other patients requiring emergency care.

4.3.6 Subtheme 6.2: Staff members recommend that substance-induced psychotic patients be separated from other emergency patients

Staff members recommended a separate entrance, waiting room, and secure consulting rooms. Some participants were of the opinion that substance-induced psychotic patients

should have an area in the district hospital but separate from the emergency department, with its own entrance. The participants expressed their views as follows:

"...all emergency units to have separate care facilities, which are appropriately staffed."

"...if they can build a separate entrance for such patients so they don't get mixed up with the sick patients in trauma and where they have a separate entrance, only for them."

"If there's maybe just a separate section in the trauma where, ok, that's for psychs."

"Open another ward or place where the psych patients go straight and where the staff can look after them only."

"...if we can get something, a system where psychs can have their own place to come to...because it's not safe for other patients. Like a room where you can put cardboards up, so they can't hurt themselves."

Recommendations to managing the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) at district hospital level and opinions shared by health workers in a general hospital discussed in Chapter 2 of this study (Burns, 2008; Chikaodiri, 2009) are similar to viewpoints by participants of this study about separating these patients to other designated areas or facilities. They also recommended improving the facilities and resources at the emergency department.

4.3.6 Subtheme 6.3: Staff members recommend improved resources and facilities at the emergency department

Findings reflected that managing the substance-induced psychotic patients will require more than one staff member to see to the patient, and as the participants indicated there is a shortage of staff in the emergency department. The majority of staff members recommended improvement in the staff complement of the emergency department which

will increase the human resource capacity to manage the patients. Surveys done on the impact of the Mental Health Care Act of South Africa (Act No. 17 of 2002) at regional and district hospitals in KwaZulu Natal yielded the opinion that the Act has made entry to care for mental health patients more accessible, but that there are big inadequacies pertaining to human resources, basic organisation, administration and training. Specialist staff members to deal with disruptive patients were wanting, insufficient bed capacity and there were no isolation rooms in emergency departments (Ramlall *et al*., 2010). The same study pointed out that the implementation of the Mental Health Care Act of South Africa (Act No.17 of 2002) has revealed deficiencies and compares with the participants' views. The participants also stressed the fact that lack of staff was not only in the category of specialist staff. **The need for more staff** was expressed. Non-medical staff members indicated the following:

> *"…we are short of staff…you can't even go to lunch. We say we have a hospital for the community, bring the patients using drugs here although you only have two staff members for 24 hours and you work night and day duty?"*

> *"…they need more nurses to watch the psych patients that can be dangerous for themselves and for the other patients and for the doctors in the hospital. The nurse must be there 24 hours, must have passion for these patients and must be trained then, I think, things will go easier."*

> *"…two, three more guys on the site…will make it better for the securities because there are more securities…and make it better for the doctor and the nurse too."*

The medical staff members responded as follows:

> *"…there are not enough people who are working in that department. So if they can have at least enough staff to work in that department. That will be good."*

> *"…if there could be more security."*

"…they should get a psychiatrist that can see these patients. It would take the load off the other doctors if everything is already going crazy and busy with emergencies."

Apart from the need for more staff, a medical staff member raised the following issue:

"…if there could be an examination room where we can go and take the patient, sit and feel safe."

A medical staff member in particular **recommended that there be emergency communication systems** put in place. Security personnel assist with protection and safety of the patients, and a medical participant therefore recommended an inter-disciplinary team approach between medical and security personnel by acquiring communication systems. However, Lim *et al*., (2011) warn that a set-up of security systems may be a problem for other healthcare users and startle them.

One of the medical staff members made the following suggestion to improve communication systems:

"…we need a two-way radio because sometimes while aggression will erupt the security must run to the phone to call for back-up. If the phone is engaged the psychotic or the aggressive patient is not going to stop because that phone is engaged. He's going on."

The same participant proposed additional ways of improving the communication:

"…have panic buttons…you wear that panic button and when you are talking with the patient, trying to calm the patient down and see the violence, the verbal abuse building up and physical violence is coming, then you just pull the panic button and everybody around comes and helps you…and to form what we use to call, the response team…All those response people will see on their pager that this is in psych ward 4 or this is in emergency department."

The findings of this study show that staff members do not have specific training, and lack skills in managing aggressive and substance-induced psychotic patients. Staff members recommended training of staff that will enable them to manage these patients better.

4.3.6 Subtheme 6.4: Staff members recommend training of staff to work with aggressive and substance-induced psychotic patients

The majority of participants drew attention to the lack of training, saying that there should be training for staff in how to deal with aggressive and substance-induced psychotic patients. Sorsdahl *et al*., (2012) found that the stigma attached to all classes of substances is high but cannot be generalised to the broader South African population. Training in managing of substance abuse disorders was found to be imperative to render efficient services to mental health users, as discussed under theme 3, subtheme 3.6, and pinpointed in findings of studies reviewed. Lack of training leaves staff feeling incompetent and reluctant (Cresswell III, *et al*., in Glick, *et al.*, 2008:45; Ramlall *et al.*, 2010; Bock, 2011 and Gateshill *et al.*, 2011).

