International Labour Office **ILO**   International Council of Nurses **ICN**
World Health Organisation **WHO**   Public Services International **PSI**

Joint Programme on
Workplace Violence in the Health Sector

WORKPLACE VIOLENCE IN THE HEALTH SECTOR
A Case Study in Thailand

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Preface

This research report has been published to illustrate the situation of workplace violence in the health sector in Thailand as well as contributing factors to, the consequences, and management of that violence. The study was conducted as part of the joint project, "Workplace Violence in the Health Sector: Country Case Studies" conducted and sponsored by four international organizations: the International Labour Office, the International Council of Nurses, the World Health Organization, and the Public Services International. The researchers would like to acknowledge and thank these organizations for choosing Thailand to be part of this project. Likewise, we are especially grateful to Dr. Mireille Kingma and Dr. David Gold for mentoring the study and editing the research report.

This study would not have been possible without cooperation from various health and health-related organizations in Chiangmai. The researchers sincerely thank them for their contributions. We are very grateful for all the suggestions and cooperation from Dr. Wuthigrai Mungmai, the Provincial Chief Medical Officer of the Chiangmai Provincial Health Officec, and Associate Professor Dr. Piya Natrwichian, the Dean of the Faculty of Medicine, Chiangmai University. Our deepest appreciation also goes to Associate Professor Dr. Wipada Kunavikitikul, the Dean, and Associate Professor Dr. Wichit Srisuphan, the senior faculty member, Faculty of Nursing, Chiangmai University, for their support and suggestions.

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Abstract

This survey study was conducted in Chiangmai, Thailand, aiming to explore the situation, contributing factors, consequences, and management of workplace violence in the health sector. Quantitative and qualitative data were collected through questionnaires as well as individual and focus group interviews. Descriptive statistic, Chi-square, and content analysis techniques were employed for analyzing data. Health and health-related organizations and the subjects were recruited through cluster random sampling and accidental random sampling techniques, respectively.

The sample consisted of 1,090 personnel from various professional groups. It was found that 54.1 % of the sample experienced workplace violence at least once in the previous years. The occurrences of verbal abuse, bullying/mobbing, physical violence, sexual harassment, and racial harassment were reported by 47.7 %, 10.8 %, 10.5 %, 1.9 %, and 0.7 % of the sample. The verbal abuse cases were mostly inflicted by staff members but by patients/clients for the bullying/mobbing, physical violence, and racial harassment cases. Patients/clients and staff members were mostly the perpetrators of sexual harassment. Males, younger and fewer working experience personnel, as well as personnel working in shifts, between 6 p.m. and 7 a.m., having interaction and physical contact with patients/clients, and working in suburban areas were more likely to experience violence. Poor workplace surroundings and reduction in staff members were also the contributing factors.

Based on qualitative data, physicians and nurses/midwives tended to be physically assaulted by patients suffering from psychiatric illness, neurological disorders, drug/alcohol abuse, and severe labor pain. Psychological backgrounds of perpetrators were individual factors whereas job stress and insecurity as well as the tradition of seniority and hierarchy in workplace were organizational factors. The national economic crisis, as well as changes and reforms of health, civil service, and political system were the indirect factors.

It was found that workplace violence had negative impact on individuals. It also reflected poor management of the organizations. Workplace violence is legally controlled by criminal laws, labor laws, and the Civil Service Act. However, policies and procedures for violence prevention and control in health organizations have not been well established. Raising awareness among health personnel is recommended. Workplace violence prevention programs, including training in stress and anger management skills, conflict-resolution skills, and skills for dealing with violent persons and situations, should be delivered. Procedures for reporting, investigation, and management should be established. Health services for both victims and perpetrators should be provided.

Workplace Violence in the Health Sector:
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A. Background

In general, Thai people view violence as consisting of physical, verbal, and sexual acts that cause physical and/or mental injury. As in other cultures, workplace violence is expressed in physical assault with or without weapons, homicide, verbal abuse, bullying/mobbing, and sexual harassment. Verbal abuse is expressed through words or verbal behaviors that humiliate, degrade, or display disrespect to individuals or groups. Bullying/mobbing is mostly perceived as verbal or non-verbal behavior of individuals or groups that annoys, disturbs, threatens, or sabotages individuals or groups. This kind of offensive behavior may be expressed once or repeatedly[1]. It includes causing uproar, destroying others' property, and protesting with violent acts. Rape, especially where the justice system is concerned[2], is likely to be considered as sexual violence rather than physical violence. Racial harassment is uncommon and found in relatively mild forms since the main minority groups are assimilated and it is difficult to isolate them as distinct groups. Hilltribe people and people migrating from neighboring countries are somewhat more distinct from other ethnic groups and individuals from them are more likely to be racially harassed than those of other groups. Rather than racism, classism -discrimination due to different social classes- obviously exists in Thai society. In the past, Thai people born into a certain class had more prestige and power than did commoners and slaves (1). These people used their power to control and intimidate those of lower status. At present, Thailand is a status-oriented society in which people are classified by birth, position, wealth, education, and age (2). Harassment due to differences in socio-economic classes is prevalent among Thai people in general while racial harassment still happens to the indigenous people. Dr. Suwat Mahattanirunkul, the director of a psychiatric hospital, recommends including harassment due to different social classes in the issue of workplace violence as a particular type of workplace violence[3].

In the past, some forms of violence, such as wife battery and the physical punishment of children, were acceptable if the perpetrators and the victims were related but unacceptable if they were strangers. Rape is a crime only if the victim is not the wife of the perpetrator (3). Marital rape is not an illegal act. Currently, Thai people are aware of violence and accept it as a national social problem. For instance, in 1997, Charoenwongsak, the executive director of the Institute of Future Studies for Development in Thailand, stated that there was an increase in all forms of violence and Thailand was changing from the Land of Smiles to the Land of Violence (1). The author referred to statistics compiled by the Research and Planning Division of the Police Department which indicated that the reported cases of physical assault and rape increased by 38.7 % and 27.0 % respectively, in 10 years. In the round table discussion co-organized by the Friends of Women Foundation, the Matichon newspaper, and the Bangkok Post newspaper on the occasion of the International Day of Action for Women's Health in 1997, domestic violence was declared to be one of the most significant health problems of Thai women

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[1] Focus group interview with the head nurses of a psychiatric hospital on October 31, 2001.

[2] In-depth interview with a judge, on October 24, 2001.

[3] In-depth interview on October 11, 2001.

(4). It can be seen that most attention is paid to family violence, as well as sexual violence against children and women, such as rape and child prostitution.

The issues related to violence in the workplace are common subjects of daily conversation. Cases of physical assault and homicide due to working conflicts, especially where monetary benefits are concerned, are commonly reported in newspapers. However, these problems are not categorized as workplace violence. Instead, they are perceived as conflicts and exploitation between employers and employees as well as among workers, which are personal problems. The issue of sexual harassment is being addressed by women's organizations but the public still view it as a private matter and taboo. Other types of violence, including physical and verbal violence in the workplace, receive little attention. For instance, in the chapter "Health and Safety of Women at Work," the main contents are related to women's health problems caused by unsafe physical environments (5). There is neither an empirical nor a theoretical literature regarding workplace violence. Most of the existing studies and literature focus on related issues such as job stress and conflict. Workplace violence has not been conceptualized yet. The prevalence and incidence have not been reported.

ILO/ICN/WHO/PSI[1] define workplace violence in the health sectors as incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health[2]. In the context of Thailand, the definition is broader than this[3]. A great number of health care providers, especially the ones who work in rural areas, live in health setting locuses. These personnel view the violent incidents that happen at their homes which are inflicted by health personnel or non-personnel, as workplace violence as well. These personnel sometimes participate in social activities held by their organizations or their communities during non-working hours and some of them are verbally or sexually harassed by their colleagues. In this case, they also perceive the incidents as workplace violence. Violence happening inside the workplace but irrelevant to working, such as physical assaults among couples due to family matters, is also considered workplace violence because it threatens other personnel's safety and well-being. It is also recognized that perpetrators can be health care providers and others, and this issue should be included in the definition. Another perception is that violent incidents are unlikely to happen during commuting and even if they do, they tend not to be work-related. To sum up, workplace violence in the health sectors in the context of Thailand may be defined as "incidents where staff are abused, threatened, or assaulted by health personnel or non-personnel inside the health settings and/or in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being, or health."

Thailand is a hierarchical society in which privilege and power are given to males, seniors, and the rich. Power-worship has always existed in Thai society (1). The use and misuse of power among privileged persons is frequently legitimated and socially justified. Hierarchical levels are certainly found among health care providers within and outside their professions. It is impossible for the personnel in this situation to be free from

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[1] The International Labour Office, the International Council of Nurses, the World Health Organization, and the Public Services International
[2] Adapted from European Commission DG-V
[3] Information from the interviews of this study

workplace violence inflicted by their colleagues. Currently, Ministry of Public Health policy is to improve the quality of health care services and management by encouraging hospitals to be formally evaluated or accredited. Consequently, many hospitals are reorganizing their workplaces. A great number of health personnel are facing substantial changes in working conditions and increasing workloads. As a result, many are experiencing more stress and conflict which in turn may lead them to more violence in the workplace. Violence can negatively affect the health and well being of individuals. It not only has consequences on the quality of health care but will also lead to more aggressive psychological and physical violence as well as other psychosocial problems. Policy and practice for the prevention and management of violence in the health sector is essential. However, empirical evidence regarding incidence, contributing factors, and impact, as well as individual and institutional responses and management to workplace violence in Thailand, is unavailable. This study was conducted as a part of the project, "Workplace Violence in the Health Sector: Country Case Studies" initiated by ILO/ICN/WHO/PSI. The aim of this study was to understand all aspects of workplace violence in the health sector in Thailand. Lessons learned and successful initiatives will then be introduced to the international and national policy-makers and the authorities in the health and health-related sectors for the improvement of personnel's health, both in Thailand and worldwide.