The following comments are evidence of the need for training that participants expressed:

> *"They can assist me if they can give us maybe two weeks course training how to deal with such patients because some of us don't know how to deal with them."*

> *"They could send us for small courses to deal with the patients."*

> *"There are courses available. Just to get someone in, train the security guards, train the nurses, train the doctors to deal with the acutely psychotic patient…, would make a huge difference for us."*

> *"…if we can have the time for regular in-service training to grab the person, to put the person down if you want to give the sedation to the person…also how to calm the person down. You talk the person down, then grab after."*

Staff members furthermore expressed the viewpoint that hospital management was not aware of their challenges in managing or assisting in managing substance-induced psychotic patients.

4.3.6 Subtheme 6.5: Staff members are of the opinion that the management of the hospital is oblivious of their recommendations

Ramlall *et al.*, (2010) found in their study of the impact of the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) that the review boards' modus operandi was insufficient and was not able to address the problems with deficiencies in infrastructure and human rights concerns. Their findings points to immediate management and higher up to take cognisance of the challenges that staff are facing, not to discard these challenges as unimportant but to show empathy and understanding. These comments reflect the challenges they experience and their expectation from management:

> *"…working with a psych is not an easy thing. That person's out of his mind. He doesn't feel what we're feeling, his mind is aggressive. So we have to go home with a thing like that and come back tomorrow. The management should acknowledge the difficulties that staff experience. We need their support and debriefing."*

> *"…nobody really seems to take note of what we are going through, it's almost futile complaining about it because there's not going to be a change sometime soon……let the staff know, that they [management] are aware of the problems and some of the challenges that we face and to take an active role in trying to resolve it."*

Challenges that participants experience in managing the substance-induced psychotic patients are similar to other hospital emergency departments and in accordance with being unprepared for implementation of the Mental Health Care Act (Act No. 17 of 2002), and its impact. It is deduced from the findings, that the hospital emergency department was not prepared for implementation (Burns, 2008; Ramlall *et al.*, 2012). The following comment by one of the participants points to the unpreparedness:

"I've been trying to speak with the Act team about people in the community to assist and visit them when we discharge them. The Act team that is at psychiatric hospitals are only tasked to go to the community and check that John is drinking medication and not using drugs. If they see that John is using drugs and starting to become psychotic, they can quickly bring the person to the hospital for a brief period to be helped promptly. In most cases the patient do not need hospitalization if they intervene early."

The emergency department is the busiest area in a hospital with regard to the crowding and human congestion, as well as emergency care that is provided. Added to these are the stress from challenges of safety and security, the insufficient resources, the relatives that staff has to contend with, and the relationships amongst professionals (Kalemoglu & Keskin, as cited in Ustundag, 2012). Staff members who work in the emergency department are under continuous stress since emergency care or assisting with care is provided in this department in the forefront of the public eye of relatives or doctors from other wards. Gaps identified and recommendations noted in Chapter 2, such as more training needed, additional staffing, shared interest as well as support, are similar to the recommendations that participants noted. These, given by an organisation to its staff members, were judged to have had positive results for staff members (Burns, 2008; Chikaodiri, 2009; Kelleher & Cotter, 2009; Ramlall *et al.,* 2010 and van Boekel *et al*., 2013).

4.4 SUMMARY

Chapter 4 is the crux of the study from which the researcher was able to gain insight into the challenges that emergency staff members experience. The challenges were described using the participants' words in the quotations supplied. The staff members who partook in the study were not reluctant to share their problems. What they shared in their experience of managing or assisting in managing the substance-induced psychotic patients in the emergency department is not identical to literature reviewed, but applicable findings from literature are similar to the findings of this study constituting the inductive reasoning and understanding gained from this qualitative study.

Different understandings were gained from the medical and non-medical staff members of substance-induced psychosis largely due to abuse of illicit substances at the hospital where the study was done. This drew attention to the number of mental health patients presenting with psychosis due to illicit drug abuse. Resentment and fear resounded in their challenges in dealing with these patients, who were depicted as different from other emergency patients. The participants' descriptive words "*dangerous*", "*aggressive*" and "*unpredictable*" as well as their explanations of the patients' agitation, gave rise to their fear. Fear and being averse to these patients were openly shared in conversation by the participants. Adding to this were the assaults that participants had experienced or witnessed. Non-verbal communication from the participants during interviews guided the researcher's sensing their fear and resentment.

The disruption of the emergency services in managing these patients came through clearly in the explanation of protection that is needed because substance-induced psychotic patients who are aggressive require restraint. This was seen to be in the interest of protection of the patient, staff and others in the emergency department. Staff members described the lack of facilities and the inappropriateness of the emergency department of the hospital in seeing to these patients. Though there were indications of the presence of teamwork, participants also expressed ambivalence with regard to teamwork. The lack of family support was seen to further hamper services to these patients, and so too the required forms that were ill-completed, taking up time of staff members. These were interpreted as causing strain on the staff members, who were already understaffed. Lack of trained staff was verbalised as a challenge across all the participants. Lack of training added to the fear of working with the substance-induced psychotic patients.