B. Methodology

In this part, the content includes the following topics: research design, population and sample, research tools, data collection, protection of human subjects, limitations of the study, data analysis, and the results.

Research Design

A survey study was conducted aiming to illustrate the incidence of all forms of workplace violence in the health sector in Thailand, as well as contributing factors, impacts, and responses at individual and institutional levels. Quantitative data were collected through questionnaires. Individual interviews and focus group interviews were conducted to obtain qualitative data.

Population and Sample

The research setting in this study is Chiangmai province, northern Thailand. In Chiangmai, there is a wide variety of health care services, including all the types of services and levels of health care available in Thailand (please see details in Appendix C). The health care services available in Chiangmai are those to be found in the national health care system of Thailand as a whole.

In the qualitative part aiming to verify the definition of workplace violence and other aspects, eight target groups were included. They were as follows:
(1) Representative organizations
(2) Private owners of health services
(3) Health sector personnel
(4) Health authorities
(5) Management
(6) Patients/clients

(7) Occupational health and safety specialists
(8) Lawyers

Data from the target group of health sector personnel were mostly obtained through 15 focus group interviews consisting of 90 personnel recruited according to availability. The number of participants in each group varied from 3 to 9. Almost all of the groups consisted of same-sex personnel from the same professions and levels. Only one group of ambulance staff members was comprised of both senior and junior individuals. The time spent in each group interview varied from 60 to 180 minutes. Focus group interviews were stopped when the obtained data became redundant. For the rest of the target groups, data were obtained through formal individual interviews and occasionally informal interviews from 25 persons. A few interviews were conducted via telephone.

In the quantitative part, all major health and health-related settings available in Chiangmai were included in order to represent the national health system. It covers the settings in all geographic levels, in rural, suburban, and urban areas, at three levels of health care[1], as well as from both government and non-government sectors. Types and numbers of health and health-related settings included in the study are summarized in Table 1 in Appendix A.

In this study, the personnel in a health sector included all professional groups as follows:
(1) All fields of medical specialists and general physicians
(2) Registered nurses/midwives, technical nurses, practical nurses, nurse aids, and health workers.
(3) Pharmacists and pharmacist assistants
(4) Dentists and dentist assistants
(5) Professions allied to medicine: nutritionists, physical therapists, social workers, research assistants, etc.
(6) Medical technologists: medical laboratory staff
(7) Managers: heads and supervisors of nursing departments
(8) Ambulance personnel
(9) Administration/clerks
(10) Support services responsible for: security, catering, kitchen, maintenance, hospital sanitation, hospital supplies, and reception.

The subjects were recruited from all health care levels and all professions by cluster random sampling techniques. Health posts/centers, community hospitals, and private hospitals were randomly selected. The specific number of subjects recruited from each health setting was estimated from the number of patient beds available in the setting. Thirty percent were recruited from hospitals equipped with more than 30 beds but less than 100 beds and 15 % from those with more than 100 beds. For small hospitals equipped with less than 30 beds, the number of subjects varied from 5 to 10. All personnel were

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[1] Three levels of health care are as follows: (1) primary care focuses on health promotion, disease prevention, and common curative care, which are provided at community health posts and health centers, (2) secondary care focuses on curative care provided at community, general, and private hospitals, and (3) tertiary care is provided by general, regional, university, and large private hospitals and focuses on curative care for complicated health problems needing medical specialists.

included for the health posts/centers. If there were no patient beds, the number recruited was approximately 10-15 % of the number of total personnel. The number of subjects taken from each professional group depended upon the number composing each group in that setting. The sample size was initially estimated at 1,450 but the actual number was 1,090.

Research Tools

Questions for focus group discussions and in-depth interviews, as well as questionnaire provided by ILO/ICN/WHO/PSI were translated into the Thai language by the researchers. One native-English speaker, one Thai physician, and one Thai judge were consulted to validate some terms. After that, one expert in the English language edited the questionnaire. Ten professional and practical nurses were invited to review the questionnaires. Some unclear terms were revised according to their suggestions.

Data Collection

Data were collected between October and December 2001. Qualitative data were collected through focus group and in-depth interviews, with audiotape recording if permission was granted. Field-notes were taken as well. Since workplace violence is a sensitive issue, the privacy, confidentiality, and safety of the subjects were protected throughout the processes of qualitative data collection. Most of the locations for focus group interviews were the meeting rooms on the Chiangmai University campus, the workplace of the researchers. Most of the individual interviews were conducted at the participants' workplaces.

For the quantitative data, the researchers and/or the research assistants contacted the relevant authorities for permission to collect data. The purpose of the research project as well as the techniques and procedures for questionnaire survey were explained. After that the researchers and/or research assistants distributed the questionnaires through accidental random sampling techniques. That is, the personnel who were available and accessible during that period were invited to participate in the study. In some health settings, the authorities preferred to administer the questionnaires themselves. To reduce biases, the accidental sampling techniques were explained in detail and justified. In the setting where the personnel were difficult to access, a person working there was invited to assist in distributing and collecting questionnaires. The procedures were explained to that person. For small workplaces in remote areas, the questionnaires were distributed and returned by mail. There was only one rural community hospital that refused to give permission for interviews but allowed data collection through questionnaires. One private hospital was excluded because cooperation was denied. One thousand, four hundred, and fifty questionnaires were distributed. One thousand, one hundred, and eighteen questionnaires were returned, a return-rate of 77.1%. Twenty-eight questionnaires were discarded since more than a half the questions were not completed. The total number of the qualified questionnaires was 1,090.

Protection of Human Subjects

Prior to data collection, the researchers asked for written permission from each workplace. All subjects participating in focus group interviews were requested to give oral consent after the explanation of the research project's objectives, procedures,

confidentiality, as well as the benefits and possible risks. The subjects could withdraw from the study any time or refuse to answer any questions. Their information was kept confidential and discussed only among the researchers, research assistants, and research consultants. If it was found that subjects were likely to do life-threatening harm to themselves or to anyone else through workplace violence, they would be referred to psychologists or psychiatrists. Each subject participating in focus group interviews was provided with a meal and three notebooks for his/her time and contributions. Reimbursment for transportation fees was also provided, ranging from 20 to 100 *baht*. All subjects participating in the questionnaire survey were recruited to the study via letters, whose contents were attached to the questionnaire. Some of them were also face-to-face contacted by the assistants who distributed and collected questionnaires.

Limitations of the Study

In some health care settings, the numbers of subjects for each professional group were estimated roughly since the exact numbers of each professional group were unavailable. In some health settings, few professionals such as physicians and dentists, were recruitment. In these groups, the return-rate was also low.

Feedback indicated that many subjects felt that the questionnaires were somewhat long. It was observable in the returned questionnaires that some questions in the final parts were not answered.

Data Analysis

Quantitative data were analyzed by the SPSS 9.0 software program. Descriptive statistics was employed to illustrate the demographic characteristics of the sample. The differences of the incidences of violence across various factors were analyzed through. Chi-square. Qualitative data were analyzed by content analysis.

C. Results

The results of this study based on quantitative and qualitative data analysis are presented simultaneously as follows:
1. Demographic characteristics of the sample
2. Magnitude, characteristics, scope of violence
3. Influencing factors in the context of workplace violence
4. Effects and impact of violence at work in the health sector
5. Individual, institutional, and systematic responses towards violence
6. Anti-violence strategies

1. Demographic Characteristics of the Sample

Demographic characteristics of the sample are described in Table 2 in Appendix A. More details are available in Total Table 1, Appendix E. The sample size was 1,090. The majority of the sample were female (72.7 %), ethnic Thai (99.9 %), aged 25-29 (22.7 %),

who worked in the government sector (70.9 %) as nurses/midwives[1] (45.5 %) with the position of staff members (77.9 %), and had 1-5 years' working experience (27.7 %). Most of the sample were married (50.7 %) and 43.5 % were single.

There were non-significant differences in the age and years of working experience between males and females. The majority of male subjects were aged 30-34 (21.8 %) and had 6-10 years of working experience (28.4 %). In the professional groups, there were significant differences between males and females. That is, the majority of males worked as staff members of support units (30.9 %), 13.9 % were physicians, and ambulance staff accounted for 12.4 %. Other characteristics were similar.

2. Magnitude, Characteristics, and Scope of Violence

In this part, the frequency of overall violence and particular types, including physical violence, verbal abuse, bullying/mobbing, sexual harassment, and racial harassment, is described. After that the characteristics of perpetrators and victims are presented.

2.1 Frequency and Types of Violence

The details regarding frequency and types of violence are summarized in Table 2 in Appendix A and in Figure 1 in Appendix B. More than a half the sample (54.1 %, N = 1,090) had reported that they were victimized at least once in the previous year. Verbal abuse, the expression through words or verbal behaviors that humiliates, degrades, or displays disrespect to individuals or groups, was found to be the most common type of workplace violence. Qualitative data supported this finding. Five hundred and twenty subjects were verbally abused (47.7 %). Most of the incidents were reported by the victims to have happened "sometimes" (87.1 %). "Once" and "all the time" were reported by 8.3 % and 4.6 %.

Bullying/mobbing, the single or repeated verbal or non-verbal behavior of individuals or groups that annoys, disturbs, threatens, or sabotages individuals or groups, and physical violence were found to be the next most prevalent form of violence. The incidences were 10.8 % and 10.5 % respectively. As with verbal abuse, most of the subjects reported that the bullying/mobbing incidents happened "sometimes" (82.2 %). Most of the physical violence victims were assaulted without a weapon (90.3 %).

The incidence of sexual harassment was low, at 1.9 % (n = 21). The majority of respondents in this category were victimized "sometimes" (76.2 %). Racial harassment was the least common type of workplace violence. It was reported by 8 subjects (0.7 %), and 62.5 % of them were victimized "sometimes."

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[1] In the Thai health care system, 4-year trained professional nurses and 2-year trained technical nurses are trained in the field of midwifery and they are eligible to work as midwives. Nursing and midwifery are not distinct professional groups. In this study, the majority of nurses/midwives were professional. Practical nurses receive one-year's training.

2.2 Perpetrator Profiles

Perpetrators' characteristics are summarized in Figure 2 and 3, and in Tables 3 and 4. More details are available in Total Table 18-22 in Appendix E. Among 584 cases of overall violence, 209 victims (35.8 %) were victimized by staff members. Approximately 30 % of the victims were victimized by patients/clients. Relatives of patients/clients and external colleagues were equally reported by 14.6 % of the victims. Approximately 91 % of the incidents took place inside workplace.

Where verbal abuse was concerned, the majority were the victims of staff members (36.5%). External colleagues, patients/clients, and relatives were reported to be the perpetrators by 15.9 %, 15.0 %, and 12.0 % of the victims. Approximately 92 % of the verbal abuse incidents took place inside the workplace. On the other hand, the majority of the perpetrators of physical violence were patients/clients (72 %). Approximately 91 % of the incidents took place inside the workplace. Most of the incidents happened between 18h00-24h00 (33.9 %) and 21.4 % happened between 7h00 and 13h00. Most of the victims did not remember which day of the week the event occurred. As with physical violence, the majority of the perpetrators of bullying/mobbing were patients/clients (33.3 %). Most of the incidents also took place inside the workplace (94.9 %). Patients/clients and staff members accounted for 47.6 % and 38.1 % of the perpetrators of sexual harassment. Almost 86 % of the incidents happened inside the workplace. Racial harassment incidents were mostly inflicted by patients/clients and took place inside the workplace.

2.3 Characteristics of Victims

Among approximately 590 victims of overall violence happening in the previous year, the majority self-reported that they were female (69.3 %), married (50.8 %), ethnic Thai (99.8 %), and 25-29 years old (22.8 %). The majority worked as nurses/midwives (45.5 %), in government sector (69.2 %), with the position of staff members (77.9 %), and had 1-5 years' working experience (27.7 %). Their work characteristics were reported as follows: full-time (91.6 %), in-shift (64.9 %), nightshift (53.3 %), interaction with patients/clients (92.0 %), and physical contact with patients/clients (63.6 %). The majority of the victims of each type of violence had similar characteristics to those of overall violence. Please see details in Total Tables 4, 6, 7, and 8.

3. Influencing Factors in the Context of Workplace Violence

Factors influencing workplace violence in the health sector can be categorized as contributing factors, organizational culture, and system reforms. The details based on both qualitative data and quantitative data are described here.

3.1 Contributing Factors

The factors contributing to the workplace violence reported in this study included individual factors of victims and perpetrators, working factors, and physical environment.

3.1.1 Individual Factors of the Victims

Victims are not responsible for the causes of violence. However, their personal characteristics can be predisposing factors.

1) <u>Sex</u> There were statistically significant differences in the experience of violence between males and female (χ^2 = 7.28, C = .08, p < .01). Please see details in Table 4 in Appendix A. There was a more tendency for males to experience physical violence, (χ^2 = 11.56, C = .11, p < .01), especially with weapons (χ^2 = 5.13, C = .21, p < .05), bullying/mobbing (χ^2 = 15.01, C = .12, p < .001), and racial harassment (χ^2 = 4.35, C = .07, p < .05) than did females. The experience of verbal abuse and sexual harassment between males and females was not significantly different (p > .05).

2) <u>Age</u> Regardless to particular types of violence, younger personnel experienced violence more than did older personnel. Among the personnel aged between 20 and 44, the 20-24 years old group experienced violence significantly more than the 30-34, 35-39, and 40-44 years old groups (χ^2 = 6.85, C = .13, p < .01; χ^2 = 18.39, C = .22, p < .001; χ^2 = 11.19, C = .19, p < .01). The 25-29 years old group experienced violence significantly greater than the 35-39 and 40-44 groups (χ^2 = 8.99, C = .14, p < .01; χ^2 = 4.17, C = .10, p < .05). When each type of violence was considered, verbal abuse was the only type that showed significant differences among various age groups similar to the overall violence mentioned before.

3) <u>Marital Status and Ethnicity</u> It was found that there was no statistically significant difference in the experience of each type of violence across marital status, and ethnicity (p > .05).

4) <u>Psychosocial Backgrounds</u> According to the focus group interview among female practical nurses on November 30, the personnel were more likely to be victimized if they had weak personalities and poor working performances. Data from both interviews and questionnaires showed that lack of defence skills was factors contributing to physical assault. Quick-witted persons tended to escape attack. Some respondents held to the traditional view that some victims invited violence, especially where sexual violence was concerned. Their opinions were that the victims behaved or dressed provocatively.

3.1.2 Working Factors

Working factors that might cause workplace violence included work characteristics of individuals, workplace location, sectors of health settings, types of professions, as well as types and services of health settings.

1) <u>Work Characteristics</u> The subjects with fewer years of working experience were more likely to experience violence, especially verbal abuse, than those with more experience. The personnel whose working experience was less than 5 years experienced violence greater than did the personnel who had 16-20 and over 20 years of working experience (χ^2 = 10.13, C = .21, p < .01; χ^2 = 7.92, C = .17, p < .01). The 1-5 years group experienced violence greater than the 11-15, 16-20, and more than 20 years groups (χ^2 = 4.82, C = .10, p < .05; χ^2 = 14.95, C = .19, p < .001; χ^2 = 12.34, C = .16, p < .001). The 6-10 years group experienced violence greater than did the 16-20 and more than 20 years

groups ($\chi^2 = 9.29$, C = .15, p < .01; $\chi^2 = 6.90$, C = .13, p < .01). Occurrences of physical violence, bullying/mobbing, sexual harassment, and sexual harassment were not found to be related to different working experience. Age and working experience were related in the positive direction. The personnel who were young also had fewer years of working experience and tended to experience violence greater than the older personnel, who had more working experience.

The subjects who worked in shifts, worked between 6 p.m. and 7 a.m., and had physical contact with patients/clients were victimized significantly greater than those who did not ($\chi^2 = 7.94$, C = .08, p< .01; $\chi^2 = 18.45$, C = .13, p< .001; $\chi^2 = 7.84$, C = .09, p< .01). There was no significant difference between those who worked full-time, part-time, and temporarily; or those who had and did not have interaction with patients/clients (p > .05).

When each type of violence was considered, it was evident that the subjects were more at risk of physical violence if they worked in shifts, between 6 p.m. and 7 a.m., had interaction with patients/clients, and physical contact with patients/clients ($\chi^2 = 8.98$, C = .09, p< .01; $\chi^2 = 12.33$, C = .10, p< .001; $\chi^2 = 14.22$, C = .09, p< .001; $\chi^2 = 12.34$, C = .11, p< .001). Verbal abuse incidents were more prevalent among the subjects who worked in shifts, between 18.00 and 7.00, and had physical contact with patients/clients ($\chi^2 = 7.77$, C = .08, p< .01; $\chi^2 = 13.38$, C = .11, p< .001; $\chi^2 = 7.12$, C = .08, p< .01). Sexual harassment was significantly evident among those who worked between 18.00 and 7.00 ($\chi^2 = 4.71$, C = .06, p < .05). There was no statistically significant difference in the experience of bullying/mobbing and racial harassment across various working characteristics (p> .05).

2) <u>Workplace Location</u> The subjects who worked in suburban areas were significantly victimized greater than those who worked in rural and urban areas ($\chi^2 = 9.81$, C = .18, p< .01; $\chi^2 = 7.87$, C = .09, p< .01). There was no significant difference in cases of overall violence between urban and rural areas (p > .05). The bullying/mobbing incidents were significantly more prevalent in suburban areas than urban areas ($\chi^2 = 6.23$, C = .08, p< .05). Some interviewees claimed that many hospitals located in suburban areas had been protested by people due to the dissatisfaction with services. Another reason given was that there were several changes in policies and practices. One participant stated that many protesters were backed up by health personnel who disagreed with these changes[1]. The details are described in the section "3C Health Reform."

Health settings along the country borders are at risk from terrorism. On January 24, 2000, Ratchaburi hospital, a general hospital located on the border in central Thailand, was the locus of one such incident. Ten guerrillas from a neighboring country in which there is civil unrest invaded the hospital, holding patients and health personnel hostage, demanding health-care, medicines, and medical supplies (6). In the military operation which followed, the guerrillas were shot dead by the Thai security forces, but all other persons involved were freed unharmed. The government denounced this event as a violation of the international rule that health settings and health personnel were not to be harmed by wars or terrorism. This situation was also unethical since it involved patients.

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[1] A conversation on 5th December with a professional nurse working in a community hospital.

3) <u>Sectors of Health Settings</u> The subjects working in private non-profit organizations experienced violence significantly greater than those working in the private profit sector (χ^2 = 10.41, C = .21, p< .001), government sector (χ^2 = 10.14, C = .11, p< .001), and religious hospitals (χ^2 = 3.98, C = .16, p< .05). In non-profit organizations, the majority of the respondents worked as ambulance staff (56.3 %), the category of personnel who had a higher tendency to be victimized than other professional groups. Explanations are given in the subsection below - Profession.

Considering each type of violence, the subjects who worked in religious hospitals and in the government sector were more likely to be physically assaulted than those who worked in the private profit sector (χ^2 = 7.5, C = .17, p< .01, χ^2 = 14.63, C = .11, p< .001). Information obtained in this study was inadequate to explain these findings. For other types of violence, there was no significant difference.