Personal challenges of staff members were interpreted as resentment and fear, more audible from medical staff members who viewed substance-induced psychosis as being self-induced, and felt resentment towards those patients who were re-admitted. Their fear related to the aggression of the patients, and having been assaulted. The non-medical staff members' fear was understood to be due the patients' agitation and their own lack of training, giving rise to retaliation with reference to a specific category of support staff members who were interviewed. The stress encountered in managing these patients was

also concluded from what was interpreted as fear in non-medical staff members from their contributions. In all the challenges the participants' recognition of the patient's right to healthcare services was clear. The concern about the problem of abuse of drugs in the community was striking, with belief that rehabilitation and reformed substance abusers could make a difference.

Participants put forward possible solutions in recommendations to management about health and the hospital to assist in managing the substance-induced psychotic patients. Literature cited in this chapter is congruent with the need for training, more staff and changes in infrastructure, with separation of these patients and support from management. Gaps were identified since there is a lack of studies relating to support staff members in health care. Chapter 5 concludes this study by summarising the foregoing chapters. Closing discussions of the findings of this study will be given. Recommendations made are based on the deductions of the researcher on the study as a whole.

CHAPTER 5
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The aim of the study was to explore and describe the challenges of emergency department staff members in managing substance-induced psychotic patients. This aim was met by the use of a qualitative research approach. The research question, namely: **What are the challenges experienced by staff members in managing substance-induced psychotic patients in the emergency department of a district hospital?** was answered in Chapter 4, which dealt with the research findings. The objectives of exploring and describing the emergency department staff members' understanding of substance abuse, their perception of the differences between substance-induced psychotic patients and other patients in the emergency department, and what it was like for them to deal with these patients, were accomplished in achieving the aim of the study.

Six themes emerged from the data analysis which was unpacked in detail in Chapter 4. Literature was used to substantiate, explain, compare and contrast with these findings. In Chapter 5, the final chapter of this study, a brief summary of the focus of each of the previous chapters will be given. Conclusions inferred from this study are discussed and recommendations to the respective stakeholders in the particular field of the study are put forward.

5.2 SUMMARIES OF CHAPTERS 1 TO 4

The researcher's choice of a qualitative research approach was considered to be the best one to address the research problem as described in Chapter 1, which served as an orientation to the study. Background information was given on substance abuse and substance-induced psychosis, including a review of the available literature to aid reasons supporting the need for more research. The choice of the attribution theory as the conceptual framework for the study was mentioned, based on the understanding which the researcher sought to gain through this study and from the reviewed literature. The researcher also alluded to the relevance of this study for social work. The research question stemmed from the research problem, which the researcher aimed to answer by

means of a qualitative approach, and an explorative and descriptive research design. The research methodology provided the process and implementation of the study, explaining the population and sampling process as well as the method of data collection and data analysis. True to the inherent characteristics of qualitative research, important aspects of ethical considerations and trustworthiness were discussed.

In Chapter 2 literature of pertinence to the topic of the study was reviewed, including the commonly abused substances and their different effects on users. In so doing, the researcher wished to draw the reader's attention to the potential of psychosis resulting from the use of illicit substances. A discussion followed on psychosis and substance-induced psychosis. Literature on international and national studies was elaborated upon in order to describe the challenges in managing substance-induced psychosis by staff members in an emergency department of a district hospital. Factors such as the effect of violence, fear and stigma in managing these psychotic patients were analysed. The attribution theory which the researcher deemed supportive pertaining to substance abusers and consequent health-related problems, including psychosis as well as stigma, fear and violence among these patients, was also discussed. The role of the social worker in relation to substance-induced psychosis in a district hospital was highlighted.

In Chapter 3 the research methodology applied to implement the qualitative research approach as well as the explorative and descriptive research design, was clarified and unpacked. The researcher included a description of the research setting as a way of introduction to the research process. The population and sampling were described, and an explanation given of the sampling procedure and the criteria used to represent the population of the study. A discussion followed, to provide the reader with insight into the preparation for data collection. This included the setting up of the interviews and also a pilot interview, which served as a trial before the main study, and which assisted in bringing about some changes such as simplifying the terminology of the interview questions, especially for non-medical participants.

The methods and instruments used during data collection, such as the use of a semi-structured interview schedule during the face-to-face interviews, were presented. An explanation was given of the interview protocol followed for all the individual interviews. The interviewing and communication techniques used were referred to, as well as explaining how and why they were used. Non-verbal communication was pointed out to have played an important role during the interviewing process and in inferences made based from the researcher's observations. The data analysis process was described through the eight steps used as suggested by Tesch (as cited in Creswell, 2009:186).

In Chapter 4 the demographic details of the participants who took part in the study were provided, also clarifying the distinction between medical staff members and non-medical staff members. Literature was used to compare and contrast the findings of the study which were presented in themes and subthemes. Conclusions drawn from the study were given in this chapter by means of the different themes that emerged from the process. The relevance of the attribution theory as conceptual theory to this study was also presented. Recommendations were outlined, followed by the conclusion as the final section of the study.

5.3 CONCLUSIONS REGARDING THE FINDINGS OF THE RESEARCH

In this section the researcher's conclusions on the research findings are presented. The conclusions are based on the six themes of the research findings discussed in Chapter 4 of this report.

5.3.1 Theme 1: Staff members have different understandings of substance-induced psychosis

It was found that staff members in the emergency department of this hospital had different understandings of substance-induced psychosis from their specific medical and non-medical perspectives.

Medical staff members in their experience of managing psychosis in the emergency department and the diagnostic criteria used, linked the presentation of substance-induced psychosis at the emergency department explicitly to the use of illicit drugs. Their

understandings indicated that psychosis could be caused through the aforementioned substances, and that their management of the patients depended on what the diagnosis was. Current literature was congruent with the findings.

Non-medical staff members, on the other hand, perceived the substance-induced psychotic patients as psychiatric patients, and in general referred to these patients as "psychs". This name created the reaction among non-medical staff members of having to be on the alert and cautious when there were substance-induced psychotic patients in the emergency department. The latter contributed to the conclusion that staff members were afraid of these patients.

The experience of participants in contact with substance-induced psychotic patients was that these patients were mostly behaviourally disturbed. The staff members' fear of these patients was very conspicuous as they perceived danger as well as unpredictability when encountering a psychotic person, and more so if the condition was substance-induced. The literature that was reviewed correlated with the findings of this study that staff members perceive threat and are fearful of these patients. It also corresponded with the unique presentations of the substance-induced psychotic patients. Existing literature also pointed to the fact that fear among staff members subsided with more contact with psychotic patients, which is in contrast with the findings of this study. The findings of this study pointed to the fact that staff members experienced constant fear in managing or assisting in managing the substance-induced psychotic patient.

5.3.2 Theme 2: Substance-induced psychotic patients' unique presentations compared to other emergency patients in the emergency department

Substance-induced psychotic patients presented differently to other emergency patients in the district hospital where the study took place, and staff members feared the aggressive and dangerous behaviour often manifested by these patients. Staff members were more at risk of injury and violence, especially those working in the emergency department, than other staff members in the hospital. Owing to these patients' unpredictability, staff members remained on the alert, creating feelings of being unsafe, resentment and fear of being injured. Staff members linked feeling afraid of violence with patients' abuse of

substances and their substance-induced psychotic behaviour. Coupled with their connection between substance-induced psychotic patients' behaviour and violence was staff members' observation of signs of agitation, verbal abusiveness and unpredictable behaviour, which made them more anxious. The fact that these patients often displayed inappropriate sexual behaviour was also different from other patients in the emergency department, and is in contrast with the literature reviewed.

5.3.3 Theme 3: Management of substance-induced psychotic patients disrupts other emergency services

The findings from this study pointed to the fact that other services in the emergency department at the district hospital where the study took place were affected and disrupted because of managing the substance-induced psychotic patients. Services to other patients also in need of emergency care were often compromised, seeing that staff members often had to act swiftly to protect themselves and other patients as well as others in the emergency department. A conclusion can therefore be drawn that aggression and violence by substance-induced psychotic patients towards emergency staff members were not uncommon, and much more frequent than to other staff members in the hospital. Existing literature correlates with these findings. In addition, emergency mental health care was on the increase in the emergency department of the hospital where the study was conducted and literature reviewed corresponds with findings. Physical restraint of these patients was the first preference to secure the safety of the staff members themselves, the patient and others people in the emergency department. Restraint and sedation of the substance-induced psychotic patients were forcibly carried out when there were indications of possible aggression. Current literature corroborated findings of restraint as first choice in conjunction with sedation under duress, in instances of the aggressive psychotic patient.

It was clear from the findings that apart from staff members needing to be on their guard, doing risk assessments all the time was necessary in order to provide protection. It was concluded from the findings that restraint was to be used out of fear of injury, and that staff members often lacked training in management and methods to restrain these patients. Staff members in the emergency unit needed to act calmly and professionally at all times while it was clear from their verbal and non-verbal responses that they experienced

managing substance-induced psychotic patients as stressful. To stay calm themselves was imperative in managing psychotic patients in the emergency department whether they were involved in doing assessments and making decisions or not.

Remaining calm proved challenging if there were staff shortages, for protection and managing of substance-induced psychotic patients, which added to disruption of services in the emergency unit. Existing literature was however in contrast, with findings that the calming use of "self" was important particularly in psychiatric emergency departments, in making correct assessments but not in medical emergency departments. In addition, current literature supported findings related to the importance of merging knowledge about psychiatric intervention with emergency medicine and management. The lack of sufficient staff members applied to non-medical staff members as well. In the event of restraint of a patient becoming necessary, more than one staff member was required to attend to an aggressive and agitated patient. Existing literature agreed with findings of staff shortages and confirmed the findings that more than one staff member were required. The conclusions from the findings were furthermore that resources (staffing and infrastructure) to protect and manage substance-induced psychotic patients in the emergency department were limited and not suitable to deal with these patients' behaviour. The staff members were, moreover, not trained for this type of situation, and lacked the necessary skills and knowledge to execute their responsibilities competently.