4) <u>Profession</u> Ambulance staffs, mostly engaging in transferring patients, experienced verbal abuse and bullying/mobbing statistically significant greater than the following professional groups: auxiliary/ancillary, allied professions, dentists, pharmacists, nurse/midwives, and physicians. The staff of administration/clerk had a tendency to experience bullying/mobbing greater than those of the nurse/midwife, pharmacist, dentist, auxiliary/ancillary, and allied professions. The staff of support units – security, catering, kitchen, and maintenance- were also more likely to experience bullying/mobbing than some professional groups, such as the nurse/midwife, auxiliary/ancillary, and allied professions. Physicians and nurses/midwives experienced bullying/mobbing significantly more than did pharmacists (p < .05). Nurses/midwives had a tendency to experience overall violence greater than technical staff (p < .05). Compared with other professions, technical staff, pharmacists, and dentists were less likely to be victimized possibly due to the fewer interactions with patients/clients.

5) <u>Types/Services of Health Setting</u> Ambulance and hospital were the health/health-related settings where violent incidents took place significantly greater than other health settings, including health centers. Physical violence took place in rehabilitation centers significantly greater than in hospitals (p < .01), health centers (p < .001), and specialized centers (p < .05). Sexual harassment was more likely to take place in specialized centers than other health settings (p < .05).

3.1.3 Perpetrator Factors. Variables regarding types of perpetrators and places of violent incidents were collected through questionnaires and interviews. The opinions of the subjects about causes of workplace violence were obtained through open-ended questions in questionnaires and interviews. Based on content analysis, psychological characteristics of perpetrators were found to be salient contributing factors.

1) <u>Types of Perpetrators and Places of Violence Incidents</u> When gender was taken into consideration in connection with types of perpetrators and places of the violence incidents, there was only one statistically significant difference. That is, males were victimized by people in the general public significantly greater than were females (χ^2 = 9.74, C = .13, p< .01). There was no significant difference in types of perpetrators and places of the violence incidents across the following victims' characteristics: age, marital status, and ethnicity.

Almost all the professional groups were victimized mostly by staff members. Both nurses/midwives and auxiliary/ancillary staff had a tendency to be victimized by staff members more than by patients/clients and relatives but physicians were mostly victimized by patients.

The victims working in the position of staff were more likely to be hurt by staff members while those of line manager, were mostly hurt by patients. These findings can be explained by the fact that the majority of nurses/midwives and auxiliary/ancillary staff in this study were staff members while most of the physicians worked as line managers, who were hurt mostly by patients/clients.

Among 113 victims of physical violence, 97 (85.8 %) worked in hospitals, divided into 23.9 % working in psychiatric units, 14.2 % in specialized units, including trauma units, and 9.7 % in supportive units. Operating rooms and management units each accounted for only 0.2 % of the physical violence incidents. Data from focus group interviews among nursing personnel partly supported these findings. For instance, one participant was hit by a psychiatric patient while he gave bedside nursing and another participant witnessed a psychiatric patient hit his colleague[1]. The interviews also provided some explanation for the high rate of physical violence among these units. That is, males tended to provide services for aggressive and uncontrollable male patients in psychiatric units and trauma units. In addition, when there were cases with risk factors for violence, such as drug abuse, males would be requested to deal with those cases. Female nursing personnel, who worked in trauma units, were also at risk for physical assault. One participant told that she was slapped while she was trying to change the clothes of a drunken head-injured patient.[2] Another participant from the same interview group was kicked so hard in the chest while she was giving bedside nursing that she fell down. She could not remember the details since it happened several years ago. One participant worked in the emergency room said that he was hit more than once by drunken patients[3]. Some patients spited on him. His colleagues were hit as well. Most of them were males. The emergency room seemed to be the high-risk unit for physical violence because all of the aggressive and uncontrollable cases had to come to this unit first. However, from the questionnaires, there were only 2.7 % of the victims working in these units.

Approximately 84 % of the bullying/mobbing cases were reported by the personnel working in hospitals. Ambulance settings accounted for 8.5 % of all incidents. In hospitals, most of the victims of bullying/mobbing worked in the support and the psychiatric units, and general medicine. As with physical violence, most of the perpetrators were patients/clients (68.5 %). The particular characteristics of the patients/clients in these units might explain why male personnel experience bullying/mobbing more than females.

The subjects who worked between 18h00 and 7h00 and had interaction with patients/clients were at greater risk for violence inflicted by patients/clients and relatives than those who did not. The subjects who did not have interaction with patients/clients tended to be victimized by staff members.

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[1] A focus group interview of male practical nurses on November 26, 2001.
[2] A focus group interview of female practical nurses on November 30, 2001.
[3] A focus group interview of male practical nurses on November 26, 2001.

From the focus group interviews, it became apparent that physicians and nurses/midwives tended to be physically assaulted inside the workplace by patients suffering from psychiatric illnesses, neurological disorders, drug/alcohol abuse, and severe labor pain. Some violent patients, including those with brain injuries, acted unintentionally but some, such as women in labor, acted uncontrollable impulse. Some incidents inflicted by psychiatric patients were unanticipated. For instance, one practical nurse witnessed his colleague sitting talk with a psychiatric patient and then the patient hit him in the face without any clue as to reason.

Nurses/midwives working in suburban or rural areas had a tendency to be physically assaulted or verbal abused by drunken relatives[1]. The incidents were likely to take place during the visiting hours, 15.00 – 18.00, corresponding with the quantitative results.

In this study, most of the ambulance personnel volunteered for not-profit foundations[2]. Most of them were non-professional and did not receive formal training. They occasionally transferred patients with drug/alcohol abuse, and less frequently with psychiatric illness or neurological disorders, but were unlikely to be assaulted by patients/clients. The reason they gave was that they were skillful in approaching and restraining patients. However, one ambulance staff member was almost assaulted by a drunken man, who was watching him rescue a car-accident patient, out of anger for the late-arrival of the ambulance. At that moment, he was totally occupied with patient and not aware of what was happening. He would have been hurt if other people at the site had not protected him. The ambulance staff members were likely to be verbally abused by people in the general public for reaching the scene late. However, when they drove fast to the scene, they were also blamed for carelessness. They were often accused of stealing patients' personal belongings. In addition, they were frequently treated disrespectfully by health care providers.

2) Psychological Characteristics of Perpetrators The psychological backgrounds of perpetrators, especially of colleagues' and supervisors', were frequently in the focus group interviews and questionnaires as significant contributing factors at the individual level. The details are as follows:

2.1) Lack of emotional and moral maturity and control, anger management skills, stress releasing skills, communication skills, reasoning, justice, harmony, patience, compassion, consideration, and respect.

2.2) Psychological stress caused by working, as well as personal, economic, and family matters.

2.3) Feelings of inferiority, envy, "บ้าอำนาจ" or power-hunger, selfishness, "อัตตา" or ego-centricity, pessimism, and competitiveness. Some subjects wrote that greater power and higher positions made the supervisors to more likely to misuse their power by verbally abusing lower position staff.

2.4) Some subjects mentioned low education but some suggested that higher education did not prevent people from being violent.

2.5) A few subjects suggested that violence was a learned behavior. If nothing happened or perpetrators did not receive any punishment for their violent acts, they would repeat them and increase their severity.

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[1] A focus group interview of female technical nurses on November 20, 2001.
[2] A focus group interview of male ambulance staff on December 8, 2001.

2.6) Many subjects mentioned that most violent behavior was a habit or personality trait acquired in childhood. Some subjects called the violent behavior "สันดาน" or "*sundan*," innate and unchangeable behavior. Some attributed it to "สันชาตญาณดิบ" or primitive instinct.

3.1.4. Physical Environment

Another factor contributing to workplace violence is the physical environment. It seemed to be a significant factor for sexual harassment. One participant in a focus group interview conducted on 9th December told about a rape incident in an operating room. It happened at night, when many rooms were vacant and dark. Another participant was almost raped inside her bedroom in the hospital campus[1]. The perpetrator worked in the support unit and could gain access to bedrooms. Many participants in interviews and questionnaires mentioned that some pathways, especially from parking areas and dormitories to the hospitals, were dark, quiet, distant, and risky for sexual harassment and robbery. Some sexual assault incidents happened inside elevators at night. Telephone obscenities were also liable to be encountered, especially during the night shifts. Answering machines might be helpful but they were unavailable in many workplaces. Telephone obscenity was also commonly encountered in hotline services. Factors relating to noise, lighting, temperature, and overcrowded rooms of workplace were mentioned in a few questionnaires.

Rooms and furniture seemed to be indirect factors in the occurrence of physical violence in psychiatric units. One participant in the focus group interview of 26th November reported that many psychiatric patients used things available in their rooms, including chairs, to assault the personnel. Patients were not allowed to keep any weapons, but were checked only once during the admission procedures. Fortunately, no incidents with weapons were reported. Easy access to the exit was also essential as the same participant said that he always sat near the door while he interacted with psychiatric patients.

3.2. Organisational Culture

In addition to individual and environmental factors, organizational culture is possibly another influencing factor in workplace violence. Here, it includes policies and management practices of health settings, human resource management, and working distress.

3.2.1. Policies, Measures, and Management Practices of Health Settings

The availability of the policies regarding "health and safety" and "verbal violence" was reported on by more than half the respondents (Total Table 32). The other policies were reported on by less than half. More than half the overall violence victims reported that there were "security measures" and "improved surroundings" in their workplaces.