Coupled with this situation was the fact that crowding and overcrowding of behaviourally disturbed patients in the emergency department infringed on the care and safety of other patients. Patients with substance-abuse problems and mental health conditions who remained in the emergency department contributed to staff members' challenges. The staff members who took part in the study preferred that substance-induced psychotic patients not be attended to at the emergency department, and rather be elsewhere in a facility to suit the specific needs of these patients, where adequate and trained staff members would be available. Existing literature supported the fact that crowding and overcrowding in the emergency department infringes on the care and safety of patients. Current literature is in agreement that challenges in the emergency department are worsened by substance-abuse problems, mental health conditions, and length of stay.

The staff members agreed that teamwork was crucial in managing the substance-induced psychotic patient, especially when restraint and sedation were needed. Perceptions of lack of teamwork were found between the medical and non-medical staff members. They perceived that there was teamwork among their own category of staff. The staff shortages, the lack of training as well as fear of these patients also affected teamwork. In addition, an overlap of duties with reference to non-medical (support) staff members, was identified. Some non-medical staff members indicated to medical staff members that a specific patient's condition was due to substance abuse, therefore adding valuable input to teamwork, and felt that it assisted in getting patients attended to as quickly as possible.

Literature were congruent that there is often overlapping in teamwork but literature did not compare to findings of positive and negative teamwork in the same category of staff. The researcher did not come across literature discussing non-medical staff members' perception of the importance of their opinion with medical staff members with regard to identifying specific behaviour and symptoms of patients. These findings were not explored among medical staff members in this study, since the assessment and diagnosis depended on the medical staff members' input and roles. The findings in this study also pointed to ambivalence with regard to teamwork in the emergency department seeing that teamwork could not be expected from staff members who were fearful, resentful and untrained.

Staff members were of the opinion that lack of interest by family members of the substance-induced psychotic patients and their lack of support were due to the problem of substance abuse, the extent of the problem in the communities, and the fact that patients were often re-admitted for the same problem. The participants experienced the lack of support from family members as an additional challenge as it had a negative influence on their services. Literature pertaining to the support of family members of the substance-induced psychotic patient in an emergency department was unavailable. The literature did discuss the effects of substance abuse on families and the importance of getting family involved in rehabilitation programmes. Existing literature was similar to the findings of this study's concern about substance abuse and that it affects all facets of an individual's life. The lack of properly completed referral documents of substance-induced psychotic

patients was particularly challenging for the medical staff, and they recommended training for medical practitioners from outside the hospital to complete these forms. Solutions in present literature, with reference to the requirement of training in mental health care settings, resembled the findings of this study. Existing literature indicated flaws with the implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) which equates to findings of the present study. Broadly speaking, untrained staff members were concluded as a universal problem, because they lacked knowledge and skills.

5.3.4 Theme 4: Staff members experience personal challenges in dealing with substance-induced psychotic patients

The emotional challenges of resentment, fear and stress that the staff members experienced in managing the substance-induced psychotic patients resonated throughout the findings, especially because they regarded it as self-harm and it demanded immediate attention in spite of other emergencies. The aggressive behaviour of these patients was resented and all staff members expressed fear of the unpredictability, aggression and agitation of substance-induced psychotic patients. Staff members either witnessed or experienced threats, inappropriate sexual behaviour and assaults (verbally and physically) of substance-induced psychotic patients in contrast with other patients in the emergency department. They also resented having to attend to these patients as stipulated in the regulations contained in the South African mental health care legislation. The fact that admissions of substance-induced psychotic patients were often repeated, was another challenge for the staff members.

It also appeared that staff members did not report incidents of violence to the management of the hospital as they perceived a lack of interest from management. Although an employee assistance programme for staff members at the hospital was available, it did not seem that the staff members made use of this staff-supportive care package. Existing literature with regard to fear becoming less with more exposure to patients requiring mental health care was in contrast to findings of the study, as the participants stressed constant fear. Documentation of violence against staff members and the value of intervention approaches were not explored in this study but were referred to in the

literature. The lack of expected quick response to the violent and aggressive patients and the expectation of immediate response by staff members in the emergency department did not synchronise with existing literature.

Medical staff members were aware that the use of a variety of substances, as well as medical conditions can result in psychosis. They however feared that they might make mistakes in diagnosing these patients, because they also needed to attend to other emergency patients, and they expressed resentment and fear of substance-induced psychotic patients. Existing literature recommended that medical staff members should have knowledge in diagnosing these patients irrespective of the resentment that they voiced. Coupled with this was the continuous stress caused by substance-induced psychotic patients and the lack of training that staff had to handle their fear, as well as the retaliation it evokes, and the controlling of these feelings. Some of the staff members were also of the opinion that medical staff members did not always prioritise these patients, which heightened non-medical staff members' stress levels. Existing literature agreed with findings of insufficient resources, inappropriate facilities and the challenges with lack of support by relatives of the substance-induced psychotic patients. The matter of teamwork in current literature only related to professionals, such as medical staff members, and was in contrast to findings of ambivalence of teamwork between the medical and non-medical staff members.

The stress that staff members experienced was mainly due to their being at risk of violence and aggression, as well as pressures and working demands in an emergency department, such as crowding in the area, fear of mismanagement or unprofessional conduct and the lack of training. Staff members indicated that they were exhausted and suffered from physical and emotional burnout which resulted in another challenge. It became obvious from the relevant literature that violence and aggression towards emergency staff members are not uncommon and that these patients are more behaviourally disturbed and agitated than other patients with a primary psychotic disorder. It was also concluded that emergency staff members often stigmatise patients with substance-induced psychosis, resent them, and are often fearful of them. The stress and burnout experienced by the emergency department staff members were no different from

what the literature refers to. A link was found in existing literature between emotional and mental features among the staff members due to the incidence of violence and aggression. In addition, staff members expressed feelings of worthlessness, incompetence, indifference, and being pessimistic about work, de-motivation and the future. What existing literature described as stress occurring due to the inability to cope and manage this type of patient, supported these findings.

A few staff members, however, indicated that they did have the tolerance to work with substance-induced psychotic patients. Others indicated that their experience and training assisted them with being able to manage the substance-induced psychotic patients. Among these emotional challenges there was thus regard for treatment of these patients and the execution of duties in the boundaries of recognised and prescribed rights. The researcher did not come across literature discussing the challenge of tolerance, though tolerance in some of the literature could be concluded as what is expected in systems such as those set out in the Constitution of the Republic of South Africa (Act No. 108 of 1996), the Mental Health Care Act of South Africa (Act No. 17 of 2002) and the Patients' Rights Charter of South Africa (2007).

5.3.5 Theme 5: Staff members acknowledge dignity for all patients

Staff members recognised patients' right to be treated with dignity, placing emphasis on the prescribed rights of the patient in their treatment or contact with the substance-induced psychotic patients. They have no choice in attending to mental healthcare users at the emergency department, who include the substance-induced psychotic patients, since treatment is compulsory in mental health legislation. Untrained staff members would prefer not to deal with these patients as they are the cause of their fear, resentment and stress. Staff members would prefer that these patients be attended to elsewhere, in a more appropriate facility. They were of the opinion that the prescribed rights of staff members, other patients and persons accessing the emergency department were disregarded.

Current literature had similar findings with regard to human rights and dignity of the patients. There were gaps in the staff requirements in terms of training, organisational and

managerial needs. The need for changes in legislation in the interest of human rights in order to improve medical as well as mental health care was emphasised.

5.3.6 Theme 6: Staff members made special recommendations to the hospital management for assistance with managing substance-induced psychotic patients

The possible solutions recommended by staff members to the hospital management in managing the substance-induced psychotic patients ranged from having separate facilities for referral of these patients, to separating them from the other patients in the emergency department, as well as having another holding area in the hospital with a separate entrance. Improved resources and facilities were also recommended. Consideration should be given to the recommendation that more staffing was needed, and the training of staff members would help with managing aggressive and substance-induced psychotic patients.

It was concluded that there is a need for safe and secure consulting rooms and that staff members are in need of training in dealing with the behaviourally disturbed in general as well as substance-induced psychotics. Adequate training would be beneficial to the staff members who fear these patients and to the patients, as well as to the onlookers when these patients are managed. Staff members felt that hospital management was not interested or not aware of their challenges and felt that there should be actions to show interest, understanding and support.

Existing literature agreed that district hospitals were not ready for implementation of the Mental Health Care Act of South Africa (Act No. 17 of 2002) and solutions in existing literature support the findings of this study. One staff member recommended that emergency communication systems be acquired. Though this would be beneficial, the thought of it scaring other patients rejected it and in existing literature it was explained that it might have adverse effects on others. Existing literature agreed with findings and conclusions of the need for training, management involvement, acknowledgement, support and interest which would bring improvements for staff members.

5.4 THE ASSUMPTIONS THAT THE RESEARCHER HELD

It was taken as inevitable that the substance-induced psychotic patient has a right to emergency healthcare. This right in a general emergency care department is unavoidable since it is prescribed by legislation although infringing on the rights of other emergency care patients, staff members and others. A second assumption was that care for the emergency staff members who provided services to these patients was lacking in skills, development and training to manage the behaviourally disturbed and aggressive substance-induced psychotic patients.

5.5 THE RELEVANCE OF THE ATTRIBUTION THEORY AS CONCEPTUAL FRAMEWORK TO THIS STUDY

The attribution theory was found to be of relevance to this study. Existing literature which described stigma as an attribution supports findings of stigma of substance-induced psychosis as self-harm and the patients being blamed for being responsible for their condition. These patients were resented and were met with irritation, and staff members preferred assisting other patients who required medical care. Some staff members regarded the psychosis as part of the problem of substance abuse in the community and not necessarily the patient's fault. The relevance of internal and external attributions was applicable to family members as well, and described by participants as causal to their denial and/or lack of support of the substance-abusing family member with psychosis. Existing literature about the relevance of these attributions was similar to the findings of the study.

Considering and understanding the attribution theory as conceptual framework for this study allowed a glimpse into the staff members' thoughts and an understanding of what they experienced from managing these patients. What existing literature on this theory described, was congruent with what the researcher experienced in the findings of this study. The researcher did not actually see the fear, resentment and stress experienced by emergency staff members in working with the substance-induced psychotic patients. This was evident in findings and in contact with the participants in the interviews and created a change in the researcher's awareness.

5.6 RECOMMENDATIONS

Recommendations are made pertaining to the qualitative research process and research findings as well as future research.