The experience of overall violence was not significantly differently affected by the availability of policies and various measures for preventing and controlling workplace violence (p > .05). However, it was found that incidents of physical violence incidents were more prevalent in the workplace in which a policy about physical violence was

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[1] A focus group interview of female technical nurses on November 20, 2001.

established (χ^2 = 3.89, C = .07, p< .05). Similarly, incidents of verbal abuse were found more in the workplace in which a policy about verbal abuse was established (χ^2 = 16.74, C = .14, p< .001). Considering each type of measure, it was found that overall violent incidents were more prevalent in the following conditions: the availability of protocols for aggressive patients (χ^2 = 8.09, C = .09, p< .01), increase in staff members (χ^2 = 4.39, C = .06, p< .05), reduced periods of working alone (χ^2 = 8.75, C = .09, p< .01), and personnel training (χ^2 = 4.27, C = .07, p< .05). These findings might be explained by taking into account the fact that the workplaces with high prevalence of violence were aware of the problem and more likely to develop policies and provide measures for preventing and controlling violent incidents. For instance, in a psychiatric hospital, nursing standards for caring for aggressive patients was available and acted upon. The details are described in Appendix D. An outpatient department for psychiatric patients of one hospital also faced with problems of violence (the focus group on 7th December). The guidelines for dealing with these patients had just been developed. After the implementation of these guidelines, it was observed that the situations improved and the personnel felt safer than before, according to the interviewee.

Where sexual harassment was concerned, the victims reported the improvement of the surroundings in their workplaces less than did the non-victimized subjects (χ^2 = 4.10, C = .07, p< .05). Qualitative data supported this finding as mentioned in the section on contributing factors.

When the patient in non-psychiatric units was potentially violent, the patient would be restrained or rarely kept in the isolation room. If there was an incident, the personnel often called for help from security guards and sometimes pretended to call the police. Physicians would be notified and tranquilizers would be administered. Although, these procedures were not well documented in some health settings, they were legitimated and commonly practiced among nursing personnel and physicians.

In the past, because there were no standard procedures, some personnel developed their own techniques. One participant told that he used to use the technique of "กั้นม่าน" or "closing the curtain" for the aggressive drunken patients (the focus group interview on 26th December). It meant struggling or hitting patients to subdue them. Although considered helpful and acceptable in his workplace then, at present this technique is no longer employed.

A physician who was falsely accused of malpractice by patients and their relatives and consequently transferred to another hospital, subsequently moved back to the same hospital[1]. He still confronted threats, mobbing, and verbal abuse from patients and relatives. His attempt to protect himself was by videotaping arguments with patients or relatives. In the same hospital, some nursing staff recorded audiotapes. The personnel considered installing videotape recorders in emergency rooms. Security guards were not helpful because they were often close to patients. A professional nurse said angrily that if the situation worsened, all 250 personnel of that hospital might have to demonstrate and even quit the job. This situation reflected the ineffectiveness of workplace violence management at organizational levels because the management aim focused only on satisfying patients, and maintaining working productivity, but ignored the issues of

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[1] Conversations with a professional nurse on 5th and 31st December.

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violence and occupational health. Unpunished perpetrators received what they wanted while victims received no protection but might also be punished. Consequently, the problems continued and got worse. The individual employees had to protect themselves and might become perpetrators.

When health personnel as perpetrators is concerned, in the government sector, the Civil Service Act may be applicable for workplace violence prevention and control in the health sector, as guidelines for punishment (7)(8). However, that the contents might not be specific or detailed enough is indicated by many subjects' comments on developing the particular regulations and management guidelines employed in their workplace. The details of the Civil Service Act are described in Appendix C. According to the criminal (3) and labor laws (9)(10), workplace violence committed by personnel or others can be dealt with legal punishment. The details are also available in Appendix C.

One participant told of her experience in dealing with a perpetrator who often verbally abused her and her colleagues (the focus group interview on 26th October). They all refused to interact or even to speak with that person. It worked and there was no negative consequence. In some verbal abuse cases, especially if the perpetrators were in high positions, the victims preferred to endure the situation and do nothing. Some victims developed personal relationships with the perpetrators to dissuade them from victimization. However, others were still victimized. It can be seen that violent incidents tended to be managed at individual levels by individual experience. Working organizations and existing regulations or laws were only partially applied and helpful.

3.2.2. Human Resource Management

It was found that physical violence incidents were more prevalent among the victims who reported that there had been a reduction in staff numbers in their workplaces ($\chi^2 = 6.13$, C = .08, p< .05). The incidents were less prevalent in the workplace in which resources were increased ($\chi^2 = 3.98$, C = .05, p< .05). These findings were supported by qualitative data mentioned in the next section. However, the experience of violence of overall and particular types was not significantly different due to the investment in human resource development such as training for career advancement, retreats, rewards for achievement, and promotion of the health environment (p> .05).

3.2.3. Sources of Distress/Discomfort in the Workplace

Distress in the workplace was reported as significant factor of workplace violence. In this study, data regarding sources of distress were obtained through questionnaires and interviews. They were summarized as follows:

1) Seniority and hierarchy is a tradition of Thai society and exists in all social units, including family and workplace. The manager of one private dental hospital, giving an interview on 1st October, suggested that workplace violence was connected to the Thai culture of seniority. Employees were unlikely to express their needs, opinions, and feelings to their employers or supervisors. Job stress and pressure thus accumulated and might incline employees to be violent. On the other hand, the passiveness of employees could lead employers or high-position personnel to victimize low-level personnel. The influence of seniority was mentioned in some questionnaires as well. At least one subject

suggested that administrators should be subject to election every four years rather than gaining positions through working seniority and holding them until retirement.

2) Job stress and insecurity due to patients' complaints was mentioned in both the interviews and questionnaires. Some subjects defined unreasonable complaints as psychological abuse because they substantially threatened their well-being. Many interviewees suggested that the dramatic increase in patients' complaints at present resulted from the declaration of patient rights, but patients and their relatives were not educated on how to request their rights in appropriate ways. Some patients/relatives misused their rights by threatening to make complaints if they did not receive what they wanted. Some patients/relatives protected their rights by employing violence through threatening, verbal abuse, and mobbing. Some complaints were unreasonable. Most of them were related to dissatisfaction with referral. For instance, some arose when patients' requests to be referred to tertiary care hospitals were refused because physicians considered them unnecessary. On the other hand, others arose because the patients whose requests were granted found were responsible for paying an excess fee. When there was a complaint, their employers tended to believe or protect the patients. A participant said angrily that health care providers were unfairly forced to deal with a conflict by the rules of "the patients are always right" and "do everything as requested by patients," and if ineffective, "repeat the former." She gave an example that the authorities decided to transfer a physician to another hospital as requested by the patients and their relatives, although that physician was not guilty of malpractice (the conversation on 5th December). Instead, it was the patients' misunderstanding. The authorities followed the request, aiming to stop the protest although it hurt the physician's feelings and threatened other personnel's security. At present, patients' rights were highly protected but health care providers' rights did not even exist, said the interviewee.

3) Workload and staff insufficiency were mentioned in many questionnaires as a contributing factor because they caused stress and conflicts. In addition, they could lead to poor quality of care, resulting in patient dissatisfaction and complaints.

4) Patients/clients were dissatisfied with the quality of care and poor physical environment and this put them and the personnel into conflict. Violence possibly took place if requests were not responded to. Many subjects mentioned slow and time-consuming services as frequently causing conflict. Illness and unexpected treatment were also sources of patient stress, occasionally expressed with anger and violence.

5) Stress from unfair treatment of employers and staff members as well as conflicts among the personnel were mentioned by many subjects.

6) Personnel, especially nurses, were in contact with a wide variety of people from different backgrounds, who had various complicated problems. These personnel needed a lot of social and life skills.

7) Low wages and little welfare was mentioned as sources of stress.

8) The personnel who were victimized might employ violence in self-defense or to relieve anger.

3.3. System Changes and Reforms

Changes and reforms in various systems are certainly essential and useful. However, they can bring chaos to individual personnel and organizations during the initial and transitional phases, as Thai people are facing now. In the health sector, personnel are all affected by health reform, changes in national health policies and practices, and civil service system reform. Political reforms and the current economic crisis also have some impact.

3.3.1 Changes in and Reforms of the Health System

In Thailand, health reform has been proceeding. Disease prevention, health promotion, and health services at primary level are the focus. In addition, the availability and accessibility of health services for all people, especially in rural areas are the priority. Health administration and management will be decentralized. Basically, local people will have more authority and responsibility for managing the primary health care settings in their communities. The line of organization of health centers and community health posts will be changed in that they might be governed by a sub-district administrative organization, under the Ministry of the Interior, instead of the Ministry of Public Health.

The Ministry of Public Health employs the system of formal evaluation and accreditation of hospitals for improving quality of care. Many main hospitals in both private and government sectors have worked for years to pass this evaluation. A great number of personnel have to work much harder before and during the evaluation phases. Many of them have to face several sudden changes in working. There have been substantial conflicts between subordinate and senior staff. Some interviewees reported that they were threatened by their supervisors if they were incapable of completing assignments on time. Another interviewee reported that a staff member had threatened to kill her/his supervisor for over-assignment (the in-depth interview on October 11).

In this year, there have been many sudden changes in the national health policies and practices, aiming to achieve the goal of health for all. Firstly, some registered nurses/midwives working in hospitals were sent to work in health centers, focusing on primary health care services, including physical examination and medical treatment for common health problems. Some of them do not have enough experience for their new roles and duties. One nurse told that she had to self-prepare and learn from her husband, a physician. She sometimes consulted her husband while she was on duty. This reorganization certainly created job stress and added to the possibility of interpersonal conflicts and violence in the workplace.

Secondly, some people were not satisfied with their obligation to go first to the primary health care settings available in their community if they wanted to pay less, because of the perception of unqualified services of those health settings. Consequently, some of them protested and threatened personnel in those health settings, as reported by newspapers.

Thirdly, it was found that the changed practice of health for all had caused organizational conflicts between one community hospital in a remote area and health centers in that area, and violence was employed as the way to resolve the conflict. One nurse working in that hospital said that there had been a protest against one physician who prescribed ORS for mild diarrhea in a patient instead of the intravenous fluid requested by

the patient's relatives (the conversation on 5th December mentioned before in the section on sources of distress). The protesters forced the hospital director to transfer that physician. Although physical violence did not happen in the protest, it nevertheless threatened the personnel's well-being and disturbed their working. The nurse added that the actual cause of the protest was the resentfulness among the health center personnel towards physicians and nurses/midwives who were sent to work in their health centers and had changed the existing working system.

Finally, there had been changes in budget management in the government hospitals. In the past, hospital payment was totally supported by the government. At present, according to decentralization policy, hospital payment is derived from government support and the hospitals' other incomes. Hospital finance management is more business-based. If hospital income and payment are not balanced, the hospital has to be responsible for the deficit. Consequently, personnel's incomes will be reduced to balance excessive expenditure. In addition, there is the phenomenon of 'scrambling' for patients.

3.3.2. Civil Service Reform

In addition to health reform, some hospitals in the government sector, especially the large ones, have been being reorganized according to the reform of the civil service system. These hospitals have more authority and self-dependence. The number of personnel employed is being reduced by the policy and practice of early retirement. In the next few years, personnel will obtain higher salaries but their welfare will be reduced and their working performance must be highly improved. These changes certainly threaten a great number of health personnel.

3.3.3. Political Reform

In the latest Constitution, enacted in the year 1998, people's rights are given more emphasis than before. As a result, patients' rights have been given a higher status and protected by health professionals. In conjunction with the policy of improvement of quality of care, protection of patients' rights had become the first priority of various hospitals. Some patients misuse their rights or seek to enforce their rights by employing violence against health care providers as mentioned before. Some participants stated that the rights of the patients were protected while those of personnel were ignored.

Currently, people vote for sub-district administration organizations. In 2001, it was the first time senators were directly elected by people instead of appointed by the House of Representatives. People have more political power than before, especially if they can influence the election. Some people are backed up by politicians and misuse their power to fulfill unreasonable demands by the use of violence. The law of the jungle law and the use of illegitimate power exist in some communities.

3.3.4. Economic Crisis

Thailand has been facing economic crisis for more than five years. This problem directly affects individual personnel's lives and well-being. It has also led to several changes and reforms in various systems mentioned above.

4. Effects and Impact of Violence at Work in the Health Sector

In this study, the impact of workplace violence on individual employees as well as the organizations and society was explored.

4.1 Impact on the Individual Employee /Worker

4.1.1 Consequences for Physical/Psychological Health and Working

1) <u>Physical Injuries</u> Among 109 subjects who were physical assaulted, 30 (27.5 %) had injuries and 8 (7.0 %) needed medical treatment. Among 104 victims, 9 (8.7 %) needed time-off. Time-off for one day, 2-3 days, one week, and 2-3 weeks were reported by 1, 5, 2, and 1 victim (see Total Table 26).

2) <u>Post-Traumatic Stress Disorders</u> The majority of the victims of overall violence developed "disturbing memories" and "avoiding thoughts" at the "a little bit" level (Total Table 25). Physical violence, verbal abuse, and bullying/mobbing had impact on "super-alert symptoms" at the "moderate" level while sexual and racial harassment had a lower impact. The majority of the victims of any types of violence reported that they did not experience "perception of everything as effort." One subject reported that she was verbally abused all the time by her colleague and bosses. She wrote down in the questionnaire that "ฉันกำลังใกล้จะบ้าแล้ว." It meant that she felt very stressful and she was getting mad and burned-out.

Being victimized is a painful experience. However, its effects varied according to various factors. For instance, during clinical practice, 4 nursing students were verbally abused for 2 hours by one particular personnel member. One student felt very depressed for days and kept telling herself that it was her fault, while the other three students coped with it well. This incident happened while the researcher was supervising them in clinic on 24th October.

The severity of the symptoms displayed in the data derived from the questionnaires mentioned above seems to be mild. These symptoms are commonly found among the victims of traumatic situations such as rape, disaster, and war. In this study, the violence incidents might not be severe enough to display high impact. The incidents might have happened long enough ago for the victims to cope with it. In addition, based on the interviews, the personnel were unlikely to feel stressful if the perpetrators were patients. If such cases, they were able to get through it easily by forgiving the patients and thinking in positive ways that the patients acted unintentionally. Where violence incidents were inflicted by colleagues, most were verbal abuse and took place from time to time. These incidents might not be traumatizing. It is suggested that some common psychological symptoms with less severity, including anxiety, depression, guilt, shame, and anger, might be more observable than post-traumatic stress symptoms.

3) <u>Common Emotional Problems: Depression, Shame, Guilt, Fear, Anxiety, and Anger</u> Personnel working with psychiatric patients stated that they felt discouraged,

anxious, frustrated, resentful, angry, uncertain, unsafe, and unhappy (the focus group on October 30). Based on a focus group interview conducted on 20th November, one female participant had almost been raped in her bedroom in the hospital dormitory by an external colleague. She kept asking if she seduced the perpetrator and caused the incident. It indicates the feelings of guilt and self-blame. The same incident happened to her colleague later. The incidents were reported to the police but nothing happened. She felt very scared and had to be transferred to another hospital. She further stated that the turnover rate of the personnel in that hospital was very high. Another participant interviewed on 30th November had been touched on her private parts once, sexually and verbally harassed once, and slapped once by patients. She was upset but she could cope quite well. She gave the reasons as being that the patients were confused with head injuries and that the incidents were common and happened to many personnel, including her supervisor. However, she really wanted to transfer to another section. One participant working in a health center in a remote area was scared to sleep there alone in the house provided. In addition, she was sexually touched by a colleague. She also wanted to transfer.

Sexual harassment also negatively affected male personnel. One participant was sexually touched by a female psychiatric patient (the interview on 26th November). He was very worried that his colleagues might misunderstand, thinking that it was he who had misbehaved. The negative impact of workplace violence on working were also found in quantitative data. That is, the victims of overall violence and verbal abuse reported that working situations for staff in their workplace were getting worse ($\chi^2 = 8.23$, C = .09, p< .01; $\chi^2 = 7.43$, C = .09, p< .01). However, the improvement in the quality of care was reported by the victims of overall violence rather than the non-victims ($\chi^2 = 4.42$, C = .07, p< .05).

4.1.2 Impact on Migrant and Other Health Personnel

Almost all the subjects were ethnic Thai. In this study, violence incidents among minority groups were too rare to evaluate their impact on migrant health personnel.

Workplace violence had both positive and negative consequences. Positively, compassion, caring, and the sense of unity could develop among the victims and their colleagues (the focus group interview on October 30). Negatively, some colleague "สมน้ำหน้า" or thought that the victims deserved it.

Several emotional problems experienced by the victims mentioned above might also be experienced by colleagues who witnessed the incidents, especially if they had close relationships (the focus group interview on 6th October). Some participants said that it seemed like the incidents occurred to them. One participant said she was afraid that she might "ถูกลูกหลง" or be assaulted by accident for being in the situation. The consequence of psychological stress was poor performance in working.

4.1.3 Gender Issues

In Thailand, health professions, especially in nursing, interest a number of gay males. Homosexuality is somewhat accepted among Thais but not widely among professionals. A great number of gay health personnel have to conceal their sexual orientation but some prefer to disclose it. One male participant considering himself female, giving an individual interview on November 30, stated that he felt very upset in

that his supervisors did not accept him as female. For instance, they blamed him for having long hair and wearing making-up. His painful feelings had developed since he was a nursing student because self-expression as a female was forbidden by the regulations of the school. He was very depressed to be forced to have short hair like males. He said that that appearance was not himself. However, he got through it because of the good support from his academic advisor. As a member of the nursing staff, he was sometimes sexually harassed by male colleagues but never by patients. He said that patients never rejected or disrespected him. His colleagues also respected him.

4.2 Consequences for Organizations and Society

The president of the association of one profession stated that workplace violence not only affected personal lives and the work performance of individual victims, but was also reflected in the problems of the organizations and the professions (the interview on 1st October) themselves even though the personnel were the victims not the perpetrators. Those organizations and professions would lose their good professional reputations for inability to prevent the incidents and to protect their members. The more incapable the profession was, the more power it lost, and the more violence the personnel experienced. One participant, who experienced and witnessed substantial verbal abuse incidents, expressed her opinion that being victimized by other professional groups meant being dominated by those professions, and seeing the dignity of the victims' profession destroyed (the conversation on December 31). All such incidents created obstacles for professional progress and development.

5. Individual, Institutional, and Systematic Responses towards Violence

5.1 Coping Strategies of Victims / Witnesses

"Telling colleagues" and "pretending that nothing happened" were the most common individual responses towards any types of violence, and they were reported by 41.4 % and 38.5 % of the victims (Total Table 23). Almost 28 % of the victims reported the incidents to their senior staff members, but only 8.3 % of the victims completed the incident form. Seeking counseling was reported by 22.7 %. Seeking help from associations or unions, prosecution, claiming for compensation, and transferring to other jobs were uncommon. "Telling friends/family" was prevalent in sexual harassment. "Transferring to other jobs" was found to follow verbal abuse and bullying/mobbing.

5.2 Reporting Procedures

The availability of the procedures for the reporting of violence in the workplace and the encouragement to report the incidents was commented on by the subjects who were victimized significantly more than by those who were not (χ^2 = 5.51, C = .07, p< .05; χ^2 = 15.27, C = .12, p< .001). The statistically significant differences were also found in the cases of verbal abuse and bullying/mobbing. However, the availability of reporting procedures was commented on less by the victims of sexual harassment than by the non-victimized subjects (χ^2 = 4.27, C = .07, p< .05). The majority of the victims of overall violence reported that investigation (63.4 %), verbal reporting (72.5 %), and completing the incident form (91.7 %) were not pursued. Among 150 subjects who witnessed physical violence, 64 (42.7 %) reported the incidents. It was found that reporting the incidents did not have negative impacts on the reporters.