5.6.1 Recommendations pertaining to the research process

- This study was done only at one hospital and should be duplicated in other district hospital emergency departments, as well as other psychiatric emergency departments.

- Medical staff members and non-medical staff members in emergency departments should be included in other studies in order to broaden the scope of findings. This will yield evidence-based findings on the perspectives of all categories of emergency staff members. It could serve to build on the findings of this study as well as to corroborate and contrast findings.

5.6.2 Recommendations pertaining to the research findings

5.6.2.1 Hospital management

- The hospital management of the district hospital should review the staffing, infrastructure and location of the existing emergency department in order to improve best practice and intervention, so as not to infringe on the prescribed rights of the patient, staff members, other patients who require emergency treatment, and the public.

- The hospital management should work on improving staff members' perceptions by visibility and a show of understanding by actively engaging with emergency staff members through routine and scheduled emergency department visits.

- Hospital management should explore, motivate and initiate alternative on-site briefing and debriefing measures for emergency staff members.

- The hospital management should encourage regular team meetings across professions with regard to the management of behaviourally disturbed and/or psychotic patients that would benefit not only the staff members but patients as well, so as to bridge the gap in teamwork perceptions and to clarify roles.

5.6.2.2 Training

- Universities should include in the training of doctors the management of acutely psychotic patients, as well as care and restraint procedures and methods.

- Nursing colleges and universities should include managing behaviourally disturbed/substance-induced psychotic patients in the training of nurses, as well as training in care and restraint procedures and methods.

- Agency-sourced companies with regard to some of the support staff categories such as security personnel should receive training in care and restraint procedures and methods in assisting with aggressive and agitated patients.

- The expertise of existing staff members who have training in the procedures and methods of care and restraint, should be enlisted as interim measures to skill staff members such as doctors, nurses, porters and security personnel who are presently managing and assisting in restraining patients.

5.6.2.3 Government and non-government departments/resources

- Ways need to be considered collaboratively and in partnership with government departments (social, health, justice, education), community-based organisations, the community, public users of health (inclusive of the substance abusers, stabilised or discharged substance-induced psychotic patients), family or significant others, to realistically revisit and strategically re-address the problem of substance abuse and health-related problems resulting from the abuse of substances. The emergency department manager and social worker could take the initiative to discuss, do a needs assessment, and then co-ordinate an initial meeting

with other managers or supervisors at the hospital where the study was done or at other hospitals, to engage in discussion.

- The Department of Health should advocate in-service training and educational programmes for emergency staff members and support staff members, which should be continuous, to keep abreast of new training developments and trends.

5.6.2.4 The role of the social worker

The social worker as part of the multi-disciplinary team needs to be examined with reference to evidence-based service being rendered to stabilised substance-induced psychotic patients and their families.

- Innovative ways should be embarked upon to address substance-abuse health-related problems, such as group work once patients are stabilised in the hospital setting prior to discharge.

- Further collaboration and partnership with government, non-government organisations and community for follow-up services to the discharged substance-induced psychotic patients, should be looked at.

- The possibility of community programmes and projects such as protective workshops for stabilised substance-induced psychotic patients should be assessed and advocated by all who forge partnership and collaboration as mentioned above in section 5.6.2.3.

- Social work intervention to the family or significant others of the substance-induced psychotic patients, such as initiating support groups at the hospital, should be embarked upon and encouraged with a view to hand over to them for continuation, by forming groups or linking with existing groups in their area of domicile.

5.6.2.5 The Mental Health Care Act of South Africa (Act No. 17 of 2002)

- Legislators should take cognisance of research studies carried out, and request the undertaking of additional research pertaining to managing substance-induced psychotic patients in emergency departments of district hospitals with reference to Chapter II, 6 (1) (a) of the Act which stipulates that "Health establishments must (a) provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice."

- The abovementioned recommendation links to the fact that the 72 hours of assessment of involuntary mental health care users include psychosis due to the use of illicit substances, with the emergency department as first area of assessment. Chapter V, 34 (1) (b) of the Act specifies: "admit the user and request a medical practitioner and another mental health services care practitioner to assess the physical and mental health status of the user for a period of 72 hours in the manner prescribed." Further research will yield more insight for planning in harmony with need and facility requirements, in respect of core standards and legislation with regard to human rights and patient rights, for consideration of amendments as well as for future legislative decisions.

- Assistance from what is termed "the ACT team" (Assertive Community Treatment Team) should feature more prominently. There should be clarification and reviewing of their role, in consultation and partnership with hospital management as well as staff members at the facilities who are required to carry out legislation, with discharged patients as well as support systems in their home and community, and other community-based organisations. This will assist the ACT team in monitoring and decreasing the re-admission of the discharged substance-induced psychotic patient.

5.6.3 Recommendations for future research

A host of other qualitative research pertaining to managing substance-induced psychotic patients in the emergency department of a district hospital could be embarked upon.

- **The family of substance-induced psychotic patients who are managed in an emergency department of a district hospital** could give insights from their perspective with regard to their lack of supportiveness, getting their support and looking at building a network of support for those affected.

- **The experiences of stable substance-induced psychotic patients of being managed in an emergency department of a district hospital** would be insightful.