Data from focus group interviews showed that reporting procedures were mostly limited to the incidents of patients/clients victimized by the personnel or the mistakes committed by the personnel. Consequently, many personnel had negative attitudes towards completing the incident form. In the accident/incident form of one hospital, the incidents of patients/clients and the personnel were put on the same form but almost all details were related to the patient/client incidents. In addition, there was no particular authority responsible for the violence cases. When there was an incident, it would be managed by supervisors or the person in charge of that unit. Occasionally, an ad hoc committee was set up to investigate a particular case. Most of the participants who were verbally abused by patients or their colleagues were less likely to report their supervisors. There was only one participant, who was verbally abused by a personnel member from another department, that completed the form and requested that the perpetrator make an apology (the focus group interview on 26th October). This case was handled by the supervisors of the victim and the perpetrator. Another case was also related to verbal abuse but the victims involved a professional group in one unit (the focus group interview on 7th December). The perpetrator used verbal abuse against a particular professional group on the internet accessible by all personnel. The senior staff of the victims were informed and investigation was performed by themselves. The incident was reported to the perpetrator's supervisor and the perpetrator made an apology. The incident was not documented and the incident form was not completed. In some cases, victims wrote anonymous letters and this method worked. It was found that one perpetrator was transferred to another workplace and another was investigated and consequently he/she quitted his/her job (the conversation on 31st December).

In some hospitals, if a patient harmed or assaulted the personnel, the incident would be recorded on the patient record. If the incident was recorded on an incident form, the in charge person was the one who completed the form instead of the victim, and the victim would sign it.

Although 60 % of the subjects reported that there was encouragement to report violence incidents in their workplaces, the findings from the interviews reported about contradicted this figure.

5.3 Investigation, Prosecution, and Other Interventions

Approximately 37 % of all reported violence incidents were investigated. Among the investigated cases, 44.4 % of the victims reported that there was no action taken against the perpetrators (Total Table 24). Approximately 37.0 % of the perpetrators received verbal warnings. Only one perpetrator received care discontinuation for physical assault. Approximately 3.2 % of the victims reported that the incident was reported to the police and the case was prosecuted. Approximately 49 % of the physical violence incidents and 50 % of the bullying/mobbing incidents were investigated. Most of the perpetrators receive verbal warnings. Two perpetrators of physical violence were reported to the police and three were prosecuted. The cases of verbal abuse and sexual harassment were less investigated, 30 % and 19 % respectively. Three out of 8 of the racial harassment cases were investigated. None of the sexual and racial harassment cases were prosecuted. From the interviews it was learned that, one of the rape case was reported to the police but nothing happened to the perpetrator and he continued to worked in that workplace (the focus group interview on 20th December). The participant explained that

the perpetrator had so much influence in the area that the hospital director could not handle it.

5.4 Rehabilitation of Victims

Almost 62 % of the physical or psychological victims received counseling services. The majority of the victims (37 %) were satisfied with the offered services at level 3 (level 1 = very dissatisfied, and 5 = very satisfied). From the interviews, the services were mostly informal and provided by supervisors or colleagues rather than professional counselors or therapists. One rape victim developed psychiatric symptoms. She was transferred to another department and received psychotherapy. At the time of this study, her condition had not improved. The participant who had almost been raped suggested that psychotherapy should be available for the sexual violence perpetrators as well. Particular services for the victims and perpetrators were unavailable in various workplaces. Initiation of group or institutional activities or building networks among the victims were not mentioned in the interviews or the questionnaires. However, coping techniques of telling the incidents to friends, family, or colleague were commonly practiced and might have had some therapeutic effect.

6. Anti-Violence Strategies

In this part, the contents focus on existing measures for violence prevention and control in various hospitals, existing policies and regulations for workplace violence, and prevention strategies recommended by the sample.

6.1 Existing Measures for Violence Prevention and Control at Hospital Levels

Among various measures for workplace violence prevention and control explored in this study, the availability of security measures and improvement of workplace surrounding were reported the most. The availability of security measures was reported by 82.0 % of the sample and 82.3 % of the victims. It was found that 77.0 % of the sample and 76.9 % of the victims reported that there were improvements in workplace surroundings. The measures of patient screening, patient protocol, restricted public access, investment in human resource development, special equipment/clothing, and training were reported by 31- 42 % of the sample and 31- 45 % of the victims. The measures of increased staff number, changing shifts, check-in procedures, restricted cash exchange, and reduced periods of working alone were reported by less than 20 % of the sample and the victims. Only 5.2 % of the sample and 6.0 % of the victims reported that no measures were adopted in their workplaces. Additional information about various measures obtained through interviews was as follows:

1) <u>Security Measures.</u> In large hospitals located in urban areas, the police were on stand by in emergency rooms. The police routinely patrolled community hospitals located in various districts. Security guards were available in all hospitals. However, some interviewees did not have much confidence in their ability to handle violent situations.

2) <u>Restricted Public Access</u> In general, offices of the government sector, including health settings, are restricted areas but members of the public are eligible to enter. In many large hospitals and community hospitals, there were security guards on duty at the hospital

entrance. However, from the researchers' observation, the traffic, especially during the peak hours, was so jammed that screening for perpetrators was unlikely done. Instead, most of their time was spent on traffic arrangement. Only in the hospitals under the Ministry of Defence and the Police Bureau, there was a routine check for identification at the entryways. If there was any suspect, the hospitals were able to refuse the entry.

3) Improving Workplace Surroundings Workplace surroundings were likely to be improved after incidents had occurred as one participant stated "วัวหายแล้วล้อมคอก" or "building a shed following the loss of cows" (the focus group interview on 26th November). For instance, after a rape incident at one hospital, the lights were on at that spot and there was a security guard on duty during the shift change. However, at the time of interview, there was no security guard available there. In an attempted rape incident in another health organization, protective balustrades were built for all bedrooms.

4) Protocols for Dealing with Aggressive Patients The Department of Mental Health, the Ministry of Public Health, provides the protocols for dealing with aggressive patients. A screening protocol is also available but is not detailed enough. It was found that psychiatric hospitals followed these protocols. The out-patient psychiatric unit of one large hospital had never had any protocols until this year when the based on those recommended by the Department of Mental Health were adopted. After the employment of the protocols, one nurse stated that the incidents of violence in her clinics diminished.

The Department of Social Welfare, the Ministry of Labor and Social Welfare, sets up the rules for care of the elderly admitted to the Home for the Elderly. Those admitted are mandated to follow these rules and are required to sign the consent before admission. Among the 18 items of these rules, four are directly related to violence prevention and control. That is, it is prohibited to speak rudely, to get into quarrels with others, to make noise disturbing others, and to have sexual relationships. Another two items are indirectly related. That is, it is prohibited to abuse drugs and alcohol, and to keep weapons and fuel. If the elderly break the rules, they will receive verbal warnings. For the second or third time, allowance (money or materials) will be reduced or suspended. If there is fourth time, they will be transferred to other buildings or other institutes. The maximum punishment is ineligibility to live in any homes.

5) Patient Screening Screening procedures for aggressive patients were available only in psychiatric units. In non-psychiatric units, including the units at risk from physical violence, there were no written guidelines and screening was not a routine practice. Individual personnel had to be alert and watchful depending on their own knowledge and experience. Reminding others of previous violence was sometimes practiced. However, it was not a routine practice and was limited to personnel who were closed.

6) Check-in Procedures for Staff These procedures were not commonly practiced and were infeasible during family visiting hours. Several years ago, a man pretended to be a doctor by putting on a gown, passed the security guards, and raped a patient in one of the patient units. After this event, all personnel who entered patient units were required to put on their identification cards and security guards became more alert.

7) Restricted Exchange of Money Although Thais prefer to purchase by cash, no incidents of hospital robbery have yet been reported.

8) <u>Uniforms</u> Most of the personnel working in health settings, including nurses, health workers, and security guards, wear uniforms. Senior staff members of the medical profession rarely wear their uniforms. They sometimes put on white gowns. Most of the personnel working in health-related settings, such as the Home for Elderly and shelters, do not wear uniform.

9) <u>Training</u> New staff members of large hospitals were formally oriented and trained in safety and accident prevention. The topics included skills for defense against physical assault. However, there was no particular training about workplace violence. Skills for conflict resolution and communications were rarely included.

6.2 Existing Policies and Regulations for Violence Prevention and Control

The issue of workplace violence in the health sector is not mentioned directly in the ministerial orders of the Ministry of Public Health. Based on the findings of this study, there is no particular policy or regulation regarding workplace violence in any hospitals. When there is an incident, management will follow the regulation for civil servants regarding the issue of misconduct. Punishment for misconduct is stipulated clearly in the Civil Service Act. It is mandated for supervisors to investigate such cases. Since workplace violence is not well conceptualized and understood, existing management practice might not be fair or helpful to the victims.

In addition to the Civil Service Act, the labor law and the ministerial orders of the Ministry of Labor and Social-welfare can be applied to workplace violence prevention and control. The Department of Welfare and Labor Protection, the Ministry of Labor and Social-welfare, provides some recommendations on long-term management of safety, occupational health, and workplace surroundings (11). There is no recommendation on management of workplace violence. In the labor protection law, there is one item applicable to workplace violence in the health sector. That is, in order to protect the health and safety of female employees who work between midnight and 6 a.m., in article 40 of the labor protection law enacted in 1998, employers are mandated to change working hours if working as such a time has negative impact (9)(10).