- **The experiences of other emergency department patients and visitors, of managing substance-induced psychotic patients** would be interesting to explore and describe.

- **The perspectives of hospital management at district hospitals of emergency department staff members' perception of managements' lack of support and oblivion of challenges** will be beneficial in providing an avenue of understanding and to assist in changing these perceptions.

- **The role of social workers in relation to stable substance-induced psychotic patients and their families** will bring efficacy to understanding experiences, challenges and for identifying gaps as well as need in services.

5.7 CONCLUSION

In conclusion, in the words of Creswell (2009:175) there are several important features of qualitative research. One is that throughout the research process, the researcher's focal point should not be on the meaning that the researcher or authors articulate. Rather, it is imperative that the researcher maintains their attention on gaining insight and understanding into the meaning that the participants assign to problems or matters (Creswell, 2009).

This is what the researcher set out to do, and based on the findings interpreted from the participants' perspective, this was achieved. The researcher's opinion is that this study holds meaning not only for staff members in the emergency department but for: other emergency departments in the bigger picture of the Department of Health; other government and non-government departments and resources; the community; the public user of the emergency department inclusive of the substance-induced psychotic patients; and for legislators.

The aim and objectives of the study were achieved and the research question was answered through the qualitative research approach. It was the best research approach to gain an understanding of the challenges that staff members experience in managing or assisting in managing substance-induced psychotic patients. As a social worker, the researcher was enriched by this journey with the participants, by what they shared. The experience and insight gained are invaluable. It is hoped that this qualitative research enriches the reader as well. Apart from the understanding gained, recommendations could be proposed to aid all who plan, give and gain access to substance-induced psychosis emergency department care at district hospital level.

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PERSONAL COMMUNICATION

Psychiatric medical registrar. 2011. District hospital. "Interview on 30 June 2011 about substance-induced psychotic patient admissions."

Clinical manager. 2012. District hospital."Interview on 5 July 2012 on management of patients in terms of the Mental Health Care Act (Act No. 17 of 2002)."

Professional nurse. 2013. District hospital. "Interview on 11 March 2013 about substance-induced psychotic patient admissions."

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APPENDIX A

INFORMATION SHEET

Project Title: The challenges experienced by staff in managing substance-induced psychotic patients in the emergency department of a district hospital in the Western Cape

This is a research project being conducted by Mrs V Williams, a registered student at the University of the Western Cape. We are inviting you to participate in this research project because you are working in the emergency department of the GF Jooste Hospital where you are managing and/or assisting substance-induced psychotic patients. The purpose of this research project is to explore and describe the challenges to staff members managing substance-induced psychotic patients in the emergency department.

You will be asked to agree to be interviewed by the researcher at the workplace. You will be asked the following questions:

1. What is your understanding of the substance-induced psychosis?

2. Tell me about your challenges in managing the substance-induced psychotic patients.

3. What it is like for you to deal with the substance-induced psychotic patients?

4. How are substance-induced psychotic patients different from other patients you attend to?

5. How can the hospital assist you with the challenges around managing substance-induced psychotic patients?

We will do our best to keep your personal information confidential. To help protect your confidentiality, only the researcher and the supervisor will have access to the data. Pseudo names will be used to protect the participants' identifying details. The audiotapes as well as the interview transcripts will be locked in a filing cabinet and will be destroyed after the final research report is completed. You will be requested to give permission to audiotape the interview and to sign an informed consent. You are however free to withdraw from the interview at any time
If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

There are no known risks associated with participating in this research project.

This research is not designed to help you personally, but the results may help the investigator learn more about the challenges that you face in dealing with substance-induced psychotic patients in a hospital. We hope that, in the future, other people might benefit from this study through improved understanding of dealing with patients of this nature.

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. You have the right to withdraw at any stage should you feel uncomfortable.

This research is being conducted by Ms Vanassa Williams a post graduate student at the University of the Western Cape. If you have any questions about the research study itself, please contact Ms Vanassa Williams at: 21 Calcium *Road,* Vanguard Estate, Athlone. Her telephone nr is: 021 6374179 and cell 0835004846. Email Address: vwilliam@pgwc.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Prof C Schenck, Department of Social Work, Tel 021 9592011, email cschenck@uwc.ac.za.

Dean of the Faculty of Community and Health Sciences: Prof H Klopper
University of the Western Cape
Private Bag X17
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Email: hklopper@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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APPENDIX B

CONSENT FORM

Title of Research Project:

The challenges experienced by staff in managing substance-induced psychotic patients in the emergency department of a district hospital in the Western Cape.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name……..

Participant's signature……..

Witness……..

Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Dr M de Jager

University of the Western Cape

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REFERENCE: RP 78/2012
ENQUIRIES: Enrico Goodman

For attention: Dr. Mariana De Jager, Ms. Vanessa Williams

Re: The challenges experienced by staff in managing substance – induced psychotic patients in the emergency department of a district hospital in the Western Cape .

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries.

[redacted]

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

c Jacobs

Ms. Charlene Jacobs
Acting Director: Health Impact Assessment

Date: 28/06/2012

cc **Ms. Patti Oickers** **Acting Director: Klipfontein & Mitchell's Plain**

Page 1 of 1