Under the criminal law, physical assaults, libel cases, obscene acts, and rape are criminal. Under the labor law, sexual harassment is criminal only if the perpetrator is a male employer and the victim is a female employee. Please see details in Appendix C. Many people preferred not to be involved in criminal or civil cases because the procedures are complicated and take much time. In addition, many people are not able to access to legal information and services.

In the government sector, if perpetrators are government servants, the regulation for civil servants can be applied, especially in terms of punishments. In the non-government sector, the victims can request investigation from councils and associations. The Lawyers Council also provides legal services for people who are not civil servants.

6.3 Prevention Strategies Recommended by the Subjects

6.3.1 Direct Measures for Violence Prevention and Control

1) Security was frequently referred to sufficient numbers of security guards should be available to dangerous areas and periods. They should be well trained regularly in handling violent situations. It was found that some of them became perpetrators. The subjects recommended that the procedures for recruiting guards include violence-prone screening.

2) Improved surroundings and the creation of safe environments were also recommended. For instance, adequate lighting should be provided along workplace pathways, especially in dangerous areas, and utilized during the shift-changing periods.

3) Some personnel working in remote community health posts, where security guards were unavailable, suggested that portable radios or telephones should be provided for all personnel, not only for the heads of the posts. For the areas too far to communicate via radio and telephone, the workplaces should be located near key villagers. Since personnel needed to count on the villagers, they should be trained in making good relationships with them and learn how to contact them for urgent help.

4) Provision of safe transportation for health settings located in isolated areas, especially at night. In problematic areas, changing the shifts from 16.00 – 24.00 to 6.00 – 18.00 was suggested.

5) Violence-prone screening should be practiced in personnel recruitment. Training for personnel should be provided regularly. The main objectives were to prevent personnel from being either the victim or the perpetrator. Training topics should include a skills for communication, relationship development, stress and anger management, emotional control, conflict resolutions, and self-defense. Ethical and moral development should be integrated in all training sessions. Violent personnel should be transferred to non-human-contact units.

6) Screening procedures and patient guidelines needed to be established in non-psychiatric units.

6.3.2. Organizational Policy and Management

1) Regulations, rules, strategies, and policies for workplace violence prevention and control should be developed and rigorously applied. Alcohol and drug abuse should not be allowed. Punishment for perpetrators should be high and seriously practiced. Victims should receive reasonable compensation, such as vacations, treatment fees, salary promotion, or pension. Health services for both victims and perpetrators should be provided. According to the focus group interview on 26th November, the male practical nurses made some interesting suggestions, saying they were unable to avoid victimization as long as they confronted uncontrollable patients/clients. They acknowledged these problems and said they were able to cope with them. However, they begged their employers to increase their wages and welfare as compensation for their risks. In addition, they suggested to setting up a hospital bursary to provide compensation for each violence incident, since it was impossible to claim from patients.

2) There should be particular persons responsible for workplace violence cases in each health setting. Networks should be developed among authorized persons and related-professions, such as policemen and lawyers.

6.3.3. Measures for Reducing Contributing Factors

1)   Since managers/supervisors/employers were both the problem and the solution in many cases, many subjects suggested only good, kind, fair, and smart ones should be engaged.

2)   Improved working systems were recommended in order to reduce conflicts and stress and increase quality of services and patients' satisfactions. This would solve the problems of work-overload and staff insufficiency.

3)   Improving the workplace atmosphere and cultivating a non-violence tradition were suggested. Social and recreational activities among personnel were suggested. Counselors for private and working problems should be provided.

4)   Improved relationships between employers, and or senior and subordinated staffs and staff members was also worth working for, recommended the respondents.

5)   Senior staff members or employers should always be accessible for reporting incidents.

D. Conclusions

In this study, more than a half of the health personnel experienced workplace violence in the previous year. Verbal abuse was the most common type while racial harassment was the least common. The greatest number of victims were females. However, males had more tendencies to experience violence, especially physical violence, bullying/mobbing, and racial harassment, than did females. Personnel who were at risk for workplace violence were those who were young, had few years of working experience, worked in suburban areas, worked in shifts and at night; and had interaction and physical contact with patients/clients. The majority of perpetrators were patients/clients, relatives of patients/clients, and colleagues. Psychiatric patients and drug/alcohol abuse patients, those with head injuries, and in severe pain, were most likely to be violent and abusive. Physicians and high-position personnel were likely to be victimized by patients while staff members tended to be victimized by their colleagues.

The psychological characteristics of perpetrators were seen by the subjects to be significant contributing factors. Stress from work-overload and substantial changes due to reforms in the health management and civil service systems were other factors. At the time of study, there was no particular regulation for violence prevention and control. Guidelines for dealing with aggressive patients were available only in psychiatric units/hospitals.

E. Recommendations

Workplace violence is perceived by health personnel as a private matter. This problem is "ภัยเงียบ" or "a hidden danger," the term employed by Dr. Kritiya Archawanijakul reflecting the fact that domestic violence in Thai society is largely ignored. Legitimating workplace violence as a health problem of employees is the

precursor for fighting this problem. Raising awareness as well as building authentic understanding and positive attitudes among health personnel at all levels is the initial strategy. All stakeholders and related-organizations, including the Ministry of Public Health, the Ministry of Labor and Social-welfare, as well as the councils and the associations of various health professionals, should be targeted as well. There should be movements to put this issue into the recommendations on safety, occupational health, and workplace surroundings provided by the Department of Welfare and Labor Protection, the Ministry of Labor and Social-welfare. The messages describing the locuses of workplace violence, the causes and contributing factors of workplace violence, the impact of workplace violence on individual employees and organizations, and on the quality of services, as well as the burdens and demands imposed on employees, should be disseminated. This can be achieved through professional publications, workshops, seminars, conferences, campaigns and exhibitions particularly in November - the month against violence - as well as during orientations of new staff, in-service education, and continuing education. This topic should be included in undergraduate and graduate programs of health sciences. The master programs of occupational health should include the topic of workplace violence in general.

Instead of the traditional practice of "building a shed following the loss of cows," prevention of violence in the workplace should be a priority. Regulation for workplace violence prevention and control in the health sector should be developed at national and organizational levels. Human resources and budgets should be allocated. Regular improvement of workplace surroundings should be emphasized, not only for violence prevention but also for improving working the atmosphere and employees' health overall. Security guards should be adequate in respect of quantity and quality. Protocols and procedures for patient screening and dealing with violent patients or relatives should be developed, especially in high-risk units.

The institution of prevention programs in each health setting should be encouraged and supported. The program target groups should include both male and female staff, especially juniors and those who have few years of working experience. These programs can be implemented through the establishment of particular programs for violence prevention or integrating them into existing workplace health promotion programs. Program activities should included training in social and life skills, stress and anger management skills, as well as in particular skills for resolving interpersonal conflicts and dealing with violent persons and situations. The incidence of workplace violence should be monitored continuously at national and organizational levels.

There should be particular persons or committees responsible for workplace violence cases, including surveillance and monitoring, documenting, investigation, victim compensation, assistance for victims and perpetrators, and perpetrator punishment. The committee should be sensitive to this problem and knowledgeable in all aspects of workplace violence, especially its causes and its impact on individuals and organizations as well as regulations and legal information association with it. Workshops for these committees are recommended.

Reporting the incidents should be encouraged. Procedures for reporting should be practical and feasible. More importantly, positive attitudes toward reporting must be developed among health personnel. That is, the message of the aim of improving personnel's well-being instead of giving punishment should be made clear. Incident forms

should be available and accessible. Anonymous letters will be an option if the personnel do not trust the reporting procedures.

The procedures for investigation and management, including punishment for perpetrators and support for victims, should be developed in concrete ways. Existing regulations in the Civil Service Act as well as existing labor laws and criminal laws should be applied as punishment guidelines. Health services for both victims and perpetrators are essential. Compensations for victims should be provided fairly. Measures adopted for prevention is another issue. They should include direct measures for violence prevention and control, and measures for reducing contributing factors, as mentioned before.

Reference

(1). Charoenwongsak, K. (1997). Moral decline: From 'land of smile' to 'land of violence,' <u>Bangkok Post Perspective</u>, June 1, 1997, 1-5.

(2). Ghosh, C. (1990). <u>The world of Thai women</u>. Calculta: Best Book.

(3). Nilthongkum, P. (1992<u>). The Civil and Commercial Code and the Criminal Code</u>. Bangkok: Chuanpiss Publishing.

(4). Ekachai, S. (1997). Women's health: Sick of inequality. <u>Bangkok Post Outlook</u>, May 28, 1-12.

(5). Denduang, N. & Tharawan, K. (1999). Health and safety of women in working, In P. Boonmongkol, N. Sunhajariya, & S. Ruangsaun (Eds.), <u>Reconstruction of Women's Thought and Health </u>(pp. 317-349). Nakornprathom: Gender Press.

(6). <u>The Bangkok Post</u>, January 25, 2000.

(7). <u>The Civil Servant Act, 1992 and the Civil Servant Act for University Affairs, 1964</u>. Documents for the seminar on "Guideline for Discipline, Personal Belongings, and Debts among Government Servants" held on November 27-29, 1996 by Chaingmai University.

(8) <u>Guideline for punishment</u>. Documents for the seminar on "Guideline for Discipline, Personal Belongings, and Debts among Government Servants" held on November 27-29, 1996 by Chaingmai University.

(9) Wilawun, K. (2001). <u>The Labor Law</u> (4th Ed.). Bangkok: Winyuchon Publication House.

(10). <u>The Labor Protection Act, Enacted in 1998</u>. Pathumthanee: Skybook Company Limited.

(11). The Department of Welfare and Labor Protection, the Ministry of Labor and Social-Welfare. (1999). <u>The management of safety, occupational health, and workplace surroundings</u>.

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